DUDLEY CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE

MINUTES OF THE MEETING HELD IN PUBLIC ON
FRIDAY 27th MARCH 2020
MEETING HELD VIRTUALLY

Quorum:
A meeting of the Committee will be quorate provided that the following are present of which one must be either the Chair or Vice-Chair of the Committee, one must be the Chief Finance Officer or Chief Nurse or their nominated representatives and one must be the Secondary Care Clinician or another Lay Member

ATTENDEES:

Voting Members

Mrs H Mosley	Non-Executive Director for Patient and Public Involvement, Dudley CCG (Chair)
Prof C Handy	Non-Executive Director, Quality and Safety, Dudley CCG
Mrs C Brunt	Chief Nurse, Dudley CCG (Part)
Mr A Johnson	Secondary Care Clinician, Dudley CCG
Dr D Pitches	Consultant in Public Health, Dudley MBC (part)

Non-Voting Members

Mrs J Emery	Chief Officer, Healthwatch Dudley
Mr P Cowley	Senior Finance Manager - Primary Care, Dudley CCG
Mrs J Robinson	Primary Care Contracts Manager, Dudley CCG
Mr D King	Head of Membership Development & Primary Care, Dudley CCG (part)

Minute Taker:

Miss T Fear	PA to the Head of Membership Development & Primary Care, Dudley CCG

No members of the public in attendance.

Committee were advised that the meeting was not quote as the Chief Finance Officer or Chief Nurse were not present.

1.0 APOLOGIES FOR ABSENCE

Apologies were received from;

Voting Members

Mr T Allen	Non-Executive Director for Governance, Dudley CCG
Mr J Smith	Head of Financial Management (Representing Mr M Hartland), Dudley CCG

Non-Voting Members

Mr T Thomik	Dudley LPC Representative
Mr D Stenson	Patient Opportunity Panel Representative
Mrs J Taylor	Primary Care Commissioning Manager, Dudley CCG
Dr T Horsburgh	Clinical Executive for Primary Care, Dudley CCG/LMC Representative

Not present

Mr. B Dhami	Senior Contracts Manger (Primary Care), NHS England and NHS Improvement – Midlands
Mrs A Nicholls	Deputy Head of Commissioning (Primary Medical Care), NHS England and NHS Improvement – Midlands
Dr A Malik	CCG Clinical Lead and GP, Dudley CCG

2.0 DECLARATIONS OF INTEREST

To request members to disclose any interest they have, direct or indirect, in any items to be considered during the course of the meeting and to note that those members declaring an interest would not be allowed to take part in the consideration or discussion or vote on any questions relating to that item.

The Chair confirmed that a review of the Conflict of Interest register and any potential Conflict of Interest from the agenda items had taken place.

Resolved:

1) **Committee noted no changes were made to those listed.**

3.0 QUESTIONS FROM THE PUBLIC

Mrs. Mosley noted that there were no questions submitted to Committee prior to the meeting.

Resolved:

1) **Committee noted that there were no questions submitted prior to the meeting.**

4.0 MINUTES OF THE LAST MEETING

The minutes of the meetings held on Friday 28 February 2020 were submitted to Committee.

Committee noted that the minutes relating to the meeting held on Friday 28 February 2020 were agreed as an accurate record of the meeting.

Resolved:

1) **Committee approved, the minutes of the meeting held on the Friday 28 February 2020 were an accurate record of the meeting.**

5.0 MATTERS ARISING/ACTION LOG

The action log was discussed and updated accordingly with the following points noted:

PCCC/JULY/2019/8.0 — GP Engagement Scheme

Committee noted the on-going work in relation to the GP Engagement Scheme. **The action was deferred to May 2020**.

6.0 PRIMARY CARE OPERATIONAL GROUP REPORT

Mrs Robinson spoke to this item to update Committee following the Primary Care Operational Group meetings held on 5 February 2020 and 4 March 2020.

The Primary Care Operational Group received seven Contract Variation applications;

- Waterfront Surgery in relation to the addition of a GP Partner effective 1 February 2020.
- Lower Gornal Medical Practice in relation to the 24 hour retirement effective 1 August 2020.
- Rangeways Road Surgery in relation to the resignation of a GP Partner effective 1 May 2020.
- Wordsley Green Surgery in relation to the addition of a GP Partner effective 1 April 2020.
- Coseley Medical Practice in relation to the resignation of a GP Partner Effective – 20 June 2017.

Committee were advised that the contract variation received from Steppingstones Medical Practice in relation to the resignation of a GP Partner effective 7 July 2020 had since been withdrawn.

It was highlighted that the variation to the Coseley Medical Practice contract was retrospective. Committee were advised that the partners had been made aware of the implications and have accepted the risks, which

included financial implications, where clawback may arise, and that the outgoing partner would not be held responsible for issues relating to the GMS contract after the date.

Although all present voting members approved the contract variations, a formal recommendation could not be approved as the meeting was not quorate. It was agreed that this would be formalised when the Chief Nurse joined the meeting or electronically if she was unable to do so.

PCOG received a summary of GMS Contract Changes 2020/21 and were assured that:

- GMS contract changes had been reflected in the contract monitoring framework
- Changes to the National QOF had been reflected in the local scheme
- A plan had been implemented regarding Role Reimbursements through the PCN DES

The group accepted changes to the Primary Care Operational Group Terms of Reference to reflect a change in membership. Members approved the changes to the Terms of Reference and agreed for the recommendation to be formalised once quorate.

PCOG received a report on Primary Care Quality and Safety matters, further detail was provided under agenda item 7.0

PCOG reviewed the Committee risk register and made recommendations set out under agenda item 9.0

Resolved:

1. **Committee noted the actions of PCOG for assurance**
1. **Committee noted the GMS Contract changes 2002/21**
2. **Committee made a recommendation to approve the following, subject to the approval of the Chief Nurse;**
    - **i) Agree the contract variations and note the changes at The Waterfront Surgery and Wordsley Green Surgery and approved the changes at Lower Gornal Medical Practice, Rangeways Road Surgery, and Coseley Medical Practice**
    - **ii) Accept the recommendation of PCOG and approve the removal of the GP Engagement Lead and addition of GP Clinical Lead to the PCOG Terms of Reference**

7.0 QUALITY & SAFETY REPORT

Mrs Robinson spoke to this tem on behalf of Mrs Brunt to provide on-going assurance to the Primary Care Commissioning Committee (PCCC) regarding quality and safety in accordance with the CCG's statutory duties.

Care Quality Commission (CQC)

Committee were advised that a CQC report for Central Clinic had been published following a recent inspection. The practice had been rated "Requires Improvement", with Requires Improvement in the Safe, Effective and Caring domains.

Since the publication of the Committee papers a further CQC inspection had been published following an unannounced visited to Dudley Wood Surgery. The practice had been placed in "Special Measures" and had been rated "Inadequate" for the Safe, Effective and Well Lead domains. Committee were given assurances that the CCG were working with the practice and had offered support. The practcie had drawn up an action place, agreed with CQC and were reporting weekly however due to COVID-19 pressures CQC had agreed that monthly reporting was more appropriate.

A query was raised in relation to the nature of support the practice had been offered. Committee were advised that the practice had been offered, Nurse mentorship, GP and Practice Manager Mentorship via internal resources. The practice had also accessed funding from the GP Resilience allocation.

Mrs Robinson agreed to share the report with members of this Committee.

Action: Mrs J Robinson

Development of PCAT

Committee were advised that the PCAT tool was now being produced using Microsoft Power BI.

Resolved:

1) **Committee noted the report for assurance.**

8.0 FINANCE REPORT

Mr Cowley spoke to this item to provide an overview of the financial position in respect of budgets reported to Committee.

The budget reported to Committee totals £48.542m

At the end of February 2020, a breakeven position was reported against delegated budgets, with a reduced locum reimbursement offsetting the overspend against Minor Surgery activity.

An underspend of £239,000 which related to the Prescription ordering direct (POD) service within primary care was reported against Core CCG budgets.

In February, a further funding allocation of £24,000 was received for the STP GPN Specialty training scheme.

Resolved:

1) **Committee noted the report for assurance.**

9.0 RISK REGISTER

Mrs Robinson spoke to this item to provide the Committee with an updated BAF & risk register.

Committee were advised that the existing risks had been reviewed and changes were proposed for approval. Committee approved the Primary Care Operational Groups recommendations subject to approval by the Chief Nurses approval.

Committee raised a query whether a new risk should be added to the risk register to reflect the on-going situation with Covid-19. Following lengthy discussions in relation to whether the risk should be recorded as a corporate or individual risk. Committee recognised that COVID-19 would need to be reflected within the Governing Bodies risk register. It was agreed that clarify would be sought from the CCG's Governance Manager in relation to how the Governing Body had captured the risk and discuss how it would be reflected for Primary Care.

Action: Miss T Fear

10.0 ANY OTHER BUSINESS

Out of area registration: In hours urgent primary medical care (including home visits) Directed Enhanced Service

Mrs Robinson spoke to this item to seek approval to roll forward the Direct Enhanced Service.

The mandated DES had been in place since September 2015 and was introduced to ensure that those patients who are registered as an out of area patient, still have access to In-hours primary care at their place of residence.

Committee were informed that 5 practices had signed up to the DES and reflected the previous locality configuration.

It was recognised that due to the current COVID-19 isolation guidance, there may be an increase in activity within the DES.

Mrs Brunt joined the meeting

Mrs Mosley informed all that the meeting was now quorate.

Committee approved the renewal of the out of area registration: In hours urgent primary medical care (including home visits) Directed Enhanced Service.

Resolved: Committee approved the renewal of the out of area registration: In hours urgent primary medical care (including home visits) Directed Enhanced Service. *Mr King joined the meeting*

Items requiring formal approval

Committee asked Mrs Brunt to approve the following items that were discussed earlier in the meeting;

- Agree the contract variations and note the changes at The Waterfront Surgery and Wordsley Green Surgery and approve the changes at Lower Gornal Medical Practice, Rangeways Road Surgery, and Coseley Medical Practice
- Accept the recommendation of PCOG and approve the removal of the GP Engagement Lead and addition of GP Clinical Lead to the PCOG Terms of Reference.

Mrs Brunt formally approved the above items.

Resolved:

1) **Committee made a recommendation to agree the contract variations and noted the changes at The Waterfront Surgery and Wordsley Green Surgery and approve the changes at Lower Gornal Medical Practice, Rangeways Road Surgery, and Coseley Medical Practice**
2) **Committee accepted the recommendation of PCOG and approve the removal of the GP Engagement Lead and addition of GP Clinical Lead to the PCOG Terms of Reference.**

11.0 DATE AND TIME OF THE NEXT MEETING

Friday 29 May 2020
1:00-3.00pm
T046/47 Third Floor
Brierley Hill Health & Social Care Centre
Venture Way, Brierley Hill, West Midlands DY5 1RU

MINUTES ACCEPTED AS A TRUE AND CORRECT RECORD

Name		**Title**	
Signed		**Date**	

NHS
Walsall
Clinical Commissioning Group

Primary Care Commissioning Committee (Public Meeting)

20 February 2020, 9.30am Jubilee House

NAME	TITLE	ATTENDED	APOLOGIES
Mike Abel (Chair)	Lay member for Commissioning	✓	
Donna Macarthur	Director of Primary Care & Integration	✓	
Sarah Shingler	Chief Nursing Officer/Director of Quality		✓
Rachel Barber (vice chair)	Lay Member	✓	
Lorraine Gilbert	Head of Finance Relationships	✓	
In Attendance			
Sara Hadley	Administration to committee		✓
Dr H Baggri	Clinical Executive, Primary Care	✓	
Carol Marston	Senior Commissioning Manager, Primary Care	✓	
John Taylor	Chair Healthwatch Walsall	✓	
Dr U Ahmad	LMC representative	✓	
Alison Simmons	Primary Care contracts & procurement officer	✓	
Jackie Bryan	Senior Commissioning manager		✓
Charlotte Gee	Communications Manager	✓	
Sara Bailey	Deputy Chief Nurse	✓	
Graham Westgate	Interim Digital Programme Lead	✓	

Notes
126/19 Notification of any items of other business New GP Contract will be covered within PCOG and Finance updates along with prescribing
127/19 Declarations of Interest Declaration of Interest as stated. Vice Chair updated conflict of interest it is not shown in minutes, Administrator to update.
128/19 Conflicts of Interest from agenda items Reviewed and managed on agenda items as required. Extended Access is an update not a decision, recognise if any discussion necessary the Clinical Lead will leave the meeting
129/19 Approval of Minutes Minutes of the Primary care commissioning meeting held on 19 December 2019 agreed as an accurate record with the amendment that the Chair Healthwatch Walsall be removed as the representative for Health and Wellbeing board.
130/19 Report on Matters Arising – Action log 122/19 – Workforce retention scheme, on agenda – Close.

120/19 – Extended access, circulate non PDF Assurance template to committee members - Close
119/19 – IT update, online consultation standing agenda item - Close
119/19 – IT update, PPLG to evaluate, on agenda - Close
119/19 – It update, direct coding into EMIS, on agenda - Close
119/19 – IT update, facilitators vacancy, Tom Robinson Dudley CCG covering routine tasks pending requests will have to be managed, is on risk register, job descriptions are being evaluated - Close
119/19 – IT update, SLA breaches and Docman update, on agenda – Close
117/19 – Contracting update, NHS111 update, on agenda - Close
117/19 – Contracting update, flu figures circulated to committee – Close
115/19 – risk register updated to include corporate risk - Close
100/19 – Review PCOG TOR and membership, TOR to come back to PCCC for approval, taken to PCOG only minor amendments on role titles - Close
96/19 – PCN stakeholder engagement event, check if possible before end of financial year, engagement with PCN's has happened with some groups in light of current changes within the CCG a wider stakeholder event would appear both valuable and timely this will be taken back to PCN's - Open
88/19 – National review of access offer both physical & digital services to be added onto next available PPLG agenda, requires updating to more relevant month – Open.
127/18 - Workforce – On Hold
112/18 – Suicide prevention strategy, on hold regular updates but sits with Policy and commissioning committee.

131/19 Committee Business

The Director of primary care updated the committee on the current situation regarding the management changes happening within the CCG.

Committee members are aware of changes happening with the new joint management structure and the impact on the committee and its move to a primary care committee in common from April 2020, discussion outside of the meeting have highlighted unease of this being the last Walsall only meeting.
An in common committee meeting will result in individual meeting per CCG but this will take place on a single time and location for decision and discussions will happen. This could result in it being more difficult for members of the public attending, as the location could be fluid and change on a regular basis. Clarity is required on how place based agenda item are dealt with, there was concern that in a large forum, members will be less confident to speak up and the level of scrutiny and challenge will be lost.
The format will be common agenda items but local matters may have to come back to a place based committee, Health Watch suggested due to the time required there are risks that local issues will be lost. The communication manager stated that the structure is still proposed and that maybe a phased approach is required. A three-month continuation of current arrangements would be beneficial, proposed to have the March meeting as a development session and retain the April meeting for the local committee carry on to discuss this topic.
There was concern that the In common meetings will happen simultaneously with a common agenda, but committee time may not be there to give time to local issues.
It was suggested that a lot of discussion can go to the STP primary care committee. March meeting dedicated to this topic, invite Sara Saville, and potential individuals who have already operated this type committee, and possibly one of the Deputy AO's.

Write to leads and chairs of the other three CCG's to the March meeting, and the March meeting will be solely in private as a development session.

Action: March meeting to be a development session in private: **DM**

132/19 Risk Register

PCCC 03 – review after agenda item
PCCC 16 – highest risk held by committee, progress is happening, leave unchanged.
PCCC 21 – review after agenda item
PCCC 22 – request how GB is going to deal with WT governance assurance report to GB and how the CCG and GP's are sighted on WT, there is ongoing and good engagement with PCN's.
PCCC 23 – PLT session took place, should now be a standard item at PTL of lesson learned, leave unchanged
PCCC 24 – review after agenda item
PCCC 25 – review after agenda item
PCCC 26 – report for information, review after agenda item
PCCC 27 – risk updated , rated as 12
PCCC 28 – risk updated , rated 9
PCCC 29 – risk updated , rated 16

133/19 Finance Report and PCOG Contracting update

The Head of Finance Relationships and the Senior Commissioning Manager updated the committee.

Finance

Overview remains the same no change to delegated position of £41m, GPFV element no additional gains and that stands at £2m. PCO claims are increasing which is positive. As at January 2020 there was an underspend of £261K against the delegated primary care budget and an overspend of £90k for the core commissioning budgets which is a result of the IM&T programme. QIPP delivery has been achieved.

The committee were taken through the slides circulated to committee members.
Enhanced guidance has been issued concerning the 2020/21 GMS Contract changes, it builds on existing guidance and the slides are from a national presentation. The number of additional roles reimbursed to support general practice has increased from 6 to 10 the new roles these include, pharmacy technicians, care co-ordinators, health and wellbeing coaches, dietitians and occupational health therapists.
All post will be 100% funded from April 2020, it will be based on capacitation, meaning each PCN should have an additional 21 members of staff. Financial technical guidance is being awaited.
PCN have struggled to get the 7 pharmacists in place, social prescribing workers PCNs have gone out to recruit their own staff and can confirm they have now recruited. There are ongoing requests for equipment and premises. If PCNs struggle with recruitment CCG are expected to offer support and a return to NHSE is required by end of February. Any non-committed monies from this year have been advised is within the overall delegated funding there are indication this underspend will be clawed back but this hasn't been confirmed. CCG involvement in recruitment will be impacted on CCG capacity within HR. Need to work quickly with the PCN's regarding next year's allocation and how the new roles with potentially impact on existing services. Guidance has

been shared with internal commissioning team and acute trust. It is anticipated that these additional roles will aid with the additional access proposed by the Government.
All PCNs are working together to work through the guidance. LMC requested if CCG could support at as STP level, Director of primary care stated that the CCG have to comply with the rules but will do all we can.
It was queried who would train and support social prescribers, as such roles were a positive for patients and should be support as much as possible, the CCG did put effort into recruitment but it has proved difficult.
Assurance meetings with PCN's feeds in both this committee and governing roles, future development of PCNs will sit under the MD role. Quality for patients, new indicators change QOF payments.
The slides also quote more doctors in general practice, this will covered in more depth in training hubs update in a later agenda item, there is work to encourage new GP's to become partners building on exiting work.
Improving access through investment and impact funding and working with PCN's. Manage variation in appointments and supporting practice to improve. Building also on existing core digital requirements.
The future could result in newly expanded role of PCN's in running urgent care in the community – this requires further guidance. Vaccination & Immunisations to become an essential rather than additional services and looking at incentives working on QOF threshold starting with MMR and then moving onto other vaccinations over time.
Quality in QOF improvement modules will continue next year which includes diabetes.
The five service specification due to start from April 2020 have been reduced to three and reduced requirements.
There will be an increase in global sum per weighted patient from £89.88 to £93.46 and a reduction in the OOH adjustment from 4.82% to 4.77% this equates to an overall increase of £3.71 per patient or 4% increase. There will be an increase in the value of QOF point from £187.74 to £194.83 an increase of £7.09 or 3.8%.
Dashboard for PCNs to complete on patient quality hopefully have improved tools for monitoring.

Action: How can this be assured that this recruitment is happening and how this will impact on patients: **DM/CM**

134/19 Primary Care Operational Group (PCOG) Update

Committee noted the report as read.

135/19 PPLG update

Committee noted the report as read. Health Watch commented on how can further engagement be encouraged, the response was that practice mangers are always copied into PPLG meeting notes to share with their PPG's, PPG's are a contractual requirement and do form part of the contractual visits, but practices do struggle. This will also be part of the new quality checks will take part in the new quality visit. Clinical lead suggested moving away from individual practices to a more PCN PPLG groups.
Committee were asked to note that Access monitoring has begun for PCOG, increased use of digital options will help share best practice.

136/19 IT Update

The Interim Digital Programme Lead presented a paper to the committee, the paper was taken as read and certain exceptions highlighted to the committee.

Docman project has been deployed and is in testing phase not yet live due to ownership of electronic document rejection process, should go live by end of month.
Status – 13 practices signed up to receive Docman 14 shown interest, 11 Docman is not required and 21 have confirmed they do not require Docman, engagement with the remaining practices continues. Project management services quality concerns regarding the service received from WHT requiring additional time to support delivery of the programme, issues with all but one project.
The action from the previous meeting regarding IT breaches, it is early days regarding the completion of the matrix nothing has been received for the programme management matrix the technical reporting matrix for January showed 40% as green, 18% as red, 29% not reported and 14% as errors. Unfortunately, there is issues with the quality of completion of the matrix and repercussions of the KPIs.

Committee were pleased reporting has started but were unhappy with the level of reporting and asked it be escalated to Finance and Investment committee and give it the highest level of attention.

137/19 Extended Access Update

The Senior commissioning manager took the report as read and highlighted some areas for the committee. The paper had previously been taken to PCOG. The report provided a breakdown of compliances, PCOG had identified SM6 – more confirmation regarding clinical leadership, and requested clarity on conditions precedents and the timescales. Queries were raised on some areas that could be done after contract, any queries to be forwarded to Senior Commissioning manger to pass onto the responsible Senior commissioning manger.

Committee requested future update on continuing and significant assurance and progress regarding this process.

Risk register, leave risk as it is, Director of primary care delegated powers to work with working group to determine if it does need reviewing.

In light of GP contract specification needs to reflected in this contract. Confirm and challenge questions PCOG questions to be shared with panel.

138/19 NHS 111 update

Committee noted the report. All practices are live, but there is no way of monitoring activity at the moment.

139/19 Workforce Retention scheme

Paul Aldridge, STP GPFV programme manager presented a presentation to the committee.

As an update from previously, there are significant workforce challenges since 2015 there has been a decrease of 11% of GP WTE, 40% of GP's are over 50 and for Nursing 60% are over 50. There has been a reverse in the GP trend last year with a WTE increase of 23.
From last year, 4 schemes have been carried forward, Portfolio careers, peer mentoring, first 5 network and post fellowships, new for this year are Phoenix GP programme and GP legacy scheme.
For nurses there have been engagement events, leadership involvement, network champions, portfolio careers, peer mentoring and nursing networks. It has been beneficial that the nursing sessions are now at the same time as the PLT.
Going forward there is work happening regarding trainee GP's and finding out what matters to them and what will retain them in the area. Looking to develop a Pharmacy network, and there is a Physician associate event taking place on 4 march would encourage GP practices and PCNs to attend, Clinical lead and LMC to promote. There is also a medical education programme for primary acre workforce, expanding training hubs who are there to also support PCNs.
LMC also offered to promote the Phoenix mid-career programme.

Committee looked into various methods to encourage the involvement in these schemes.

Action: Reduce risk: **DM**

140/19 Items for Information Only

- Online consultation update
- Estates update, Town centre issue with timescale particularly assurance requested by Council potential financial gap and time scale would put ETTF funding at risk. Increase risk on register.

Action: Increase Town centre risk: **DM**

The committee noted the above items.

141/19 AOB

None

142/19 Date of next meeting

19th March 2020 9.30am – Board Room, Jubilee House

Primary Care Commissioning Committee (Extraordinary meeting)

26 March 2020, virtual meeting at 5pm

NAME	TITLE	ATTENDED	APOLOGIES
Mike Abel (Chair)	Lay member for Commissioning	✓	
Donna Macarthur	Director of Primary Care & Integration	✓	
Rachel Barber (vice chair)	Lay Member	✓	

Notes

An extraordinary meeting of Walsall's PCCC meeting was convened on 26th March 2020 at 5pm. The Director of Primary care and the Chair and Vice chair of the PCCC held a teleconference to consider a one item agenda. The establishment of a Home Visiting service to support the primary care response to the Coronavirus pandemic.

A paper outlining the service had been circulated prior to the meeting. The Director of Primary Care confirmed that the details of the proposal had been shared with the finance team and that they had given their assurance to the costings. The resilience of primary care is being significantly tested and will come under greater pressure over the next few weeks as the number of cases of Covid 19 increases and the primary care workforce is similarly impacted due to illness and self-isolation

It is recognised that this is a costly service but these are unprecedented times and the need to establish a service is time critical. The additional costs will be collated by finance to form part of any submission on the additional expenditure that has resulted as a result of the pandemic

A question was asked as to whether you would pay just for the number of visit's undertaken or the 12 proposed on a daily basis. It is noted that it was very likely that more than 12 will be required quite rapidly. (*Post meeting it was confirmed that due to the requirement to engage clinicians to be ready to undertake visits the costs we for the service as a whole – but the provider agreed to keep this under review should demand be less than expected)*

The committee agreed to support the proposal - it was also agreed to support up to two further escalations of 8 home visits a day. Beyond this the committee would need to review the case for any further expansion

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE

Minutes of the Primary Care Commissioning Committee (PUBLIC)
Tuesday 3rd March 2020 at 2.00pm

PA125 Stephenson Room, 1st Floor,
Wolverhampton Science Park WV10 9RU

MEMBERS ~

Wolverhampton CCG ~

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

NHS England ~

Bal Dhami	Senior Contracts Manager – Primary Care, NHSE	No

Non-Voting Observers ~

Dr S Sinha	Treasurer - Wolverhampton LMC	Yes
Jeff Blankley	Chief Officer of Wolverhampton LPC	Yes
Tracy Cresswell	Wolverhampton Healthwatch Representative	No
Dr Ankush Mittal	Consultant in Public Health, WCC	No

In attendance ~

Peter McKenzie	Corporate Operations Manager (WCCG)	Yes
Sarah Southall	Head of Primary Care (WCCG)	Yes
Gill Shelley	Primary Care Contracts Manager (WCCG)	Yes
Sukhdip Parvez	Patient Quality and Safety Manager (WCCG)	Yes
Mike Hastings	Director of Operations (WCCG)	No
Diane North	PCC Committee Administrator (WCCG)	Yes

Welcome and Introductions	
WPCC652	Mr L Trigg welcomed everyone to the meeting and began by advising that the meeting wasn't quorate. Mr McKenzie advised that as a result of not being quorate, the committee wouldn't be able to make any final decisions today and that the items on the agenda were for assurance. If any decisions needed to be made they would have to be done virtually after the meeting or deferred to the next meeting. As there was one member of the public present members introduced themselves as did the member of public.
Apologies	
WPCC653	Apologies were received from Sue McKie, Sally Roberts, Steven Marshall, Mike Hastings, Dr Ankush Mittal, Dr M Kainth and Dr D Bush
Declarations of Interest	
WPCC654	Drs S Reehana and Ashgar declared that as GPs they had a standing interest in all items relating to primary care however, there was nothing of conflict in today's papers.
Minutes of the Meeting held on the 4th February 2020	
WPCC655	The minutes of the previous Primary Care Commissioning Committee held on 4th February 2020 were approved as an accurate record. **RESOLVED: That the above was noted.**
Matters Arising from previous minutes	
WPCC656	Further detail in relation to the Prescribing data overspend (as detailed in the Q3 Finance report last month) was received by the committee. **RESOLVED: That the update was noted.**
Committee Action Points	
WPCC657	**Action 40 (Minute No: WPCC540) Quality Assured Spirometry Business Case** Report presented today. Action closed. **Action 47 (Minute No: WPCC607) An update on the implementation of the New Communications & Engagement Strategy.** Report presented today. Action closed **Action 48 (Minute No: WPCC645) Further details in relation to the Prescribing overspend from the Q3 Finance report (Feb 20) to be provided.**

	Information provided. Action closed. **RESOLVED: That the above is noted**
Primary Care Update Reports	
WPCC658	Primary Care Quality Report Mr S Parvez presented the Quality report summarising the following key points: He confirmed there had been no serious incidents reported in February 2020 and that one new Quality Matter had been escalated to the Practice Information Gathering Group (PIGG). The Flu programme had progressed somewhat since the previous reporting period but wasn't as expected so any learning from this year would be used to improve performance next year. There were no new Care Quality Commission (CQC) visits to Wolverhampton GP Practices in February 2020 and out of 42 practices there was only one requiring improvement which was being supported. Several practices were due CQC inspections as a result of changes in provider or previous CQC ratings. Mr Parvez continued by saying that there had been 2 cases of MRSA bacteraemia attributed to WCCG in the last few months due to the blood culture taken within 48 hour of patient admission. One was for a patient in a residential home and another in their own home. Mr Parvez had been involved with the Root Cause Analysis (RCA) and that the outcome would be shared across the system. He continued by saying that the average IP audit score from all practices was 95% and for March there were 5 further practice visits planned. Workforce activity continued with the focus on GP mentorship, mid-career support and GPs nearing retirement. GP and GP retention was to continue at STP level and work with NHS retention teams continued with a plan in place by end of February. Under the National First Five initiative developed by the Royal College of General Practitioners (RCGP) work continued to support career development and encourage GPs to consider staying in the Black Country. Work was also planned to identify local GPs transitioning into permanent roles in Wolverhampton. He informed that the Black Country STP has successfully won a bid to host 10 newly qualified GPNs and support them through the GPN Fundamentals programme at Birmingham City University. The two Wolverhampton PCNs taking part had both successfully recruited candidates. There was a question as to how timely the CQC provide feedback following

	Practice visits as one practice had been visited in December and was still awaiting their action plan. There was a query in relation to Coronavirus and staffing. Mrs Southall confirmed they would be looking at drawing GPs from retirement from the National Performers List but would need to be mindful of their competencies. It was recommended that any information gathering would be best done now rather than last minute. This was noted. The LPC representative asked what might be done differently for next year's flu vaccine programme and how community pharmacy might assist in that in a collaborative way such as with Primary Care Networks (PCNs). Mr Parvez advised that the acute Trust were doing some work to identify the reasons why the general public didn't wish to receive the vaccine along with work on data collection from care homes. There had also been a delay with the over 65s flu vaccine which had impacted this year. Mrs Southall reported that despite extensive planning work taking place this year and willingness from PCNs to deliver, they hadn't been able to offer the flu vaccine for logistical reasons such as the cold chain supply, ordering and being paid for activity. These issues had since been resolved and should ultimately lead to improvements in the coming year. She advised that PCNs would also be able to offer appointments out of hours and at weekends as well as in hour's appointments. Patients were also encouraged to access the flu vaccine at their community pharmacies. She felt the lack of advertising had impacted this year. It was suggested that although the Friends and Family Test (FFT) provided figures in relation to the numbers of returns received it would be a useful addition to provide the details of the feedback. The issue of arithmetic errors was again raised which was acknowledged and would be reported back to the team. Mrs Southall suggested that as the workforce retention work was already being reported bi-monthly to committee to have a discussion with the Quality team as to whether there was a need to include it in both reports. **RESOLVED: That the above is noted.**
WPCC659	**Primary Care Operational Management Group Update** Mrs S Southall provided a verbal update on the meeting which took place on Wednesday 12th February 2020. Papers were circulated giving the Risk Register and a review of the Primary Care Matrix enabling the Operational Management Group to identify practices requiring a visit. The Hub offer from NHS England was to be discussed at a meeting on 4th March 2020. The main changes associated with the offer were around finance and financial support and the organisation needed to understand those implications before providing feedback.

	There were currently no Practice mergers expected but more would commence post year-end from May 2020. The Estates and IP update was that practices were achieving a high level of scoring. Identified underspend of the delegated budget would be used to improve standards further with work to commence imminently. Mrs Southall advised that there had been an update from Public Health on the Coronavirus. Measures had been stepped up in relation to drive-through testing and this was being arranged with involvement from Clinical Directors and was expected to be operational next week. The work would take place in partnership with the Acute Trust. There may be a need to call on retired GPs and nurses. It was expected that Healthcare Assistants, non-qualified nurses and non-registered nurses would be able to support the work. Training would be provided through the Acute Trust Infection Prevention Team in conjunction with Public Health with the aim of preventing patients attending healthcare settings where there may be vulnerable patients. The Quality report was presented giving an update on the contract review visits. A piece of work was being undertaken across the STP to develop an escalation tool to enable CCGs to manage emerging concerns on a collective basis in a more consistent way. A policy for resilience and caretaking was also being developed, which should be available to committee around May time. It was suggested that in relation to the Coronavirus that Clinical Directors would need to be informed due to the short timescales for delivery and that there were some concerns that each CCG in the Black Country had its own approach. This would be picked up. It was confirmed that the drive-through would be a booth manned by two trained testers. Testing kits would be provided and would be sent to a laboratory. The finer logistics were still being worked on. **RESOLVED: That the above is noted.**
WPCC660	**Update on the Implementation of the New Communications & Engagement Strategy** The report was made available to committee for information. Any questions could be directed to the CCG inbox **wolccg.ccg@nhs.net** and would be passed on. The report was accepted by committee **RESOLVED: That the above is noted.**
WPCC661	**Primary Care Assurance Report – Q3** Mrs S Southall confirmed that the report covered Q3 Oct-Dec 2019 and that the assurance pack was presented to the Milestone Review Board in January 2020. Further detail was provided in relation to areas marked amber.

	Mrs Southall advised that there were 15 statements associated with maturity of Primary Care Networks which had resulted in the amber rating for the Primary Care Networks Assurance Statement. She advised that unfortunately due to development plans not yet being finalised, largely in relation to the delay of the DES specifications, they were unable to conclude. This was a problem nationally with many networks considering how they were going to resource it. Mrs Southall advised that Communication and Engagement was back on track however in January 2020, when the plan was reviewed with the Commissioning Support Unit (CSU), some areas had gone off target which was largely associated with extended access. This had since been addressed and the analysis of Urgent Care activity had been extended. Social Prescribing Link workers were now embedded and being utilised across the PCNs. The amber ratings were to do with the numbers of referrals in Q3 not being quite as expected but there had been a recent increase in activity. Sound Doctor reporting wasn't able to confirm, at network level, how many patients had seen certain videos, only that they had been accessed. This wouldn't be resolved until the transition to the EMIS clinical system. The NHS 111 interoperability arrangements were now back on track. The non-achievement was based on the interoperability of clinical systems and NHS 111. Mrs Southall went on to say that workflow optimisation was an area of concern due to having invested heavily in this. The training had been well attended initially by practices with many going back and building on what was already in place. There was work to determine which practices had an auditable process in place, as if the effectiveness of the work couldn't be measured, it would be difficult to demonstrate value for money on the investment. QOF+ there were concerns around serious mental health and learning disability health checks and support had been offered to practices. With improving access in Q3 the utilisation threshold dipped below the national threshold of 75% to 70% but this was now on track with extended access appointments being a key care navigation point for all reception staff. A number of bullet points on the GP contract 2020/21 were included in the report however there would be a presentation to committee today and this would be circulated to members with the minutes. In relation to the PCN Workforce, new roles had been added from April 2020 and reimbursement had increased from the current 70% to 100% for all roles

	RESOLVED: That the above was noted.
WPCC662	**GP Contract Summary** Mrs S Southall gave a presentation to committee on the GP contract 2020/21 which focused on nine priority areas including additional roles, more doctors into General Practice, releasing time for care, improving access for patients, vaccinations & immunisations reform, QOF, the Primary Care network specifications and the impact investment fund. A hard copy handout was available to members attending and a copy would be circulated with the minutes. It was reiterated that there was support from the CCG for all the Primary Care Networks to ensure delivery of the requirements. It was felt that Wolverhampton was fortunate to have PCNs and Clinical Directors working so well together and to such a high standard. **RESOLVED: That the above is noted.**
WPCC663	**Quality Assured Spirometry Update** The report provided an update on the training arrangements and delivery models that were currently taking effect. The Spirometry Service model had been approved by this committee in 2019. Mrs Southall continued by saying that the qualifications for spirometry were being achieved and each PCN had identified a delivery plan and staff to receive the training. The training took place in September 2019 with a supplementary session in December 2019 and staff were now building their portfolios, to demonstrate competency, with a view to providing the service from May 2020. Wolverhampton Total Health who had been trained previously had been providing the service since September 2019. From May 2020 it was expected that there would be an increase in activity in PCNs and a decrease at the Trust with the only activity going through the Trust being for the RWT Primary Care Network. **RESOLVED: That the above is noted.**
WPCC664	**Any Other Business** There was no further business.
Details of Next Meeting	
WPCC665	**Tuesday 5th May 2020 at 2pm,** PA125 Stephenson Room, 1st Floor, Technology Centre, University of Wolverhampton Science Park WV10 9RU **Note:** Should the need for a meeting in April arise this will be advised nearer the time otherwise the next planned meeting is for May (as above). If a meeting is required in April it will take place on Tuesday 7th April at 2pm, PA 125 Stephenson Room.

Sandwell and West Birmingham Clinical Commissioning Group

Primary Care Commissioning Committee

Date: 5th March 2020 **Time** 10:00 – 12:00

Venue: Kingston House **Room:** Boardroom

PUBLIC MINUTES

Attended:

(RS) Ranjit Sondhi	Lay Member (Chair)
(AA) Dr Ayaz Ahmed	GP Representative
(CE) Carla Evans	Head of Primary Care
(CS) Carly Sheldon	Senior Primary Care Accountant (Finance)
(JJ) Julie Jasper	Lay Member
(JMc) Jane McGrandles	Head of Primary Care Contracts (Contracts)
(JR) Janette Rawlinson	Lay Member
(KG) Dr Karl Grindulis	Secondary Care Consultant
(LMa) Leon Mallett	Commissioning Transformation Manager (GPFV)
(PL) Phil Lydon	Senior Engagement Manager
(CMP) Carlos Marques-Pestana	Primary Care Contracts Manager
(AC) Alex Clark	Primary Care Contracts Manger
(AF) Alexia Farmer	Healthwatch Sandwell Manager
(SS) Simon Somers	Primary Care Quality Lead (Quality)
(AC) Andy Cave	Chief Executive Officer, Healthwatch Birmingham

In attendance:

(CO) Craig O'Keeffe	Business Support Officer (notes)

Apologies:

(BM) Dr Robert Morley	Executive Secretary, Birmingham Local Medical Committee
(RSu) Dr Ray Sullivan*	GP and Sandwell Local Medical Committee
(TM) Therese McMahon	Board Nurse
(MW) Matt West	Financial Controller (Finance)
(MB) Manoj Behal	CCG IT Lead
(AL) Andrew Lawley	Head of Premises and Capital Development (Estates)
(HP) Hannah Peach	High Cost Drugs Pharmacist (Medicines Quality)

INTRODUCTION	
1.	Apologies for Absence
1.1	Apologies were shared with committee members (please see page 1).
2.	Declarations of Interest
2.1	Members noted that prior to the meeting taking place; a review of the Conflicts of Interest checklist in compliance with the Conflicts of Interest guidance took place.
2.2	RS confirmed he held an indirect personal conflict of interest in one of the Primary Care Network transfer items (Pioneers for Health South to Pioneers for Health Central) covered under item 16 given a relative worked in one of the practices who formed part of the transfer request. Committee agreed that JR would take the role of Chair for this item and RS could stay in the room but not contribute to the discussion or decision.
2.3	RS also highlighted a potential perceived professional interest in item 17 (Holly Road Relocation) given his involvement with the Nishkam Health Board. Committee agreed that JR would assume role of chair for this item also and that RS would not take part in discussion or decision.
2.4	AA as a member GP of SWBCCG was noted to hold a direct pecuniary interest in item 12 (PCCF 2020/21) where committee were being asked to approve the final draft of the document to be published and shared with practices. As such it was agreed that AA could stay and participate in discussion around the item.
3.	Minutes of Previous Meeting
3.1	The minutes of the previous meeting held on 6th February 2020 were agreed as a true and accurate record.
4.	Action Log and Matters Arising
4.1	The actions were reviewed and updated or closed as required.
4.2	<u>Declarations of Interest Register</u> JR confirmed she had shared some queries with Jodi Woodhouse regarding items which remained as interests in her name on the register (later in the meeting Jodi confirmed via email to CE that the quality team were currently reviewing JR's query and would make any necessary alterations as necessary). It was noted that a fresh copy of the register is requested each month.
5.	Chair's Actions
5.1	No chairs actions had been taken.

PERFORMANCE	
6.	Finance Update
6.1	CS provided a summary of the finance update paper which was circulated to members prior to the committee. It was noted that the paper included information around the current financial year (2019/20) and planning information in relation to the next financial year (2020/21).
6.2	CS highlighted updates to the 2020/21 financial plan following publication of key contract values by NHS England which have had an impact along with further changes which have been made to the PCN DES contract (including additional roles reimbursement from 70% to 100%, QOF alterations, increases to global sum payments, care home premium payments to PCNs per bed and the introduction of the new to partnership payment).
6.3	It was noted that there had been information around allocations for the DES received from NHS England the day prior to the meeting and before the report was prepared. CS briefly detailed this allocation of £788k which it was confirmed varied against original estimates; including £172k for the Care Home premium (less than the £204 originally estimated) and £204k in relation to the number of QOF points available. CS also noted that the additional roles reimbursement (£1,930k) would be centrally held with CCGs being able to draw down on this once the current allocation was fully utilised.
6.4	A readjusted estimated cost pressure of £3.5m rather than the £3.9m detailed within the report was now thought to be more accurate.
6.5	Assurance was given that the CCG was expecting a breakeven position by the end of the current financial year.
6.6	JR queried based on some of the unexpected cost pressures which had been identified over the current year what preparations could be made in advance of potential pressures for the coming year with the example of Covid-19 highlighted as an example. CS confirmed that the primary care operations group would be closely monitoring the management plan whilst it was noted that it was not yet fully clear what financial impact there would be in relation to Covid-19 and what central funding would be available.
6.7	KG queried management and reporting of financial updates moving forward once Primary Care Commissioning Committee's are held in common across the Black Country and West Birmingham CCGs moving forward. It was noted that each of the four separate CCG's would continue to report on their own accounts. Following further query around support and possible cross subsidising between CCG's CS confirmed that no such plans had been taking into consideration for 2020/21. RS suggested that any potential cross subsidising be considered carefully given the possible inequity which could be created in the system.
6.8	CS offered a further update in relation to the additional roles being offered as a part of the PCN DES. The two roles covered were confirmed to be Social Prescribing Link Workers (funded at 100%) and Clinical Pharmacists (funded at 70%). It was noted that although the CCG had 15 PCNs altogether, 31 roles were confirmed to be available given one of the networks had transferred a clinical pharmacist from an NHS England scheme and were still eligible to apply for funding for an additional role. Of the 31 available roles it was noted that 20 applications had been received with 14 being successful and 6 returned to the respective applicant network for additional information.
6.9	It was noted that there were 9 potential applications which had not been received, based upon

	available intelligence from communication with and visits to the PCN's some expected costs had been built into the financial position on the basis that some further applications would be shared. Communication emphasising the importance of making the applications had been shared with networks and further communication made as necessary.
6.10	There was a forecast spend of approximately £451k against the £809k allocated, CS confirmed that some additional guidance had been received from NHS England in relation to appropriate means of utilising underspend for addition roles which included clinical pharmacist roles recruited into after 17th February, bringing forward available roles from April 2020 and supporting of recruitment costs.
6.11	Whilst there was not a decision around utilisation of underspend required at that meeting, Committee were asked to endorse the possibility of seeking a chairs action around utilisation of any underspend depending on what other information is received from NHS England and PCN applications for roles are received.
6.12	It was noted that there had been an increase in the funding of Clinical Pharmacist roles (from 70% to 100% nominal funding) from April 2020 which it was suggested would likely result in an increased interest.
6.13	RS queried the social prescribing link worker roles and level of interest in these, it was noted that this was a relatively new role to most of general practice and there had been some provider availability issues from a Sandwell perspective initially. It was suggested that there was now a greater level of information and understanding around the role of social prescribers available to networks and more provision options available to Sandwell based networks.
6.14	Following query by JJ about the possibility of a late influx of applications reducing the additional roles underspend, CS confirmed that the CCG were not expecting this would be the case based on intelligence and that it was currently March.
6.15	JR highlighted concerns around the potential inequalities in the event of some but not all PCN's were offering their patient populations access to social prescribing link workers as an example. LMt confirmed that work was ongoing in the Black Country and West Birmingham area to work with general practice and raise awareness of the array of new roles and explore their benefits which are available whilst in terms of the additional roles it was confirmed that offers were based on an equal approach.
6.16	Discussion was held around the clinical pharmacist role with acknowledgement of the specialised nature of the role and the challenges that would be expected in recruiting the right people to the roles. LMt acknowledged that on a wider system level a great deal of work would be required moving forward to identify and reduce any gaps in the workforce.
6.17	Committee noted the update and agreed for a chairs action to be sought in relation to the additional roles underspend once all applications and associated information had been received.
7.	Risk and Issue Register report
7.1	CE provided a summary of the presented risk and issue register report following a review of all risks which were conducted by the Primary Care Commissioning Operations Group on 27th February 2020.

7.2	Updates had been entered against appropriate risks with no recommendations made for changes to any risk scores or closure.
7.3	JR made some comments / suggestions:
7.4	• PC02_19c - queried if additional consideration would be required in relation to recent reports of increased cases of mumps given its included within the same vaccination.
7.5	• PC01_18a – suggested that the external assurance information should be updated considering recent CQC inspections and their findings. CE confirmed that the operations group would review this.
7.6	• PC08_19a – queried if there were any further updates, JMc confirmed that there had been a recent update which had suggested that there was a reduction in registered patients to approximately 1,900 patients whilst no concerns had been identified.
7.7	• PC10_18c - JR suggested that some additional concluding information could be added against the risk to reflect the lessons learnt by the CCG and outcome of the tribunal case.
7.8	• PC12_18b TB Screening – JR queried if there was any learning that the CCG could apply from the work and support being conducting by Hayley Donkersley (Cancer Research UK) who supports practices in SWBCCG to improve cancer screening uptakes.
7.9	CE agreed to share this feedback with the operations group and risk leads appropriately.
7.10	Committee noted the update.
8.	GPFV Update
8.1	LMt welcomed questions from members around the update which had been circulated prior to the meeting and did not require any decisions. LMt noted that there was still no confirmed update in relation to the training hub at present whilst it was suggested that an operational implementation was expected from mid-summer.
8.2	RS queried the progress around workforce strategies. LMt confirmed that there had been a slight delay in returning those workforce strategies requiring additional information back to networks given other commitments and the release of the contract changes and network specifications. A further update around the progress of the strategies was expected in April whilst no significant issues were expected given the level of additional information necessary.
8.3	Committee noted the update.
9.	Contracting Update
9.1	CMP welcomed any queries from members in relation to the contract update which had been circulated to committee prior to the meeting.
9.2	Committee noted the update
10.	Digital Update
10.1	MB had submitted his apologies, CE provided an update in his absence.

10.2	It was noted that work was progressing well to reinstate the 10 patient kiosks with a further detailed report expected from MB at April's meeting.
10.3	Following confirmation from MB at February's committee around the successful bid for capital funding for screens within practices. It was confirmed that funding had been received and a message was expected to be shared with practices from the CCG soon inviting expressions of interest.
10.4	Committee noted the verbal update
11.	Engagement Update
11.1	PL welcomed questions from members in relation to the report which had been circulated prior to the meeting.
11.2	JR queried walk-in centre consultation and the breadth of people who had been consulted. PL confirmed he could share a copy of the consultation report with JR whilst it was noted that efforts had been made to engage with as wide array of patients as possible with additional support from the CSU this year.
11.3	It was also noted that following previous feedback, the engagement team would be conducting a what matters to you exercise targeted at working men, further updates would be given in due course.
GOVERNANCE AND BUSINESS	
12.	PCCF 2020/21
12.1	AA as a member GP of SWBCCG was noted to hold a direct pecuniary interest in item 12 (PCCF 2020/21) where committee were being asked to approve the final draft of the document to be published and shared with practices. As such it was agreed that AA could stay and participate in discussion around the item.
12.2	CE briefly summarised the report which was circulated to members prior to the meeting and which outlined the second round of consultation previously agreed by committee. The feedback received from two practices during this second stage was outlined, some recommended changes had been put forward to committee along with justifications.
12.3	Queries / comments were welcomed from members.
12.4	JJ highlighted some discussion at that months governing body and feedback collected around a suggested importance on recognising the potential impact of emergency mobilisation in response to Covid-19 and the impact this would have on practices ability to fulfil requirements within the PCCF. It was noted that at present no decision was expected to be made around PCCF or QOF whilst it was confirmed that the situation was being closely monitored. AA highlighted some of the challenges and additional pressures he had encountered so far around coronavirus and expressed his concerns at a worsening scenario. JJ shared concerns at the handling of information and messaging around Covid-19 on a wider scale and the importance of clear and correct information being portrayed
12.5	KG acknowledged the alterations in wording within the DMARDs target and agreed this as suitable given prior discussion. KG queried the inclusion of other 100% targets within the document such as the osteoporosis e-learning requirement target within standard 3. It was

	confirmed that a 100% target in the circumstance of this type of training had been deemed to be appropriate given its relative simplicity.
`12.6	RS thanked committee members for their feedback and discussion around the document over the previous months and the team for their hard work in putting the latest document together, committee were asked to approve the final draft of the document for it to be published / circulated to members. **Decision: Committee approved the final draft of the 2020/21 PCCF Document and for it to be published / shared with members accordingly.**
13.	Phlebotomy LIS Contract Extension
13.1	CE outlined the pre-circulated report which was seeking approval for the extension of the Phlebotomy LIS Contract for West Birmingham.
13.2	Outlined within the paper was the background of the different arrangements in Sandwell and West Birmingham and the previous difficulties in establishing a more effective means of delivery. It was noted that the extension of the contract had been endorsed by the procurement team and a breakdown of potential costs shared (£0.42 per patient on a quarterly basis for West Birmingham practices resulting in an approximate cost depending on number of practices who sign up the agreement of £92,860).
13.3	Whilst not directly in relation to the LIS contract, JR queried if there was a requirement to review the communications of phlebotomy services for patients in general given some personal and anecdotal evidence suggesting that there was some ambiguity around the ability to 'walk in' for appointments. CE agreed that there was potential for this to be reviewed to ensure that messaging around the services and their availability was clear and accurate. **Decision: Committee approved the Phlebotomy LIS Contract extension by a period 12 months until 31st March 2021.**
14.	Sub-Contracting of GMS Services at Your Health Partnership (YHP)
14.1	JMc provided a brief summary of the sub-contracting application of GMS Services at Your Health Partnership with SWBHT leading on from discussion at February's committee.
14.2	It was acknowledged that following agreement at February's committee, additional information and clarification had been sought in relation to the arrangement and had been provided to the CCG.
14.3	Following review of the additional information it was recommended that committee approve the sub-contracting application. Following query, it was noted that Dr Ian Sykes would be resigning from his role as a contract holder at Your Health Partnership with effect from April.
14.4	**Decision: Following discussion at February's meeting and the additional information which had been supplied by Your Heath Partnership, Committee approved the sub-contracting**

	application.
15.	Contract Merger Requests
15.1	CMP briefly summarised two different contract merger requests which had been received, committee were being asked to consider the recommendations to approve both requests.
15.2	Merger Application – M88629 Hill Top Medical Centre and M88616 Great Bridge Partnerships for Health
15.3	The application for Hill Top Medical Centre (with a patient list size of 1,979 as at 01/01/2020) to be merged with the Great Bridge Partnerships for Health (with a patient list size of 11,261 as at 01/01/2020) was outlined. It was acknowledged that as previously agreed at committee, Hill Top Medical Centre had relocated to Cordley Street (a branch site of Great Bridge Partnership for Health) with a greater level of access to clinicians and access across a variety of sites expected should the merger be agreed.
15.4	Both contracts were GMS and no issues with practice boundaries had been identified. It was noted that there would be a cost associated with merging of clinical systems which was estimated to be between £8k – £10k through the Clinical Support Unit. Following query it was acknowledged that this cost did not relate specifically to hardware but was more in relation to migrating of patient records, it was confirmed that the CCG was responsible for such costs and that MB had confirmed an available budget.
15.5	It was confirmed that the practices were continuing had conducted engagement starting in November which had received positive feedback from patients. Both practices were confirmed to have been rated 'Good' by the CQC and were part of the same Primary Care Network. If successful, patients would receive confirmation of the change and merger.
15.6	If approved by committee, the merge would be completed in the next financial year with a planned date of 1st May 2020 depending on the merger of the clinical systems.
15.7	**Decision: Committee approved the merger application for Hill Top Medical Centre and Great Bridge Partnership for Health.**
15.8	Merger Application – M85085 Ann Jones Family Health Centre and M85164 Newport Medical Practice
15.9	The application for Ann Jones Family Health Centre (with a patient list size of 1,807 as at 01/01/2020) to merge with Newport Medical Practice (with a patient list size of 10,410 as at 01/01/2020) was outlined.
15.10	Both contracts were GMS with no practice boundary issues having been flagged. It was confirmed that the merger would represent an improvement in access to clinicians and access to different sites given their current co-location with a branch site of the Newport Medical Practice. It was acknowledged that the CCG would be responsible for the cost associated with the merging of clnical systems and similarly to the previous request this would be conducted by the Clinical Support Unit at an estimated cost between £8k - £10k.
15.11	Patient engagement had been conducted with positive feedback and no concerns having been raised. It was noted that both practices currently belonged to different Primary Care Networks although there was a PCN transfer request to be reviewed by committee as a part of item 16

	recommending the transfer of Ann Jones to Urban Health which Newport Medical Practice was a part of.
15.12	**Decision: Committee approved the merger application of Ann Jones Family Health Centre and Newport Medical Practice.**
16.	PCN Transfer Requests
16.1	RS confirmed he held an indirect personal conflict of interest in one of the Primary Care Network transfer items (Pioneers for Health South to Pioneers for Health Central) covered under this item given a relative worked in one of the practices who formed part of the transfer request. Committee agreed that JR would assume the role of Chair for this discussion and RS could stay in the room but not contribute to the discussion or decision.
16.2	<u>Application for PCN Transfer: M85085 Ann Jones Family Health Centre</u> JMc briefly outline the application for transfer of Ann Jones Family Health Centre from the Modality PCN to Urban Health PCN. This followed the decision by committee to approve the merger of Ann Jones Family Health Centre with Newport Medical Practice who were a practice in the Urban Heath PCN.
16.3	<u>Application for PCN Transfer: M85176 Kirpal Medical Practice, Y00412 Dr Bhalla & Partners and M85721 Holyhead Primary Health Care Centre</u> JMc outlined the application for transfer of the three practices from Pioneers For Health (South) to Pioneers For Health (Central). It was acknowledged that the transfer application had originated following a significant breakdown in the working relationship between these practices and the others in Pioneers For Health (South).
16.4	It was acknowledged that the CCG had held discussions with the practices concerned and that a resolution did not seem realistically possible. It was confirmed that in the event of the application for transfer being agreed, Pioneers For Health (South) would be left with a total combined patient population of approximately 21,095 patients which was significantly under the minimum list size of 30,000 specified by NHS England for a PCN.
16.5	As part of the original network configurations which were agreed by Committee in May 2019 it was acknowledged that an exceptional circumstance had been agreed with regards to a combined patient population of a similar amount by the committee and subsequently NHS England in the form of Pioneers For Heath (North) given their unique position and that there was a significant number of new houses being developed nearby, it was suggested that adapting the same principles committee adhered to in reviewing the network configuration requests originally that such an exceptional circumstance would not be agreeable for Pioneers For Health (South) in the event of the application being agreed. It was acknowledged that there was a number of potential options available which the CCG were exploring with the three practices who would be remaining in the Pioneers For Health (South) PCN should the transfers be agreed, this included working with one of three nearby PCN's in the area.
16.6	Given the breakdown in working relationship between the practices and the options available to facilitate a solution to the list size of the Pioneers For Health (South) PCN in the event of the transfer being agreed, it was recommended that committee approved the transfer request of Kirpal Medical Practice, Dr Bhalla & Partners and Holyhead Primary Health Care Centre.
16.7	Discussion was held around the importance of understanding governance and having the appropriate governance in such an arrangement, JR queried if any additional work had been conducted with networks around understanding and developing the necessary governance

	structures and processes. LMt confirmed that a programme of Practice Development had been rolled out to practices which covered governance although it was acknowledged that this could be an area which the CCG explored further to offer additional training to networks. **Action: LMt / CE agreed to explore the possibility of provision of additional training for networks / Clinical Directors around Governance.**
16.8	**Decision: Committee approved the transfer of M85176 Kirpal Medical Practice, Y00412 Dr Bhalla & Partners and M85721 Holyhead Primary Health Care Centre from Pioneers For Health (South) to Pioneers For Health (Central).**
17.	Holly Road Relocation (M85081)
17.1	RS highlighted a potential perceived professional interest in this item given his involvement with the Nishkam Health Board. Committee agreed that JR would assume role of chair for this item also and that RS would not take part in discussion or decision.
17.2	JMc briefly summarised the paper which outlined a proposed relocation of the Holly Road practice to the Slieve Surgery, this followed a change in the contract holders of the Holly Road practice on 31st March meaning that both practices now had the same contract holders. It was also noted that the current premises for Holly Road would no longer be available from 1st April 2020 and that no concerns had been identified in relation to the relocation.
17.3	It was confirmed that letters had been sent to patients of the practice to inform them of the closure of the current site and their right to choose and options available to them (with 16 other practices being located within a 1 mile radius). It was recommended that committee approve the relocation.
17.4	**Decision: Committee approved the relocation of Holly Road to the Slieve Surgery as outlined in paper.**
18.	APMS Expiration - Y00492 Summerfield Group Practice
18.1	CMP briefly summarised the paper in relation to The Y00492 Summerfield Group Practice contract due to expire on 31st March 2021, after being extended for 10 years in 2011. It was confirmed that there are 2 options available to the CCG, list dispersal and re-procurement.
18.2	In order to enable the Committee to reach a decision on the future of the contract, a scoping exercise will be undertaken which will involve a patient listening exercise. Due to the large number of registered patients at the practice as at January 2020 (7,900), it was recommended that committee endorsed CCG officers to state a preferred option for pre-procurement of the APMS contract.
18.3	Following a scoping exercise, a more detailed report would be bought back to Committee for their review and decision.
18.4	KG queried if there were other practices located in the same premises. JMc confirmed that there are three other practices in the same building, two of which are BSOL CCG practices with relatively small list sizes and another SWBCCG contracted practices.
18.5	**Decision: Committee endorsed the preferred option of re-procurement as a part of the**

	patient listening exercise.
19.	CEPN/Training Hub Overview
19.1	LMt provided a brief summary of the paper which had been circulated to committee following discussion at February's meeting.
19.2	LMt highlighted the innovative nature of the work conducted in what was unique in the Black Country when first initiated. LMt also highlighted the instrumental involvement of the project co-ordinators who had been in post throughout the lifespan of the training hub (Alyson Hall, Mani Badhan and Nancy Szilvasi).
19.3	JR thanked LMt for the report and acknowledged the vale in such work in highlighting the great work which has been conducted. JR queried next step and if the report should be taken to Governing Body to further showcase what has been achieved.
19.4	Committee noted the update
20.	GP Contract Update (20/21 to 23/34)
17.1	CE confirmed that a presentation summarising the key points of the contract update document. Given the short amount of available time at that committee, CE proposed that the presentation be circulated following the meeting for members review. CE welcomed any feedback or further queries via email should that be agreed.
17.2	**Action: CE agreed to circulate a presentation which she had developed summarising the key changes in the GP Contract Update (20/21 to 23/24).**
ANY OTHER BUSINESS	
21.	Any Other Business
18.1	<u>Covid-19</u> CE noted that the Black Country and West Birmingham Emergency Preparedness Resilience and Response (EPRR) team had a dedicated situation room setup in the CCG and were working hard to keep up to date with latest guidelines and changes in the situation. CE noted that clear communication with practices was key and assurances / feedback were being collected from practices around contingency plans and challenges being faced.

Primary Care Operational Group

Terms of Reference for Approval

PRIMARY CARE COMMISSIONING COMMITTEES IN COMMON

DATE OF MEETING: Tuesday 23rd June 2020

AGENDA ITEM: 5.3

Title of Report:	Primary Care Operational Group – Draft Terms of Reference
Purpose of Report:	To share a draft terms of reference for Primary Care Operational Groups in each CCG to adopt.
Author of Report:	Sarah Southall, Head of Primary Care Wolverhampton/GPFV Programme Director
Management Lead/Signed off by:	Donna MacArthur, Director of Primary Care
Public or Private:	Public
Key Points:	A work stream was formed in May 2020 comprising of representation from each CCG Primary Care Team to review the terms of reference for Primary Care Operational Groups (PCOG) in each CCG. The work stream have compared membership, inputs/sub groups and reporting arrangements to pre-existing primary care commissioning committees and concluded upon a common terms of reference for the committee in common to consider. The draft terms of reference have been shared with members of Primary Care Operational Groups in each place and final amendments made to the attached version. The terms of reference include reference to the desire to work to a common quality assurance framework, this does not currently exist and would need to be developed in collaboration with the Quality Team.
Recommendation:	The committees accept and support the proposed terms of reference for adoption in each CCG to achieve a common approach and consistent focus.
Conflicts of Interest:	No conflicts of interest identified whilst preparing this report.
Links to Corporate Objectives:	
Action Required:	☐ Assurance ✔ ☐ Decision

Implications:	
Financial	N/A
Assurance Framework	N/A
Risks and Legal Obligations	N/A
Equality & Diversity	N/A
Other	N/A

PRIMARY CARE OPERATIONAL GROUP
Terms of Reference

Purpose

The role of the Primary Care Operational Group (PCOG) is to operationally support delivery of the delegated responsibilities relating to the commissioning of primary medical services. The PCOG will have delegated responsibility from the Primary Care Commissioning Committee (held in common for all CCGs) and the respective terms of reference.

The purpose of this group is to maintain an overview of the CCG(s) operational support to primary care providing assurance to the Primary Care Commissioning Committee that will be held in common.

Duties & Responsibilities

The overall objective for this group will be to ensure that the work required by the Primary Care Commissioning Committee delegated and held at CCG level to maintain an overview of activity and will require routine reporting to the committee include:-

- **Strategy** - implementation of the CCG and STP strategies for primary care based on national and local priorities that ensure stakeholders remain engaged at place level and priorities both national and local are recognised including GPFV strategic changes.
- **Workforce** – in addition to the workforce component of the STP Primary Care Strategy general practice training and development will be fundamental to the Black Country Training Hub operating standards. Needs analysis spanning all staff groups, recruitment attraction and retention initiatives plus quality assurance of training practices and student placements.
- **Quality –** Triangulate all relevant data and information to identify issues and concerns through routine review of the primary care assurance framework. This will be a standard information set designed to identify patient safety, experience and clinical effective trends and queries for discussion and where necessary improvement and assurance measures will be identified.
- **Contract management –** discussing and agreeing actions or recommendations to support local practices and practitioners whose performance is giving cause for concern and requires action as per their respective contractual terms. Maintain timely delivery of a prioritised contract review for all contracts (GMS/APMS practices) extending to PCN DES, QOF and Locally Commissioned Services in partnership with other commissioners including Public Health using the approved review tool.
- **Proposed Mergers/Practice Developments –** discussing initial proposals and supporting programmes of development within local practice and consideration of all amendments to the contract register in the wider context of safe services and sustainable general medical service provision. Make recommendations to the Primary Care Commissioning Committee in relation to contract changes, the establishment of new GP practices, re-procurement of existing practices and closure of GP practices.
- **Enhanced Services –** discussing issues such as uptake and performance of existing services and the development of new proposed services including time limited incentives to improve performance and/or address population health need. The clinical governance model should seek to ensure both national and local population health needs are recognised and prioritised for inclusion in the respective framework/offer to general practice to secure on-going quality improvements.
- **Digital –** work programmes to enable the ongoing development of new and existing technology and informatics within primary care will be considered as part of the GPIT update. The respective programme of work will be recognised and considered to ensure timely and effective delivery and also extends to data quality considerations pertaining to GP clinical systems and clinical coding ie QOF, enhanced services etc.

- **Estates –** primary care estate development updates will be discussed spanning the range of programme opportunities prioritised in line with the Estates Strategy. Regular reports from the strategic estates and Capital Review Group and details of Primary Care Infrastructure fund bids will be shared.

The group will use this overview to direct action within both the CCG and make recommendations to the committee for decision, assurance and/or approval.

Given the extensity of this group reports from sub groups including QOF/Frameworks, Training Hub, Quality including flu planning etc will be accepted and form the basis for discussions at the Primary Care Operational Group Meetings.

Membership
Representatives for this group comprise of regular formal members and other representatives who may attend periodically:-

Formal Membership
- Head of Primary Care (Chair) or nominated representative identified by Director of Primary Care
- Primary Care Contracting
- Quality Team
- Medicines Optimisation
- IM&T Programme Manager
- Estates
- Place Based Commissioning Team
- NHS England Primary Care Contracting
- Finance
- Practice Manager
- Training Hub
- GP member (may be governing body)
- Local Medical Committee (LMC)

Other representatives that may attend intermittently including:-
- Local Pharmaceutical Committee (LPC)
- Health Watch
- Communications Team
- Engagement Team

In order to assist with agenda setting other representatives will be encouraged to attend at least one in three meetings, one per quarter.

Meetings will be supported by dedicated administrative support to ensure agenda setting takes place with the chair ahead of each meeting and also to enable timely distribution of meeting papers, no less than 3 working days prior to the meeting date.

Meeting Frequency
Meetings should be held at monthly intervals with the expectation that there will be no less than ten meetings held per financial year.

Quorum Requirements
Meetings will be deemed quorate provided there are 4 formal representatives present and must include representation from the CCG Primary Care Team.

Recognition is given to the need for formal representatives to identify a nominated deputy to attend these meetings on their behalf should they be unable to attend in person.

Governance & Assurance Reporting
As a sub group of the Primary Care Commissioning Committee in Common regular assurance reports will be prepared and shared collectively among all CCGs to enable one combined report to be considered at each committee meeting.

Report to the Committee will confirm progress on all areas responsibility delegated and for decision making and will escalate other issues on an exception basis as required. This will include supporting the Committee in reporting its decisions and actions to other groups and committees at place and strategic level, where appropriate as structures become established.

The committee will be furnished with a breadth of information as per the group's responsibilities detailed above. There may be items requiring furtherance and in exceptional circumstances matters of concern will be raised with the CCG Executive Team in the period between committee meetings, should the need for urgent decision arise.

Representatives from CCG Teams including quality, finance, commissioning etc will be expected to ensure they also provide assurance within their respective departmental reporting to other relevant committees including Audit, Quality and Safety etc.

Any conflict(s) of interest in membership/involvement in this group will be declared by those involved & managed via the Chair of the group. The agenda will include Declarations of Interest at the top of the agenda to ensure conflicts are managed accordingly by the chair before any detailed discussions take place.

There will be practice level information discussed within these meetings that will require colleagues attending these meetings to observe confidentiality of information shared and its sensitivity. Therefore, members and those in attendance will be asked to sign and abide by a confidentiality statement.

Audit & Review
Periodic review of the role of this group & its performance may be undertaken in conjunction with the CCGs Audit Program and/or instruction from the Audit & Governance Committee.

The group will review its terms of reference annually. Any changes identified will be made to the terms of reference and version control adjusted accordingly prior to submission to the Primary Care Commissioning Committee for approval.

Primary Care Commissioning Committee

Comparison of local risk registers

PRIMARY CARE COMMISSIONING COMMITTEES IN COMMON

DATE OF MEETING: Tuesday 23rd June 2020

AGENDA ITEM: 5.4

Title of Report:	**Comparison of local PCCC risk registers**
Purpose of Report:	To compare the current risks held by each PCCC and determine the issues that are common to all or that would be better addressed at a regional level rather than locally.
Author of Report:	Sara Saville Head of Corporate Governance Walsall CCG
Management Lead/Signed off by:	Donna Macarthur Director of Primary Care and Integration Walsall CCG
Public or Private:	Public
Key Points:	Comparison of the Black Country and West Birmingham CCGs Primary Care Commissioning Committees risk registers Proposal for interim risk management arrangements for the risks which are relevant at both system and local level.
Recommendation:	1. The committees are asked to review the risks and decide which of these risks should be managed through the committees in common arrangements and which ones are better with local management. 2. Primary Care Commissioning Committee Chairs are asked to review the local risks identified by the committee in recommendation 1 and agree with the support of the committee members, the most appropriate forum for any remaining risks for future management.
Conflicts of Interest:	None identified
Links to Corporate Objectives:	
Action Required:	✔ Assurance ✔ Decision
Implications:	
Financial	N/A
Assurance Framework	N/A
Risks and Legal Obligations	N/A
Equality & Diversity	N/A
Other	N/A

1 Introduction

Each Primary Care Commissioning Committee holds a local risk register which is maintained by the committee. As the four Black Country CCGs start to work together it is important to start to understand what the local issues are and what are the issues that are shared across the region and can be managed jointly.

2 Comparison

In order to start that dialogue the committee is presented with a high level description of the risks held on each of the CCGs Primary Care Commissioning Committee risk register in appendix 1.

At first glance it is apparent that each committee holds a different number of risks; Walsall 12, Sandwell and West Birmingham 10, Wolverhampton 6 and Dudley 4. The risk rating also varies with only Walsall holding red rated risks.

There are a number of risks that are similar across the organisations which are indicated in bold; workforce, estates, PCN development and regulatory issues. The residual rating for these risks vary which is will be a combination of variance in moderation of allocation of risk ratings, local variation in the extent of the issue and effectiveness of controls. These risks would lend themselves to a discussion at the committees in common, for both management of controls and also sharing learning.

There are a further 21 risks between the organisations out of which there is potential for another 7 risks which could be relevant across the system and a further 15 risks which have a more local relevance.

In the longer term, as the primary care commissioning arrangements are developed, the committees in common should be mindful that risks arising from delegated functions will need to remain the responsibility of these committees.

All the other risks range from ratings of 6 to 12. It should be noted that whilst each CCG works with a 5x5 risk matrix, the allocation of the red, amber, yellow and green varies between them as illustrated in table 1 below

Table 1

Risk Matrix Comparison by CCG	Red	Amber	Yellow	Green
Dudley	20-25	10-16	5-9	1-4
Walsall	15-25	8-12	4-6	1-3
Wolverhampton	15-25	8-12	4-6	1-3
Sandwell and West Birmingham.	16+	8-15	4-7	1-3

3 Risk management

The risk management process to support the collaborative working across the Black Country CCGs has not been agreed to date. This will be developed as the governance arrangements are embedded and the staffing structure is in place to support its implementation. In the interim it is appropriate that the committee agree a process to ensure that all the risks previously identified through the primary care commissioning committees are reviewed with a view to either close them down or continue the mitigation through application of controls locally or at a system level.

The specific arrangements for the local risks may differ at each place as the place governance processes are likely to reflect elements of current practice whilst we move towards more uniform structures. The place assurance meetings and or the primary care operational groups are likely to be the most appropriate forums to manage the remaining local risk.

4 Recommendations

1. The committees are asked to review the risks and decide which of these risks should be managed through the committees in common arrangements and which ones are better with local management.
2. Primary Care Commissioning Committee Chairs are asked to review the local risks identified by the committee in recommendation 1 and agree with the support of the committee members, the most appropriate forum for any remaining risks for future management.

Appendix 1

Comparison of Primary Care Commissioning Committee Risk Register as of May 2020

CCG	Risk description	Residual risk rating	System/Place
Walsall	**Workforce**	4x4=16	S
Walsall	**Estates NHS PS GP leases**	4x5=20	S
Walsall	GP premises	4x5=20	P
Walsall	GP engagement with PBC	2x4=8	S
Walsall	GP SI process	3x4=12	P
Walsall	GP IT	4x3=12	P
Walsall	Extended hours contract	3x3=9	P
Walsall	Slippage of town centre dev	3x4=12	P
Walsall	**PCN dev**	3x4=12	P
Walsall	Improve support to PC	2x3=6	P
Walsall	PC informatics resource	3x4=12	P
Dudley	**Regulatory issues**	2x4=8	S
Dudley	**Workforce**	4x3=12	S
Dudley	**Estates NHSPS**	2x3=6	S
Dudley	Finance - sustainability	2x4=8	P
SWB	**Regulatory issues**	2x4=8	S
SWB	Measles immunisation	2x3=6	P
SWB	Financial – Babylon	3x4=12	S
SWB	**PCN dev**	3x3=9	S
SWB	**Workforce**	3x4=12	S
SWB	Latent TB	3x3=9	S
SWB	Social prescribing	2x2=4	P
SWB	Financial - overspend	3x2=6	S
SWB	Capacity pressure on individual practice	3x4=12	P
SWB	Health app uptake	3x3=9	P
W'ton	PC Counselling service	12	P
W'ton	**Workforce**	9	S
W'ton	Digital first	8	S
W'ton	Patient Choice	6	P
W'ton	New ways of working	8	S
W'ton	Access to estates funding	8	S

M88038 Linkway Medical Practice

Application for the Closure of Central Clinic Branch Site

PRIMARY CARE COMMISSIONING COMMITTEES IN COMMON

DATE OF MEETING: Tuesday 23rd June 2020

AGENDA ITEM: 6.1

Title of Report:	M88038 Linkway Medical Practice – Application for the Closure of Central Clinic Branch Site
Purpose of Report:	To consider the request from Linkway Medical Practice to close their branch site Central Clinic, Horseley Road, Tipton, DY4 7NB
Author of Report:	Jane McGrandles Head of Primary Care Contracts SWBCCG
Management Lead/Signed off by:	Lisa Maxfield/Donna Macarthur
Public or Private:	Public
Key Points:	Linkway Medical Practice has applied to close Central Clinic Branch Site. There have been no objections raised to the proposal from either patients or local stakeholders. The Premises Review Panel has considered the documentation and recommend to the PCCC that approval is given to close Central Clinic**.**
Recommendation:	That approval is given by the Sandwell and West Birmingham CCG Primary Care Commissioning Committee to close Central Clinic branch site of Linkway Medical Practice
Conflicts of Interest:	N/A
Links to Corporate Objectives:	To improve the health of our population by reducing inequalities in health outcomes and improving the quality of and access to services
Action Required:	☐ Assurance ✔ ☐ Decision
Implications:	
Financial	If approval is given to close the site, the whole building will be declared surplus, resulting in the CCG saving 86k per year in void costs and GP premises costs.
Assurance Framework	N/a
Risks and Legal Obligations	N/a
Equality & Diversity	EQIA completed
Other	N/a

10th June 2020

M88038 Linkway Medical Practice – Application for the Closure of Central Clinic Branch Site

1. Introduction

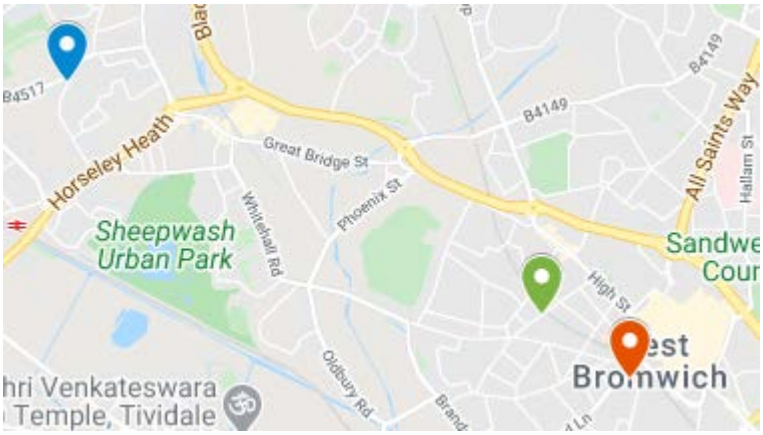
In July 2019 the Linkway Medical Practice applied to the CCG to permanently close their branch site, Central Clinic, Tipton. Following a meeting with the CCG, the Practice agreed to undertake a more detailed consultation, in particular with their vulnerable patients and/or carers.

In March 2020, as part of the COVID-19 response, the CCG gave approval to the Practice to temporarily close Central Clinic to allow all of their clinicians and staff to work at their main site and second branch site.

On the 28th April 2020, after carrying out additional patient consultation, the practice submitted a further request to close Central Clinic on a permanent basis.

2. Background

Linkway Medical Practice M88038 is a GMS Practice with a registered list size of 13,890, it has a main site at the Lyng Medical Centre and two branch sites one at Dartmouth Medical Centre and the second at Central Clinic.



The above map shows the location of the three sites.

Red pin – Linkway Medical Practice (Main site)

Lyng Medical Centre

Frank Fisher Way

West Bromwich

B70 7AW

Green pin – Dartmouth Medical Centre (Branch site)

1 Richard Street

West Bromwich

Birmingham

B70 9JL

Blue pin – Central Clinic (Branch site)

Horseley Road

Tipton

DY4 7NB

Central Clinic is an NHS Property site. Currently the Practice is occupying the premises under a 'lease at will', whereby they are only required to give one month's notice to vacate the building.

NHS Property Services have approached the Practice to sign a 25 year lease, which they have turned down due to their intent to apply to close down the site.

The Practice have confirmed that the closure of the branch site will not have an impact on their practice boundary.

Linkway Medical Practice and Dartmouth Medical Centre sites are open every day. The distance from Central Clinic to Dartmouth Medical Centre is 2.5 miles. It takes 7 minutes in the car; 23 minutes on the Bus (numbers 42 and 43) or 26 minutes (number 74). Walking distance is 46 minutes.

There are six other Practices within a mile of Central Clinic.

3. Rationale for Closure

When operational, Central Clinic is open Monday to Friday from 08:30 to 18:30 closing at 1pm on a Thursday, when Central Clinic is closed during core hours the patients access services at one of the other two sites.

In July 2019, 840 patients accessed their Primary Care from Central Clinic, by December 2019, following further patient consultation, this had reduced to approximately 600 patients, since then the number continued to reduce with the majority of the patients choosing to receive their primary care at either the Linkway or Dartmouth Street, and a small number making the decision to register with a new Practice.

Linkway Medical Practice contacted all patients by letter advising them about their proposal to close the branch site and asking for their views. Vulnerable patients and/or their carers were contacted by telephone.

The Practice provided support to those vulnerable patients who chose to register with a neighbouring Practice to ensure their registration was completed satisfactorily.

By permanently closing the Central Clinic branch site, Linkway Medical Practice state they will be able to maximise the value of the resources they have available and ensure the patients receive the level of clinical care that they are entitled to.

The Practice reports that they have capacity to accommodate patients that would otherwise be seen at Central Clinic at their two other sites and would still have capacity to register new patients.

All specialist services (i.e. diabetic and respiratory clinics) are provided at the Linkway Medical Practice and Dartmouth Medical Centre.

The Practice have engaged with the Head of Premises and Capital Development, who supports the application.

4. Finance Implication of Closure

Currently, over half of the Central Clinic site is empty and costs the CCG £61,000 per annum for the void space, in addition to this, the GP section of the building costs the CCG £25,500 per annum, should the application for closure be approved, the CCG will be able to declare the whole building as surplus, resulting in its sale and removing it from the CCG system costs within a period of 6 months, or sooner if the building is sold earlier.

5. Patient Engagement

Patients were initially informed at two Patient Participation Group (PPG) meetings of the Practice's intent to apply to close Central Clinic. Patients who were not members of the PPG, or were not present, were informed through posters in the waiting room and opportunistically when patients attended surgery.

Targeted phone calls were undertaken for all vulnerable patients to ensure both the patient and where appropriate, the carer, were both aware of the intention to apply for the closure.

Patients were assured that they would be able to continue to see their normal GP, as all staff would be transferred over to the other sites.

The Practice has received no complaints about the proposed closure.

6. Staff Engagement

Staff have been redeployed to Linkway Medical Practice for the COVID-19 response, and it is proposed this arrangement continues should the application to close be successful.

A staff consultation has taken place where a meeting was held with practice staff, the Business Manager and the GP Partner.

All staff concerns were discussed individually with staff. The staff currently working at Central Clinic were at risk of lone working due to low numbers, so would benefit from better team working at one of the other sites.

7. Premises Review Panel

The Premises Review Panel consisting of the Non - Executive nurse board member (Chair) Head of Engagement & Communications, Head of Primary Care, Senior Finance Manager – Primary Care, Primary Care Quality Lead, CCG IT Lead & Technical Officer and Head of Premises & Capital Development reviewed the application to close the site.

The panel considered the fact that a very small proportion of the practice list accessed their Primary Care from Central Clinic and that these patients were used to attending the main site at the Lyng and at Dartmouth Street, when the branch site was closed on a Thursday afternoon, for specialised clinics and nurse appointments.

It was noted that all vulnerable patients(or carers) had been contacted individually by telephone and were either agreeable to attend one of the other two sites or chose to register with a GP Practice closer to their home.

The Head of Estates confirmed that closure of this site was identified in the CCG Estates Strategy and it was noted that whilst there would be a short term increase in costs to the estates budget due to there being void space, the costs to Primary Care would decrease.

The IT Lead confirmed that he was aware of the Practice's intention to apply to close the site, so work undertaken at Central Clinic has had an IT exit plan in mind.

The 6 neighbouring practices were approached for comment. No objections or concerns were raised to the proposed closure of the branch site. One Practice approached the CCG to confirm that they had capacity to register any/all patients who may be affected by the proposed closure.

The Panel therefore make a recommendation to the PCCC to approve the application to close the branch site at Central Clinic Tipton.

8. Conclusion

The Linkway Medical Practice has applied to close its branch site at Central Clinic Tipton, all patients who accessed their Primary Care services from Central Clinic have either agreed to go to the main or second branch site for their primary care with a small proportion opting to register with a new GP Practice.

In the short term there will be increase in void space costs, but this will cease 6 months after closure.

The Premises Review Panel made a recommendation to the Committee that the closure of Central Clinic is approved.

9. Options

Option 1- Refuse the Application to Close Central Clinic

The CCG would inform the Practice of the outcome of the application and the practice would continue to be responsible for the site. Cost savings identified by the estate's teams would not be realised.

Option 2- Approve the Application to Close Central Clinic

The CCG would inform the Practice of the outcome of the application and the practice would commence to close down the site. The estates team will be able to mark the building as surplus to demand, commencing the 6-month time period after which the CCG would no longer be liable for void costs. Patients will continue to access services from Dartmouth Medical Centre and Linkway Medical Practice as usual.

10. Recommendation

Option 2

Approve the immediate closure of the Central Clinic branch site.

Primary Care Frameworks and Locally Enhanced Service Payments Quarter 1 2020/21

PRIMARY CARE COMMISSIONING COMMITTEES IN COMMON

DATE OF MEETING: Tuesday 23rd June 2020

AGENDA ITEM: 6.2

Title of Report:	Primary Care Frameworks and Local Improvement/Enhanced Service Payments (Quarter 1 2020/21)
Purpose of Report:	To provide an overview position for each CCGs primary care frameworks and enhanced service payments/activity.
Author of Report:	Sarah Southall, Head of Primary Care Wolverhampton/GPFV Programme Director
Management Lead/Signed off by:	Donna MacArthur, Director of Primary Care
Public or Private:	Public
Key Points:	A work stream has been formed to review the position in each place/CCG for their respective Primary Care Frameworks and Local Improvement/Enhanced Services. The primary focus has been to identify the state of readiness for 2020/21 and secondly to reduce the likelihood of variation among CCGs regarding dispensation and payment as a result of Covid-19. 3 CCGs have quality improvement frameworks in place with variation in level of investment and state of readiness to launch with practices within their respective membership(s). 1 CCG has opted out of the National Quality Outcomes Framework (QOF) and has a local all encompassing framework that has been agreed with their Primary Care Commissioning Committee prior to Covid-19. Identification of local enhanced services commissioned by each CCG and how practice income will be preserved due to the impact of Covid-19 affecting the ability of practices to provide commissioned services.
Recommendation:	The committees accept all 3 recommendations listed within the report.
Conflicts of Interest:	CCG committee members who are GPs will be conflicted by the content of this report.
Links to Corporate Objectives:	List corporate objectives here please….
Action Required:	☐ ✔ Assurance ✔ ☐ Decision

Implications:	
Financial	Yes – a consistent approach is recommended for payments may to member practices for both frameworks and enhanced services as detailed within the report.
Assurance Framework	N/A
Risks and Legal Obligations	N/A
Equality & Diversity	None of the protected characteristics are affected by the content of this report.
Other	N/A

1 Purpose

To update the committee in common on the work of a newly formed task and finish group and the findings from those meetings associated with CCG Primary Care Frameworks, identification of local enhanced services and the payments they would ordinarily attract.

2 Key Points

2.1 Work Stream

The work stream was formed in May and comprised on representatives from each CCGs Primary Care Team, meeting at fortnightly intervals. The common purpose and focus for discussion was to determine the status of each CCGs primary care framework(s) and also to determine what enhanced services were in place to ensure that as far as possible a common approach to launching those schemes and continuation of payment during the national pandemic (Covid-19) were considered so that a consistent approach could be achieved.

2.2 CCG Quality Improvement Frameworks

Each CCG has a locally commissioned framework. In Dudley the commissioning arrangement also includes funds that would ordinarily be aligned to the National Quality Outcomes Framework, an integrated framework has been commissioned in Dudley combining both funding sources in one scheme. This variation has been agreed with NHS England. The other CCGs continue to adhere to the requirements of national commissioning (QOF) and supplement this with local investment in addition to further improve quality outcomes for their patient population.

Work stream members representing each CCG have reviewed the position regarding scheme status and readiness to implement, the Dudley scheme had already been approved and was therefore able to launch as usual on 1 April 2020. In the other three CCGs this wasn't feasible. The table below provides an overview of the position for each CCG taking account of the position with end of year reconciliation for 2019/20 scheme(s) and the intended arrangements for 2020/21 scheme(s) including the value and anticipated launch date for each scheme.

CCG	2019/20 Reconciliation	2020/21 Scheme Value	2020/21 Scheme Anticipated Launch	Recommendation
Dudley	Complete	£7.2 million	Scheme live April 2020→	Scheme mobilised with guidance for provision during Covid period.
Sandwell and West Birmingham	Complete	£8.3 million	Quarter 1 & 2 funding repurposed to address Covid-19 Care Home Response	See separate Report.
Walsall	Complete	£1 million	September 2020	Draft scheme(s) to be approved at local PCCC(s) in July and external provider engaged to build new searches in GP clinical systems ready for go live in September.
Wolverhampton	Offers made, completion by end of June	£3 million	September 2020	

Representatives from each CCG confirmed that there had been consideration given to the impact on service delivery as a result of Covid-19 with particular reference to guidance issued by NHS England ie Standard Operating Procedure for Primary and Community Services. This guidance advocates how care should be delivered whilst safeguarding practice staff and patients from the risk of infection posed by Covid-19. The sub group concluded that each framework should include guidance on how indicator sets could be delivered differently taking account of limitations arising from Covid-19. Therefore, two sets of assumptions will be detailed in each indicator set, delivery during Covid-19 and business as usual as interactions with patients via telephone/video are advocated in the first instance and only arranging face to face on site attendance where technology does not allow ie physical intervention.

The working group continues to meet regularly to ensure each framework is able to mobilise as per the intentions detailed above. With the exception of Dudley CCG who have an approved indicator set that is based on population health need, all other CCGs are prioritising indicator sets based to ensure population health need and their relevance to the recovery phase of Covid-19 are prioritised along with recommendations that had been made to standardise indicators that are clinical priorities supported by the system's Clinical Leadership Group ie cardiovascular disease, asthma etc.

A final point at this stage is to recognise the shorter timescale for delivery of the scheme(s) in 2020/21 and therefore those CCGs who are mobilising their schemes later in the financial year will ensure trajectories are adjusted to reflect the shorter scheme duration and a sliding scale for partial achievement.

2.3 Local Enhanced Services

The work stream has also recognised variation that exists in commissioning of of enhanced services in primary care. The content of each framework and other services that are also commissioned locally in each CCG differ among CCGs.

There is an opportunity for the work stream to explore in more detail the feasibility of whether some of the enhanced services could/should be included in each CCGs framework and where this wouldn't be viable but the service is still required to achieve a consistency in specification and payment for that service. This approach would seek to achieve a reduction in the current gap in variation and could be the next area of focus for the work stream.

2.4 Payment

During the early stages of the Covid-19 the CCGs committed to a consistent approach for end of year reconciliation and payments for those services ie payments of 2019/20 would be no less than payments made in 2018/19.

In line with that approach payments for enhanced services across all CCGs will, as far as possible be consistent and in recognition of the importance of preserving practice income that would be achieved under normal circumstances aspiration payments for frameworks will continue to be made based on 2019/20 achievement. In the case of enhanced services, payments will be made to mirror achievement for the same period in 2019/20 with the expectation that where a shortfall in performance has arisen, due to Covid-19, practices continue to receive income and plan for the reduction in activity to be rectified in the final half of the financial year ie October 2020 onwards. In practical terms practices will be required to plan additional capacity to manage demand for enhanced service delivery.

3 Recommendations

The committee should support the recommendations made pertaining to local frameworks and the timescales for implementation.

The committee should consider and confirm their support for further work to be undertaken to reduce the variation in content of quality frameworks and locally commissioned service, including consistent service specifications and payment.

Finally, the committee should confirm their support for a consistent approach to preserving practice income across all CCGs, and the importance of managing demand from October to March 2021 to achieve a comparable level of performance with 2019/20 activity.

SWB CCG Amended Primary Care Commissioning Framework (PCCF) for 20/21

PRIMARY CARE COMMISSIONING COMMITTEES IN COMMON

DATE OF MEETING: Tuesday 23rd June 2020

AGENDA ITEM: 6.3

Title of Report:	SWB CCG Amended Primary Care Commissioning Framework (PCCF) for 20/21
Purpose of Report:	To inform committee of the work that has been undertaken to review the PCCF for 20/21 in light of COVID 19 and the options that have been considered in finalising an amended framework. To gain approval for the amended framework and the principles around delivery and payment.
Author of Report:	Carla Evans, Head of Primary Care SWB CCG
Management Lead/Signed off by:	Michelle Carolan, Managing Director Sandwell
Public or Private:	Public
Key Points:	1. The PCCF 20/21 was originally approved at the SWB CCG PCCC in March 2020. 2. A review has been undertaken in light of COVID with 3 options being considered. 3. The preferred option was Option 2 – To undertake a review of each standard to assess deliverability during COVID 19, making any necessary amendments. 4. A number of amendments have been made but the original targets for Diabetes, Cardiovascular Disease, Respiratory and Mental Health remain in place as aspirational targets. 5. Standard 11 Demand Management has been removed from the PCCF with just over half of the associated funding for this standard being re-purposed to fund a Care Homes LIS. The balance of funding has been moved into Standard 1 together with requirements around Advice and Guidance and Single Point of Access. 6. Consideration has been given to providing practices with an income guarantee as outlined in the recommendation.
Recommendation:	1. To approve the outcome of the review of the PCCF 20/21 in light of COVID 19 and the amended PCCF requirements which will be commissioned from 1st July 2020. 2. To approve the continued ringfencing of PCCF funding and provide a guarantee to member practices that they will retain their 70% delivery payments and that if further spikes in COVID 19 occur in the remainder of 20/21 and they have achieved at least the minimum outcome targets they will receive the full payment for those particular requirements.
Conflicts of Interest:	Dr A. Ahmed and Dr R. Sullivan are conflicted as they have a direct financial interest in the PCCF as GMS contract holders within SWB CCG.
Links to Corporate Objectives:	S4 – Review, Performance Manage, Discharge Public Accountabilities

Action Required:	☐ Assurance ✔ ☐ Decision
Implications:	
Financial	£149,250 of investment from the PCCF has been re-purposed from Standard 11 Demand Management to fund the Care Homes LIS therefore the total PCCF Investment for 20/21 is £8.3m (£14.24 per patient)
Assurance Framework	N/A
Risks and Legal Obligations	N/A
Equality & Diversity	N/A
Other	N/A

Working together for healthier futures

SWB CCG Amended Primary Care Commissioning Framework (PCCF) for 20/21

NHS Dudley Clinical Commissioning Group
NHS Sandwell and West Birmingham Clinical Commissioning Group
NHS Walsall Clinical Commissioning Group
NHS Wolverhampton Clinical Commissioning Group

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1. Introduction

1.1 The Primary Care Commissioning Framework (PCCF) for 20/21 was originally approved by the Sandwell and West Birmingham CCG Primary Care Committee in March 2020. However, following the decision to suspend the PCCF 19/20 on 19th March the revised framework for 20/21 was not formally commissioned with practices.

1.2 Following Simon Steven's Letter of 29th April[1] we have now entered the second phase of our response to COVID 19 with an ask for primary care to deliver as much routine and preventative work as can be provided safely. The latest national guidance and standard operating procedures for General practice in the context of coronavirus (COVID-19) also states that "We are now in the second phase of the pandemic response following our 29 April letter. Practices should be focused on the restoration of routine chronic condition management and prevention wherever possible, including vaccination and immunisation, contraception and health checks."[2]

1.3 In light of this and our local plans around restoration and recovery, a review of our previously agreed PCCF for 20/21 has been undertaken in light of the new model for general practice during COVID 19 to determine where amendments would be required. This paper details the options considered, the outcome of the review and recommendations to approve an amended framework together with a practice income guarantee.

2. Review of PCCF 20/21 in light of COVID 19

2.1 Prior to commencing a review of the PCCF for 20/21 a decision was made via the Managing Director for Sandwell through the incident room to commission a Care Homes Local Improvement Scheme to fund the delivery of the COVID-19 care home support model outlined in the NHSE letter of 1st May. It was agreed that the funding for the LIS would be re-purposed from the Demand Management Standard within the PCCF and as such this standard would be removed from the framework for 20/21.

2.2 The funding for the Care Homes LIS represents just over half of the funding for the Demand Management Standard (£149,250) and as such, the balancing amount has been transferred into Standard 1 Primary Care Access and Onward Referral together with the indicators around Advice and Guidance and Single Point of Access.

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[1] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/second-phase-of-nhs-response-to-covid-19-letter-to-chief-execs-29-april-2020.pdf

[2] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/CO485_guidance-and-standard-operating-procedures-general-practice-covid-19.pdf

2.3 As part of the wider review of the PCCF for 20/21 three options were considered:

- Option 1 – To launch the PCCF as agreed in March 2020 with no amendments.
- Option 2 – To undertake a review of each standard to assess deliverability during COVID 19, making any necessary amendments.
- Option 3 – To undertake a more radical review of the PCCF to refocus efforts on targeting work towards population groups most adversely affected by COVID 19.

2.4 In considering these options the following things were taken into account:

- Feedback from our clinical leads, commissioning leads and our PCN Clinical Directors on behalf of their member practices.
- The desire to resume local primary care frameworks at the earliest opportunity in line with our restoration and recovery plan.
- The need for primary care to have certainty around the income from the PCCF and the appetite for significant change during an already uncertain period.
- The deliverability of the PCCF within the new model of general practice mandated during COVID 19.
- The backlog of work practices are likely to have to 'catch up'
- The potential for further spikes in COVID 19 together with winter pressures
- The need to continue to strive to meet the nationally mandated targets contained in the NHS Oversight Framework
- The desire not to lose momentum on the Long Term Plan ambitions

2.5 Having taken all these things into consideration option 2 was determined to represent the most pragmatic approach as it would allow us to conduct a timely review of the individual requirements of each standard in light of COVID 19 and be in a position to launch the PCCF from 1st July 2020. It also offered the benefit of ensuring that practices would have familiarity with the framework so would be able to focus their efforts on planning operationally how to deliver the work based on a remote model of working rather than having to spend time digesting a completely new set of requirements.

2.6 In light of this a detailed review was subsequently undertaken in conjunction with the clinical and commissioning leads of all of the requirements in each standard with amendments made as appropriate to reflect the new model of general practice and the principle of remote consultation with minimal risk assessed face to face contact.

2.7 In considering the individual outcome targets associated with each of the standards some amendments have been made as detailed in appendix 1 (Changes to PCCF 20/21 following review in light of COVID 19). We will also be making changes to how practices code their work to allow exception coding in instances where patients decline certain aspects of the care delivery. This will ensure we are able to recognise that during COVID 19 despite the clinician's

best attempts to deliver the required care there will inevitably be patients who do not wish to access elements of care that have to be delivered face to face.

2.8 However, for the targets in the clinically based standards (Diabetes, CVD, Respiratory and Mental Health) it is recommended that the original targets remain as aspirational targets with a further review being undertaken in December to assess whether any reduction in targets is required in light of actual events during this time and practice performance to date.

2.9 In order to plan for this eventuality the review of the PCCF has taken into consideration the level of reduction that could be applied at this time and concluded that if required we would remove all of the upper targets within the Diabetes, CVD, Respiratory and Mental Health Standards and base full payment on achievement of the lowest targets for each requirement.

3. Practice Income

3.1 Whilst a review of the PCCF has been undertaken and amendments made in light of COVID together with a further recommendation to conduct a second review of the targets in the clinical standards in December there remains an element of nervousness within our member practices around a potential loss of income.

3.2 In light of the uncertainty for the remainder of this financial year, and the fact that the income from the PCCF represents a significant percentage of the total practice income, committee are asked to consider approving an income guarantee for practices.

3.3 The PCCF is paid on the principle of 70% payment for delivery which is made in advance through quarterly payments and a balancing payment of up to 30% based on achievement of the various outcome requirements in each standard. It is therefore recommended that we provide a guarantee to practices that the funding for PCCF will continue to be ringfenced with practices guaranteed to retain their 70% delivery payments and if there are further spikes in COVID 19 and they have achieved at least the minimum outcome targets they would receive the full payment for those particular requirements.

4. Recommendations

4.1 The Sandwell and West Birmingham CCG Primary Care Commissioning Committee is asked to consider the following recommendations:

4.2 To approve the outcome of the review of the PCCF 20/21 in light of COVID 19 and the amended PCCF requirements which will be commissioned from 1st July 2020.

4.3 To approve the continued ringfencing of PCCF funding and provide a guarantee to member practices that they will retain their 70% delivery payments and if further spikes in COVID 19 occur in the remainder of 20/21 and they have achieved at least the minimum outcome targets they will receive the full payment for those particular requirement

	Removed
	Replaced

Changes to PCCF 20/21 following review in light of COVID 19

Standard 1 – Primary Care Access and Onward Referral	
This standard has been re-written to be relevant to the revised model of access for general practice, including two of the requirements from the previous Demand Management Standard (Advice and Guidance and Single Point of Access).	
Original Outcome Requirements	**Amended Outcome Requirements**
1. Practices must be open from 8.00am to 6.30pm, Monday to Friday, ensuring that patients can access the practice and its services in person and via telephone i.e. practice doors and telephone lines must be open. 2. Demonstrate the practice is offering a minimum of 90 clinical consultations per 1000 patients per week (weighted population). (This is based on the period Monday to Friday, 8am to 6.30pm. Appointments for enhanced services including extended hours and weekend working are excluded). Clinical Consultations are those provided by a GP (including a training GP) nurse practitioner, practice nurse, physicians associate, clinical pharmacist, healthcare assistant or other allied health professional (e.g. Physiotherapist) (includes	**Advice and Guidance** 1. An improvement in the % ratio of advice and guidance requests compared to e-RS referrals • If demonstrate a 5% ratio of advice and guidance requests compared to e-RS referrals – 15% payment **Single Point of Access (SPA)** 2. An improvement in the % ratio of SPA referrals compared to direct ED referrals. • If demonstrate a 70% ratio of SPA referrals compared to direct ED referrals – 15% payment

face to face, telephone or other innovative method). 3. Demonstrate active use of text messaging as a method for reducing DNAs. 4. Record the number of DNAs monthly, to be reported at end of year.	
Standard 2 – DMARDs	
The only changes to this standard are to remove the target around shared care as it is not deemed to be an appropriate use of time during COVID 19 to be chasing consultants for ESCAs where these are not already in place. There is still a requirement to ensure that shared care is read coded in the clinical system so the principle remains. The coding for blood monitoring will allow for exceptions to be recorded where a patient declines to attend for a blood test but following a clinical risk assessment the decision is made to continue to prescribe.	
Original Outcome Requirements	**Amended Outcome Requirements**
1. Ensure that at least 80% of the prescriptions issued for the drugs listed above have a read-code for shared care documented in the clinical system. 2. Ensure that all patients on DMARDs have appropriate blood monitoring. However, for the achievement of PCCF practices must ensure that 95% of DMARDs prescribed by the practice have a read code documented in the clinical system to confirm appropriate blood monitoring has been carried out in accordance with local/national guidelines (as per the ESCA).	1. Prescriptions issued for the drugs listed above should have a read code for shared care documented in the clinical system. 2. Ensure that all patients on DMARDs have appropriate blood monitoring. However, for the achievement of PCCF practices must ensure that 95% of DMARDs prescribed by the practice have a read code documented in the clinical system to confirm appropriate blood monitoring has been carried out in accordance with local/national guidelines (as per the ESCA). During COVID-19 Patients should continue to be invited for their regular blood tests, and this should be read-coded in the clinical system. When patients are not willing to attend for blood monitoring, clinicians should undertake a risk assessment to

	review the appropriateness of ongoing treatment, documenting the outcome in the patient record.

Standard 3 - MDTs	
This standard has been reviewed to refocus the MDT on those vulnerable groups and patients at risk of unplanned admissions. The outcome requirements have been adjusted to reflect that a reduced number of MDTs will be held over the 9 months period and a specific target set for assessment of Osteoporosis.	
Original Outcome Requirements	**Amended Outcome Requirements**
1. Provide evidence of 6 MDT meetings held and attendees at those meetings. 2. Create and maintain a register of patients identified at risk of unplanned admissions. 3. Patients identified as having experienced a fall in the last 12 months are subsequently reviewed at an MDT meeting as appropriate and referred to the appropriate falls service if required. 4. Patients who are aged 50+ identified as having experienced a fall in the last 12 months and sustained a fragility fracture to be assessed for Osteoporosis using: • FRAX - can be used for people aged between 40 and 90 years, either with or without BMD values, as specified; or • Qfracture - can be used for people aged between 30 and 84 years. BMD values cannot be incorporated into the risk algorithm; or	1. Provide evidence of 4 MDT meetings held and attendees at those meetings. 2. 75% of patients aged 50+ with a no cause fall OR sustained a fragility fracture in the last 12 months to be assessed for Osteoporosis using: • FRAX - can be used for people aged between 40 and 90 years, either with or without BMD values, as specified; **OR** • Qfracture - can be used for people aged between 30 and 84 years. BMD values cannot be incorporated into the risk algorithm; **OR** • By referring the patient to an Osteoporosis Service 3. All GPs to complete the RCGP Osteoporosis eLearning module (2 CPD points available)

• By referring the patient to an Osteoporosis Service 5. All GPs to complete the RCGP Osteoporosis eLearning module (2 CPD points available)	

Standard 4 – Carers	
The requirement to offer and undertake carer's health checks has been removed from the standard and replaced with a requirement for carers to be proactively contacted by the primary care team to assess current needs and signpost to appropriate support services or social prescribing.	
Original Outcome Requirements	**Amended Outcome Requirements**
The following apply only to carers who are registered with the practice. 1. Demonstrate the addition of new carers to the register each year. 2. Evidence that 95% have been offered a health check. 3. Evidence that 95% have been offered a flu vaccine. 4. Increase year on year the number of carers health checks completed or maintain performance above the 75th centile for CCG wide performance.	The following apply only to carers who are registered with the practice. 1. Demonstrate the addition of new carers to the register each year. 2. Evidence that 95% have been offered a flu vaccine. 3. Evidence that 70% of carers have been proactively contacted by the primary care team to assess current needs and signpost to appropriate support services or social prescribing.

Standard 5 – Diabetes	
The only change to this standard is to reduce the requirements for audits from 5 to 3.	
Original Outcome Requirements	**Amended Outcome Requirements**
Prevention (5%) 1. Refer a minimum of 20% of patients (18 years and over) identified with a HbA1c between 42-47 (6-6.4%) mmols taken in	**Prevention (5%)** 1. Refer a minimum of 20% of patients (18 years and over) identified with a HbA1c between 42-47 (6-6.4%) mmols taken in the last 12

the last 12 months who do not have an existing diagnosis of diabetes (excluding patients that have already attended) to the NDPP and read code accordingly.	months who do not have an existing diagnosis of diabetes (excluding patients that have already attended) to the NDPP and read code accordingly.
Management (15%)	**Management (15%)**
2. Diabetes Management (10%):	2. Diabetes Management (10%):
a) Improve the proportion of people diagnosed with diabetes (type 1 and type 2) who receive all eight care processes • If achieve 60% of diabetic patients – 7.5% payment • If achieve 55% of diabetic patients – 5% payment • If achieve 50% of diabetic patients – 2.5% payment	a) Improve the proportion of people diagnosed with diabetes (type 1 and type 2) who receive all eight care processes • If achieve 60% of diabetic patients – 7.5% payment • If achieve 55% of diabetic patients – 5% payment • If achieve 50% of diabetic patients – 2.5% payment
b) Improve the number of people achieving all 3 treatment targets from the 19/20 baseline - 2.5% payment	b) Maintain the number of people achieving all 3 treatment targets from the 19/20 baseline - 2.5% payment
3. Audits (5%): (please note nil returned audits will not be paid) a) The practice must undertake a clinical audit and maintain a spreadsheet of all patients seen/reviewed within the DiCE clinics using table 3 in appendix 3.	3. Audits (5%): (please note nil returned audits will not be paid) a) The practice must undertake a clinical audit and maintain a spreadsheet of all patients seen/reviewed within the DiCE clinics using table 1 in appendix 3.

b) The practice to undertake a clinical audit for all patients that have had a hypoglycemia ambulance call-out, A&E attendance or hospital admission. c) As part of Primary Care Upskilling the practice will complete and retain their Primary Care Development Plans using the template in Appendix 5 for each clinician working with the DiCE team. d) Completion and submission of the diabetes GLP-1 Audit data collection form contained in Appendix 3, table 1. This is a snapshot audit of all patients on GLP1 therapy within the practice, irrespective of the initiating clinician, to determine whether NICE criteria for continuation (as specified in audit template) has been met. e) Completion and submission of the insulin audit data collection form contained in Appendix 3, table 2. This is an audit of insulin initiations (if relevant) or dose changes or switches over the financial year and can include review of case studies. This is irrespective of whether insulin was initiated by the practice. **Structured Education (5%)** Improve the uptake of structured education (2 or more sessions as per NDA criteria also includes undertaking on-line digital programmes) within 12 months of diagnosis:	b) The practice to undertake a clinical audit for all patients that have had a hypoglycemia ambulance call-out, A&E attendance or hospital admission using table 2 in appendix 3. c) As part of Primary Care Upskilling the practice will complete and retain their Primary Care Development Plans using the template in Appendix 5 for each clinician working with the DiCE team. **Structured Education (5%)** Improve the uptake of structured education (2 or more sessions as per NDA criteria also includes undertaking on-line digital programmes) within 12 months of diagnosis: • If achieve 7.5% attendance – 5% payment.

• If achieve 7.5% attendance– 5% payment • If achieve 5% attendance – 2.5% payment **Individualised care planning (5%)** Patients with a HbA1c of 58mmol/mol (7.5%) and above must have an annual care plan in place using the CCG template. • If achieve 70% of patients with care plans in place – 5% payment • If achieve 60% of patients with care plans in place – 2.5% payment.	• If achieve 5% attendance – 2.5% payment **Individualised care planning (5%)** Patients with a HbA1c of 58mmol/mol (7.5%) and above must have an annual care plan in place using the CCG template. Care plans should be undertaken remotely with patients. • If achieve 70% of patients with care plans in place – 5% payment • If achieve 60% of patients with care plans in place – 2.5% payment

Standard 6 – Cardiovascular Disease (CVD)

The CVD standard has been refocused to concentrate on the management of patients with an existing diagnosis. As such the outcome requirements around active case finding to improve actual to expected prevalence have been removed.

Original Outcome Requirements			Amended Outcome Requirements		
Standard	**Outcome**	**Payment**	**Standard**	**Outcome**	**Payment**
Hypertension (7.5%)	Achievement of the actual to expected hypertension prevalence ratios.	a) 75% of the expected number of people with high BP are detected = 3.5% payment b) 65% of the expected	Hypertension (7.5%)		

		number of people with high BP are detected = 2% payment			
	Practices are required to carry out a QRISK2 assessment for patients on the hypertension register aged 25-84 years.	a) 70% of patients aged 25-84 years on the hypertensive register have a QRISK2 score = 4% payment b) 60% of patients aged 25-84 years on the hypertensive register have a QRISK2 score = 3% payment		Practices are required to carry out a QRISK2 assessment for patients on the hypertension register aged 25-84 years.	a) 70% of patients aged 25-84 years on the hypertensive register have a QRISK2 score = 7.5% payment b) 60% of patients aged 25-84 years on the hypertensive register have a QRISK2 score = 5% payment
			Atrial Fibrillation (7.5%)	Achievement of the recording of CHA2DS2-VASc score and treatment for AF (using measurable Read or SNOMED CT code to be provided by CCG).	a) 90% people with AF and a record of CHA2DS2-VASc score of 2 or more are offered/treated with anticoagulation

Atrial Fibrillation (7.5%)	Achievement of the recording of CHA2DS2-VASc score and treatment for AF (using measurable Read or SNOMED CT code to be provided by CCG). Practices are required to conduct a warfarin patient safety audit using the template in appendix 8 to ensure optimal TTR for	a) 90% people with AF and a record of CHA2DS2-VASc score of 2 or more are offered/treated with anticoagulation drug therapy = 4.5% payment b) 80% people with AF and a record of CHA2DS2-VASc score of 2 or more are offered/treated with anticoagulation drug therapy = 3% payment a) Evidence of audit completion for CCG assurance = 3% payment		Practices are required to conduct a warfarin patient safety audit using the template in appendix 7 to ensure optimal TTR for patients on warfarin. For those where this is suboptimal with no justifiable cause to warrant variation, consider pragmatic approach to offer alternative	drug therapy = 4.5% payment b) 80% people with AF and a record of CHA2DS2-VASc score of 2 or more are offered/treated with anticoagulation drug therapy = 3% payment a) Evidence of audit completion for CCG assurance = 3% payment

	patients on warfarin. For those where this is suboptimal with no justifiable cause to warrant variation, consider pragmatic approach to offer alternative anticoagulants not withstanding ascertaining the risk of bleeding and utilising creatinine clearance to offer NOAC as an option	
Cholesterol (7.5%)	Achievement of appropriate treatment for patients with high cholesterol.	a) 90% of patients on the practice register with a high risk of CVD (QRISK2 score of 10% or more) are offered/treated

	anticoagulants not withstanding ascertaining the risk of bleeding and utilising creatinine clearance to offer NOAC as an option	
Cholesterol (7.5%)	Achievement of appropriate treatment for patients with high cholesterol. Referral of patients to the Familial Hyper-cholesterolaemia (FH) service for genetic screening, diagnosis and appropriate management (using CCG search criteria embedded within clinical system)	b) 90% of patients on the practice register with a high risk of CVD (QRISK2 score of 10% or more) are offered/treated with lipid lowering medication = 3.5% payment b) 10% of patients with Cholesterol greater than or equal to 9 mmol/L that meet the West Midlands Familial Hyper-cholesterolaemia Service referral criteria are referred to the FH service

	Referral of patients to the Familial Hyper-cholesterolaemia (FH) service for genetic screening, diagnosis and appropriate management (using CCG search criteria embedded within clinical system)	with lipid lowering medication = 3.5% payment a) 25% of patients with Cholesterol greater than or equal to 9 mmol/L that meet the West Midlands Familial Hyper-cholesterolaemia Service referral criteria are referred to the FH service for diagnosis = 4% payment
Heart Failure (7.5%)	Achievement of the actual to expected prevalence ratios for Heart Failure	a) 65% of expected HF patients are diagnosed = 3% payment b) 55% of expected HF patients are diagnosed = 2% payment

		for diagnosis = 4% payment
Heart Failure (7.5%)	Evidence of Heart Failure patient review and treatment using the **CCGs HF clinical template** (using measurable Read or SNOMED CT code 'annual heart failure review and 'max tolerated dose').	a) 65% of HF patients have been reviewed and treatment optimised as clinically appropriate using the PCCF HF clinical template = 7.5% payment b) 55% of HF patients have been reviewed and treatment

	Evidence of Heart Failure patient review and treatment using the **CCGs HF clinical template** (using measurable Read or SNOMED CT code 'annual heart failure review and 'max tolerated dose').	a) 65% of HF patients have been reviewed and treatment optimised as clinically appropriate using the PCCF HF clinical template = 3.5% payment b) 55% of HF patients have been reviewed and treatment optimised as clinically appropriate using the PCCF HF template = 2% payment			optimised as clinically appropriate using the PCCF HF template = 5% payment

Standard 7 – Mental Health	
There have been no changes to the requirements in this standard as the national targets around annual physical and mental health checks remain for 20/21.	
Original Outcome Requirements	**Amended Outcome Requirements**
Percentage of **total** SMI register who **actually receive** an annual physical and mental health check in accordance with the delivery requirements identified below (excludes exception reported patients) Payment will be made on achievement of the core physical health check consisting of all 6 key elements: • If achieve 60% of register = 20% payment • If achieve 70% of register = 30% payment	Percentage of **total** SMI register who **actually receive** an annual physical and mental health check in accordance with the delivery requirements identified below (excludes exception reported patients) Payment will be made on achievement of the core physical health check consisting of all 6 key elements: • If achieve 60% of register = 20% payment • If achieve 70% of register = 30% payment
Standard 8 - Cancers	
There have been no changes to the requirements within this standard.	
Original Outcome Requirements	**Amended Outcome Requirements**
The percentage of patients who DNA screening who are followed up: **Breast** If 80% of DNAs are followed up – 10% payment If 70% of DNAs are followed up – 5% payment **Bowel** If 80% of DNAs are followed up – 10% payment	The percentage of patients who DNA screening who are followed up: **Breast** If 80% of DNAs are followed up – 10% payment If 70% of DNAs are followed up – 5% payment **Bowel** If 80% of DNAs are followed up – 10% payment

<table>
<tr><td>If 70% of DNAs are followed up – 5% payment

Cervical

If 80% of DNAs are followed up – 10% payment
If 70% of DNAs are followed up – 5% payment</td><td colspan="2">If 70% of DNAs are followed up – 5% payment

Cervical

If 80% of DNAs are followed up – 10% payment
If 70% of DNAs are followed up – 5% payment</td></tr>
<tr><td colspan="3">Standard 9 – Medicines Management</td></tr>
<tr><td colspan="3">The requirements have been revised to reduce the workload required to fit the 9 month period.</td></tr>
<tr><td colspan="2">Original Outcome Requirements</td><td colspan="2">Amended Outcome Requirements</td></tr>
<tr><td colspan="2">Reduce prescribing of Over The Counter medicines/ Promote Self-Care (20%)</td><td colspan="2">Reduce prescribing of Over The Counter medicines/ Promote Self-Care (20%)</td></tr>
<tr><td>Measure</td><td>Target Reduction</td><td>Measure</td><td>Target Reduction</td></tr>
<tr><td>Practice needs to reduce cost per 1000 patients to the 25th percentile of practices (Q3 19/20)
Award will be based on comparing Q4 19/20 with Q4 20/21 data</td><td>Percentage of the award is stratified according to achievement of reduction in cost per 1000 PU from baseline:

£3000 – 12.5%
£4000 – 10%
£5000 – 7.5%
£6000 – 5%
£7000 – 2.5%

If practices have already achieved ≤£3000 cost per 1000 PU they will need to maintain or reduce from baseline to achieve full award</td><td>Practice needs to reduce cost per 1000 patients to the 30th percentile of practices - £4375

Award will be based on comparing Q4 19/20 baseline with Q4 20/21 data</td><td>Percentage of the award is stratified according to achievement of reduction in cost per 1000 PU from baseline
<table>
<tr><th>Prescribing spend Cost per 1000 patients</th><th>% of award</th></tr>
<tr><td>£4375</td><td>12.5%</td></tr>
<tr><td>£4750 (40th percentile)</td><td>10%</td></tr>
<tr><td>£5250 (median)</td><td>7.5%</td></tr>
<tr><td>£6000</td><td>5%</td></tr>
<tr><td>£7000</td><td>2.5%</td></tr>
</table>
Practices who have already achieved ≤ £4375 per 1000pts at baseline need to reduce or maintain prescribing spend</td></tr>
</table>

PCNs need to reduce cost per 1000 patients to the 25th percentile of practices (Q3 19/20)	Practices will achieve an additional 5% reward if all practices within the PCN meet the target. If any practices within the PCN do not achieve the target, but can show a 50% reduction from baseline, they will receive 2.5% of this reward.	PCNs need to reduce their average cost per 1000 patients to the 30th percentile of practices OR PCNs not predicted to achieve the target by Q3 will need to formulate a PCN-level action plan (minimum 3 QI points)	The average PCN spend is ≤ £4375 cost per 1000 patients Completion of action plan and submission to Meds Quality team by 15th January 2021
All prescribing clinicians should demonstrate completion of an e-learning on Self-Care by Quarter 3 20/21		All prescribing clinicians should demonstrate completion of HEE e-learning for Health 'Successful Self Care Aware Consultations' by Quarter 3 20/21	
Implement Low Value Medicines Policy (20%)		**Implement Low Value Medicines Policy (20%)**	
Practices who achieved targets in 2019/2020 need to maintain the total actual cost of all LVMs prescribed (by comparing Q4 19/20 with Q4 20/21 data). Practices who did not meet last year's targets, will need to continue to reduce in line with 2019/2020 targets.	Reduce or at least maintain total actual cost (comparing Q4 19/20 with Q4 20/21 data)	Practices who achieved targets in 2019/2020 need to maintain the total actual cost of all LVMs prescribed (by comparing Q4 19/20 with Q4 20/21 data). Practices who did not meet last year's targets, will need to reduce to the median spend for 19/20	Reduce or at least maintain total actual cost (comparing Q4 19/20 with Q4 20/21 data) OR Reduce total actual cost to £2000 by Q4 20/21
Practice needs to reduce total actual cost of LVM (Part 2) prescribed.	Minimum 40% reduction (comparing total cost from Q4 19/20 with 20/21 PrescQIPP data)	Practice needs to reduce total actual cost of LVM (Part 2) prescribed.	Minimum 40% reduction (comparing total cost from Q4 19/20 with 20/21 PrescQIPP data)
If Part 1 and Part 2 targets attained across the PCN, the practice will receive a bonus award of 5%.		If Part 1 and Part 2 targets attained across the PCN, the practice will receive a bonus award of 5%.	
Diabetes Quality Improvement Programme (20%)		**Diabetes Quality Improvement Programme (20%)**	

Reduction in prescribing of blood glucose testing strips (BGTS) for patients who do not meet criteria for self-monitoring and quantity review for those on Sus	At least 80% of patients who are inappropriately prescribed BGTS on/ after 1st April 2020 should be stopped	Reduction in prescribing of blood glucose testing strips (BGTS) for patients who do not meet criteria for self-monitoring and quantity review for those on SUs	At least 80% of patients who are inappropriately prescribed BGTS on/ after 1st April 2020 should be stopped Review quantities of test strips issued to patients on SUs in line with guidance
Never prescribe together: DPP4i's and GLP1-RA's	100% patients identified to stop these combinations by April 2021	Never prescribe together: DPP4i's and GLP1-RA's	100% patients identified to stop these combinations by April 2021
T2DM Patients over the age of 65 on sulphonylureas or insulin with moderate to severe frailty have personalised HbA1c targets	All patients in this cohort (identified on/ after 1st April 2020) will receive a review between 1st April 2020 and 31st Dec 2020 and audit submitted to Medicines Quality Team by Dec 2020	T2DM Patients over the age of 65 on sulphonylureas or insulin with moderate to severe frailty have personalised HbA1c targets	All patients in this cohort (identified on/ after 1st July 2020) will receive a structured medication review between 1st July 2020 and 31st March 2021.
	At least 50% of this cohort of patients will have a relaxed HbA1c target (ie >58 mmol/mol)		At least 50% of this cohort of patients will have a relaxed HbA1c target (ie >58 mmol/mol)
Respiratory (20%)		**Respiratory (20%)**	
Asthma % asthmatic patients prescribed a SABA requiring 6 or more short acting beta 2 agonist inhalers in a 12 month period Baseline = April 2019 – March 2020	Of all asthmatics prescribed a SABA, 26% (or fewer) should receive 6 or more SABA inhalers in 12 months between April 2020 and March 2021		

Measured period= April 2020 – March 2021	Where practices have a baseline ≤ 26%, this should be maintained If >26% of SABA patients receive 6 or more inhalers between April 2020 and March 2021, half of the reward will be allocated if their baseline is halved		
COPD Patients on single or dual combinations of ICS-LABA-LAMA	All patients should receive an annual review, including ongoing appropriateness of existing treatment. At least 80% of inhalers prescribed for COPD patients should be in line with the Black Country Guidelines prioritising review of patients on Seretide Evohaler and equivalents to newer formulations/devices	COPD Patients on single or dual combinations of ICS-LABA-LAMA	All patients should receive an annual review, to include ongoing appropriateness of existing treatment and with a view to consolidate to dual/triple therapy devices. This will improve patient compliance and avoid the requirement for multiple inhalers. All pts reviewed should be on a formulary approved inhaler. At least 80% of inhalers prescribed for COPD patients must be in line with the Black Country Guidelines, prioritising review of patients on Seretide Evohaler and equivalents (unlicensed use)

Antimicrobial stewardship (10%)		Antimicrobial stewardship (10%)	
Practices to attend CCG antimicrobial event (venue, date TBC)	At least one clinician from each practice should attend the training and provide evidence of shared learning to all relevant staff	Audit – Submission of snapshot audit of antibiotic prescribing in all practices where total volume antibiotic prescribing is above the National target at baseline (annualised to March 2020) Education - Complete SWB CCG antimicrobial webinar (details TBC)	
Total number of antibiotics prescribed in 2020/2021 National Target as per PHE	Total volume antibiotics target ≤0.965 items/ STAR PU (TBC) TBC	National Target as per NHSE/I (currently ≤0.965 items per STAR-PU) for year ending 2020/21	Total volume antibiotic prescribing target ≤0.965 items/ STAR PU (TBC) by March 2021
Medication Safety (15%)		**Medication Safety (15%) - NOACs**	
PINCER – all patients identified at risk during the baseline searches (ran between January 2020 – March 2020) will have received a clinical review.	The practice must demonstrate that all patients identified as being at risk from PINCER indicators A-L have received a review. This will be evidenced by submission of a summary outcomes template.		
NOAC/DOACs Appropriate monitoring of NOACs is carried out: -annual LFT and FBC, -serum creatinine (frequency based on	At year end, practices should demonstrate a reduction in numbers compared to baseline for indicators A-L.	NOAC/DOACs Appropriate monitoring of NOACs is carried out -annual LFT and FBC, -serum creatinine (frequency based on	Practices can evidence a robust recall system to ensure drug dose and monitoring is in place for NOAC patients

patient's calculated creatinine clearance)		patient's calculated creatinine clearance)	Details of the recall system should be included in the submission
For patients with AF: -assess the risk benefits of anticoagulation by reviewing the HASBLED/ CHA_2DS_2-VASc score. -HASBLED should be repeated annually.	Practices can evidence a robust recall system to ensure drug dose and monitoring is in place for NOAC patients Templates on prescribing systems to be completed demonstrating all patients prescribed NOACs as identified at baseline (on or after 1st April 2020, prescribed in the last 4 months) have had the appropriate monitoring, dose and compliance check, counselling as well as concurrent antiplatelet review.	For patients with AF: assess the risk benefits of anticoagulation by reviewing the HASBLED/ CHA_2DS_2-VASc score. HASBLED should be repeated annually.	Templates on clinical system to be completed indicating all patients prescribed NOACs at baseline (on or after 1st April 2020, prescribed in the last 4 months) have had: • Drug monitoring • Dose check • Compliance check • Patient counselling
Patients are prescribed the correct dose of NOAC as per indication, renal function and where applicable age and weight Review any other antiplatelet medication co-prescribed with NOACs	Concurrent antiplatelet review •CHA2DS2-VASc and HASBLED score reviewed	Patients are prescribed the correct dose of NOAC as per indication and renal function (plus age/ weight if applicable) Review any other antiplatelet medication co-prescribed with NOACs	•Concurrent antiplatelet review •CHA2DS2-VASc and HASBLED score reviewed

Standard 10 – Respiratory					
The requirement to provide ARTP (Association for Respiratory Technology and Physiology) Spirometry has been removed as this test is not recommended during COVID 19 and has been replaced by a new requirement to follow up COVID 19 related discharges.					
Original Outcome Requirements			**Amended Outcome Requirements**		
Provide ARTP accredited spirometry	Provide spirometry for all newly diagnosed COPD patients, performed by an appropriately ARTP qualified staff member. (NICE, 2019, ARTP, 2019)	a) 90% of newly diagnosed patients receive in-house or practice subcontracted accredited spirometry = 5% payment	COVID 19 Follow up	Patients who are discharged following acute admission for COVID-19 are followed up by the practice within five working days of receipt of the discharge notification using the CCG developed COVID19 discharge template.	a) 75% of patients receive a follow up = 2.5% payment b) 90% of patients receive a follow up = 5% payment
COPD clinical template	Patients on the COPD register to receive annual reviews (to match QOF) but using the CCG COPD clinical template.	a) 50% achievement = 2.5% payment b) 80% achievement = 5% payment	COPD clinical template	Patients on the COPD register to receive annual reviews (to match QOF) but using the CCG COPD clinical template.	a) 50% achievement = 2.5% payment b) 80% achievement = 5% payment
COPD care planning	Patients on the COPD register to receive a written individualised COPD Management Plan (MP) following annual review, which is also stored in the electronic patient record. Priority given to patients deemed to be at risk of exacerbations.	a) 30% achievement = 2.5% payment b) 50% achievement = 5% payment	COPD care planning	Patients on the COPD register to receive a written individualised COPD Management Plan (MP) following annual review, which is also stored in the electronic patient record. Priority given to patients deemed to be at risk of exacerbations.	a) 30% achievement = 2.5% payment b) 50% achievement = 5% payment

Asthma management planning	Registered Asthma patients, who have •had a hospital admission in the past 12m; or •been given oral steroids (4 or more courses) for a flare up within 12m; or •been given nebulised/rescue bronchodilator in surgery within 12m are considered to be at high risk of exacerbations Receive: •a written individualised Management Plan (MP) which is also stored in the electronic patient record, to include Home Peak flow monitoring, •are recommended to use self-help apps	a) 50% achievement = 2.5% payment b) 90% achievement = 5% of payment	Asthma management planning	Registered Asthma patients, who have •had a hospital admission in the past 12m; or •been given oral steroids (4 or more courses) for a flare up within 12m; or •been given nebulised/rescue bronchodilator in surgery within 12m are considered to be at high risk of exacerbations Receive: •a written individualised Management Plan (MP) which is also stored in the electronic patient record, to include Home Peak flow monitoring, •are recommended to use self-help apps	a) 50% achievement = 2.5% payment b) 90% achievement = 5% of payment
Exacerbations	Patients given rescue bronchodilators on the surgery premises (Nebulised solution via oxygen or an	a) 50% achievement = 2.5% of payment	Exacerbations	All patients who are admitted following an exacerbation are reviewed within 14 days of discharge	a) 50% achievement = 2.5% of payment

	inhaler & Spacer) must be given a STAT dose of oral steroids; unless contraindicated and their management plan updated accordingly. (Regardless of whether the emergency services are called; as with Chest pain protocol with GTN & Aspirin). Best practice would indicate: •ALL patients are followed up within 3 days of rescue bronchodilator if not admitted. •All patients are reviewed within 14 days of discharge (if admitted) by telephone, or face to face.	b) 80% achievement = 5% of payment		Update management plan accordingly	b) 80% achievement = 5% of payment
Paediatrics – Asthma AND viral Wheeze care planning	Patients aged 0-18 with or without a diagnosis of asthma who have 3 or more courses of oral steroids in the last 12 months should be reviewed (including assessment of adherence, assessment of inhaler technique/spacer use and issued a personalised	a) 50 % of patients receive a review/follow up = 2.5% payment b) 75% of patients receive a review/follow-up = 5% payment	Paediatrics – Asthma AND viral Wheeze care planning	Patients aged 0-18 with or without a diagnosis of asthma who have 3 or more courses of oral steroids in the last 12 months should be reviewed (including assessment of adherence, assessment of inhaler technique/spacer use and issued a personalised	a) 50 % of patients receive a review/follow up = 2.5% payment b) 75% of patients receive a review/follow-up = 5% payment

	asthma/wheeze management plan).			asthma/wheeze management plan).	

Standard 11 - Dementia	
The targets in the outcome requirements have been reviewed and amended to provide a PCN incentive to encourage practices within a network to work collectively on identifying and diagnosing dementia, linking in to the work networks are doing under the Care Homes LIS and the PCN DES Enhanced Health in Care Homes Service.	
Original Outcome Requirements	**Amended Outcome Requirements**
1. Dementia diagnosis (10%) Local GP QOF Registers should be systematically updated to reflect the numbers of patients diagnosed with Dementia, in line with the minimum 67% of estimated prevalence of people aged 65 years and older, to consistently be achieved across the PCN / CCG Achievement of the actual to expected prevalence ratios for Dementia will attract the following payments: • 75% of patients with a confirmed diagnosis of dementia - 10% payment • 65% of patients with a confirmed diagnosis of dementia - 5% payment • 55% of patients with a confirmed diagnosis of dementia - 2.5% payment.	**1. Dementia diagnosis (10%)** Local GP QOF Registers should be systematically updated to reflect the numbers of patients diagnosed with Dementia, in line with the minimum 67% of estimated prevalence of people aged 65 years and older, to consistently be achieved across the PCN / CCG Achievement of the actual to expected prevalence ratios for Dementia will attract the following payments: • 67% of patients with a confirmed diagnosis of dementia - 5% payment • An additional 5% payment will be made to practices where their PCN achieves an overall rate of 67% of patients with a confirmed diagnosis of dementia
2. Diagnosis training (10%) At least one GP per practice will be required to attend training on how to identify and diagnose patients with Dementia. This will enable amore timely diagnosis for those patients that can be safely	**2. Advanced Care Planning Training (10%)** At least one registered healthcare professional will be required to complete the CCG's virtual training on Advanced Care Planning (ACP)

diagnosed in primary care and do not need to be referred to the memory assessment service. The payment for this training will be funded by the CCG.	
3. Advanced Care Plans (10%) Diagnosed patients will have Advanced Care Plan (ACP) in place using the agreed CCG template – the Treatment Escalation and Resuscitation Status Form: • 80% of all diagnosed patients – 10% payment • 70% of all diagnosed patients – 5% payment • 60% of all diagnosed patients – 2.5% payment.	**3. Advanced Care Plans (10%)** Diagnosed patients will have Advanced Care Plan (ACP) in place using the agreed CCG template – the Treatment Escalation and Resuscitation Status Form: • 65% of all diagnosed patients have an ACP in place – 5% payment • A further 5% payment will be payable to practices where their PCN collectively achieves 65% of all diagnosed patients with an ACP in place.

6.2 – Appendix 2

NHS
Sandwell and West Birmingham
Clinical Commissioning Group

Primary Care Commissioning Framework 2020/21






healthcare without boundaries

Foreword

Primary care is, as it has always been, a gateway to the NHS. Therefore primary care development becomes an essential part of our culture and philosophy in the CCG. We have a strong history of working in partnership with member practices to improve quality for patients.

In April 2015 we took a determined step further by taking on responsibility for commissioning primary care. The development of this Primary Care Commissioning Framework is an exciting opportunity for us, collectively, to deliver something special for primary care and our patients. This arguably represents the single biggest initiative we have developed as a member organisation.

The scheme represents a joint pledge by practices and the CCG to work together to further enhance primary care, improve quality and deliver consistent and fair services for our patients. We want to encourage as many practices as possible to join us in delivering this exciting new scheme.

In developing the scheme we have taken on board feedback from member practices and patients. The standards we have designed reflect areas where we know performance could be improved as well as the experiences of patients and clinicians. Our members advised us that these initiatives should be brought together into a single, easy to administer scheme that is realistic but challenging.

There is general recognition among the general practitioners and wider society that, in its first four years, the scheme has already been a qualified success. There has been a significant increase in access for patients. The identification of carers has improved. We are better at identifying risk of falls. There is improved identification of hypertension as well as of atrial fibrillation. There are more cancer screening follow ups, more health checks for patients living with serious mental illness and an increase in the number of patients added to diabetes registers.

These are substantial gains. But we have also learned that some of the standards that we measure need further refinement. We want a framework that is even more focused, more fit for purpose but equally less burdensome to administer.

I want to thank everyone who has been involved in developing this scheme. I know a lot of work has already been put in by clinical leads, CCG teams and by clinicians in our member practices. I am genuinely excited by the opportunities this scheme presents and would encourage everyone to take up the challenge and take part with even greater vigour and commitment.

Ranjit Sondhi, CBE

Vice Chair

NHS Sandwell and West Birmingham CCG

Acknowledgement

Thank you to Bolton CCG for sharing their scheme with us.

Contents

Section One: Background

Introduction

Our ambition is to deliver consistently high quality care for all our patients. The NHS definition of quality encompasses three equally important parts:

- ✓ Care that is clinically effective – not just in the eyes of clinicians but in the eyes of patients themselves
- ✓ Care that is safe
- ✓ Care that provides as positive an experience for patients as possible.

High quality care is only achieved when all three dimensions are present - not just one or two of them.

We are committed to the development of 'primary care at scale' and believe that resourcing and supporting general practices to provide high quality care and services, can provide a solution to a number of problems confronting the NHS.

This Primary Care Commissioning Framework (PCCF) has helped to develop general practice, encourage partnership working and deliver improvements in clinical outcomes for patients. The scheme offers a consistent and equitable set of initiatives for the whole population that will improve health and wellbeing. It also supports our wider strategy of developing a place based approach and primary care resilience through working at scale. As we move forward the PCCF will also support the development of primary care networks as practices further identify opportunities to work more closely together in networks to best meet the needs of their population.

Following engagement and assessment of local needs, five key themes (pictured right) were agreed to form the basis of the PCCF.

In developing the PCCF for 2020/21 we have listened to members' feedback to inform the final version of standards.

There are a total of 11 standards in the PCCF for 2020/21 which link to one or more of the five themes. All standards must be delivered if we are to deliver the necessary primary care transformation at scale. Each standard contains delivery, support and output/outcome requirements.

Why do we need a PCCF?

Our population

The total registered GP population is 578,140 (January 2020). The population is ethnically diverse compared to the England average (48.5% non-white). The population is also relatively transient with both inward and outward movement, particularly amongst the black and minority ethnic (BME) communities. Approximately 1 in 20 households state they cannot speak English well or at all.

The CCG population is young compared to England, particularly across the West Birmingham wards. Women and men aged between 20 and 34 years account for the largest proportion of the population. Only 12.5% of our population is aged 65 years and over compared to the England average of 17.7%.

The general fertility rate (the total number of live births per 1,000 women of reproductive age (ages 15 to 49 years) in a population per year) in Sandwell and West Birmingham is consistently above the England average with a slight upward trend over the last decade.

Our health and services

Life expectancy for both males and females is significantly lower than the England average. Furthermore, both males and females experience ill health earlier and for longer compared to the England average. In Sandwell and West Birmingham females live with some form of ill health on average for 29.8% and males for 25.2% of their life.

Life expectancy and healthy life expectancy: SWBCCG and England, 2010-12.

	Life Expectancy (years)		Healthy Life Expectancy (years)	
	SWBCCG	England	SWBCCG	England
Males	76.8 (76.5-77.2)	79.2	57.4 (57.2-57.6)	63.5
Females	81.7 (81.4-82.0)	83.0	57.4 (57.2-57.6)	64.8

Source: Healthy Life Expectancy (HLE) at birth and age 65 by Clinical Commissioning Groups (CCG): England 2010-12.

We are in the worst quartile compared to CCG peers for potential years of life lost (PYLL) from causes considered amenable to healthcare. The premature mortality rate (<75 years) for cardiovascular disease, respiratory disease and cancer is worse than peer CCGs. Although the rate has been declining, the CCG still has one of the highest rates of infant mortality in England.

Prevalence of diabetes in the CCG is amongst the highest in England, whereas for other disease areas prevalence is similar to England. However, review of actual to estimated prevalence for various conditions shows a wide variation in diagnosis by GP practice.

The proportion of people who report that they feel supported to manage their condition is lower than the England average. We have a higher rate of unplanned hospital admissions for chronic ambulatory sensitive conditions (adults) and emergency admissions for acute conditions that should not usually require hospital admission.

Overall the reported patient experience of GP services is worse than our CCG peers.

Wider determinants of health

Health is determined by a complex interaction between individual characteristics, lifestyle and the physical, social and economic environment. Most experts agree that these 'broader determinants of health' are more important than healthcare in ensuring a healthy population.

Below are some of the wider determinants that adversely impact on our population's health:

- Our population experiences significantly higher levels of deprivation than the England average
- 36.9% of children live in poverty (England 21.8%)
- Educational attainment for both children and adults is improving locally but remains lower than the England average
- Our population experiences 2.5 times higher unemployment than the England average
- A higher proportion of our population is employed in lower paid, manual and routine jobs
- More than 1 in 10 households are defined as overcrowded
- Homelessness across the area is higher than the England average
- Many households do not have access to a car or van.

Although the CCG and GP practices cannot always directly impact on aspects included within the wider determinants of health, there is an important role for primary care. Improving the understanding and identification of the wider determinants of health in primary care and signposting people to local support services will have a positive impact for both the individual and primary care (for example, fewer appointments, reduced prescribing and better patient experience).

What will the PCCF deliver?

The PCCF has a clear aim:

To ensure that primary care delivers high quality care and sustainable services to all patients now and in the future.

This aim will be delivered through five key themes:

Access and experience

This theme encompasses how primary care can positively impact and influence access to services whilst providing improvement/ excellence in patient experience. Access is not simply about opening times; it includes alternative and innovative ways of working, communication with patients, delivery of services and the consequence on other health and social care services.

The experience that a patient receives from primary care can have a significant impact on their health and also their usage of healthcare services across the system. Better patient experience is associated with improved health outcomes.

Outcomes and variation

A key focus of the PCCF is to improve outcomes for both individuals and the whole population. Variation exists between practices; some is unwarranted and adversely impacts on outcomes. This theme encompasses reducing inequality and inequity within our population.

Our ambition is to reduce avoidable admissions and support the transfer of services into a community based setting closer to the patient's home. We want to increase capacity and access into primary care and develop and embed integrated services to improve patient experience and ensure a seamless patient journey.

Quality and workforce

The right people with the right skills are fundamentally important to building primary care at scale. Primary care has access to appropriate and relevant training to enable safe, effective and efficient working practices now and in the future.

An important aspect of quality is patient safety, including safeguarding. We are committed to ensuring that the number of incidents are minimised, with appropriate reporting, monitoring and learning procedures in place when they do. Primary care at scale places an even greater emphasis on ensuring patient safety is delivered effectively.

Effective medicines management by primary care is increasingly important, including appropriate prescribing through; antibiotic stewardship, minimising waste and adherence to local formularies.

Wellbeing

This highlights the importance of a greater emphasis on empowering and enabling individuals and the population to maintain or improve their wellbeing. Wellbeing is more than improving ill-health, it is about taking a proactive approach to health (mental and physical), social needs and care.

Prevention is better than cure. Early identification of risk factors and disease typically leads to better prognosis. Smoking is still the most preventable cause of death in England, although deaths associated with obesity are rapidly increasing. Effective use and referral to local resources, including lifestyle services and the route to wellbeing website can have a beneficial impact on an individual's wellbeing and additionally on their subsequent need for healthcare.

Partnerships and equity

This theme overarches the four other themes. In order for the PCCF to be a success and to deliver primary care at scale, partnership-working is vital. The delivery and development of primary care across the CCG is at different stages. We recognise that primary care could look different in the future.

The PCCF has been designed to acknowledge these uncertainties and also to enable primary care to develop various partnership arrangements. Primary care will have the autonomy to deliver aspects of the PCCF through effective partnership arrangements that are not prescribed. Partnership arrangements will enable primary care to deliver new or existing high

quality, equitable and efficient services that meet the needs of local communities and improve health outcomes.

Support from the CCG

We have a strong history of investing in primary care development; this new scheme represents the biggest investment so far. We recognise that practices cannot achieve the standards in isolation, and we will be supporting practices to deliver the standards outlined in the PCCF. For each of the standards in this document, we have outlined the support practices can expect from our teams.

As a minimum practices can expect us to:

- Offer advice and support regarding all aspects of the PCCF
- Offer regular visits to discuss progress
- Develop and supply IT templates for data entry
- Support you with prescribing data
- Organise regular education and training events.
- Implement a monitoring/reporting system

Further information is included in each of the standards.

Expected outcomes of the PCCF

Improved access to general practice

- Responsive to patient needs
- All practices open 8am – 6.30pm Monday to Friday
- Access to both male and female clinicians

Improved health outcomes for patients

- Improved care for patients living with long-term conditions
- Physical and mental health needs are met.

Reduced health inequalities

- A reduction in the inequality of life expectancy within the population compared to England as a whole
- Improved support and better care for carers and people with mental health conditions.

Reduced variation

- Improved accuracy of disease prevalence recording by practice
- Greater consistency in high quality primary care service provision.

Value for money (VFM)

- Delivers high quality health services efficiently and effectively
- Delivers high levels of patient satisfaction
- Improves the health and wellbeing of our population.

Benefits of the PCCF

For our patients:

- Better access to primary care services when they need it
- Better experience when using GP services
- Improved health through early intervention and quality care
- Improved support for healthcare needs, closer to home
- Less wasted journeys for unnecessary hospital appointments.

PCCF in the Context of COVID 19

A detailed review has been undertaken in conjunction with the clinical and commissioning leads of all of the requirements in each standard with amendments made as appropriate to reflect the new model of general practice and the principle of remote consultation with minimal risk assessed face to face contact. In delivering the PCCF for the remainder of the year practices will need to consider how the majority of this work can be completed remotely with patients only being seen face to face for those aspects of care that cannot be delivered through a telephone or video consultation.

Section Two: Contract and Payment

Contract basis

This contract will be mutually dependent upon the 'core' contract. This means that only a provider currently offering essential primary medical services to a list of patients under either a General Medical Services Contract (GMS), Personal Medical Services Contract (PMS) or Alternative Provider Medical Services (APMS) will be eligible of providing the services required under the Primary Care Commissioning Framework. This mutual dependency means that the Primary Care Commissioning Framework may be legitimately commissioned exclusively from local general practice.

Each individual practice that signs up to the Primary Care Commissioning Framework will be asked to sign an agreement as an enhancement of the Primary Care Contract. Practices can choose to work collaboratively with other practices at scale, in order to implement a co-ordinated approach to any of the standards.

Pre-requisites for signing up to the contract

In order to be eligible to sign up to the Primary Care Commissioning Framework practices must:

1. Be open from 8am to 6.30pm Monday to Friday. This can be delivered through federated arrangements which have been approved by the CCG.
2. Be part of a Primary Care Network

Signing up to the contract

1. Practices who wish to sign up to the Primary Care Commissioning Framework are required to sign Schedule One (a participation agreement).

2. Practices who wish to enter federated arrangements to deliver elements of the PCCF will be required to complete and submit Schedule 2 (federated arrangements) to the CCG for approval to commence federated service delivery.

3. Practices will be required to send the above signed documents to swbccgprimary.carecontracts@nhs.net

Payment mechanism

- Each practice commissioned to provide the Primary Care Commissioning Framework that meets the standards could potentially receive the additional £14.24 per head. These additional payments will be processed locally by our finance department. Payments will be made on the basis of weighted population.
- Payments will be adjusted for list size changes on an annual basis with 1st April being the baseline. Only in exceptional circumstances will list size changes be reviewed more frequently (5% or greater increase to list size). *NB. Any reduction in list size will not be adjusted until the start of the next financial year.*

- Payments will be made in five instalments across the year, with the fifth payment being reconciliation to the amount due, based on delivery of the standards set within the Primary Care Commissioning Framework. This could result in payments back to the CCG if deliverables are not achieved.
- Payments for delivery will be made by the end of the first month of each quarter.
- Payments for achievement will be made after the close of the financial year, once the performance data has been approved.

Payment for delivery

70% of the payment for the PCCF will be paid to practices in 'exchange' for:

- Signing up to the contract
- Agreement to enable the CCG to access appropriate primary care data for the purposes of the PCCF to monitor practice progress, for payment purposes and to support the development of new standards (non-patient identifiable).
- Implementation of all of the delivery requirements in each respective standard.

The CCG reserves the right to reclaim any payments from any practice that is not able to demonstrate compliance with the above arrangements, as set out by the weightings in Table 2 (see next page). Practices are reminded that this may result in a reclaim of payments against all standards because of the requirement to implement all of the delivery requirements in each respective standard. Decisions relating to payment will be made by the Primary Care Commissioning Committee on a case by case basis.

In addition the principle of nil activity, nil payment will apply where practices are unable to demonstrate activity against a particular standard. For example, if no ECGs are undertaken within the PCCF year, the practice will not receive the corresponding payment.

Payment for achievement

30% of the payment will be paid on delivery of the defined outputs/outcomes.

The payment arrangements for outputs/outcomes are described under each standard.

The standards have been weighted according to the level of priority and level of effort required. Table 2 provides a breakdown of these weightings.

Principles for payment of the 30%

The 30% resource has been allocated to reflect the triple aim of:

- Value for money
- Improved population health
- Better quality and improved experience for patients.

We are committed to working with practices to deliver continual improvements in primary care.

It is recognised that some of the standards may be more difficult to deliver individually and practices are encouraged to work together at scale within their Primary Care Networks in order to implement a co-ordinated approach to the standards. This reflects the current direction of travel being seen locally and nationally in primary care.

Table 2: Standards and weightings

2020/21

Standard	%	£ per patient
1. Primary Care Access and Onward Referral	17%	£2.44
2. DMARDs	8%	£1.20
3. Access to multi-disciplinary team (MDT)	8%	£1.20
4. Carers given priority	5%	£0.70
5. Patient-centred care - Diabetes	11%	£1.50
6. Cardiovascular Disease	15%	£2.20
7. Mental Health	7%	£1.00
8. Cancer awareness and follow-up	6%	£0.80
9. Medicines Management	8%	£1.20
10. Respiratory	7%	£1.00
11. Dementia	7%	£1.00
Total	100%	**£14.24**

Outputs/outcomes

Individual practice performance will be reviewed in line with the requirements outlined within individual standards.

Payment schedule

Payments will be made on a quarterly basis for the delivery element of the contract with up to a further 30% based on achieving outputs/outcomes:

By end April 2020	25% of total delivery payment*
By end July 2020	25% of total delivery payment*
By end October 2020	25% of total delivery payment*
By end January 2021	25% of total delivery payment*
By end May 2021	Up to 100% of outcome payment [#]

* Of the projected annual income per practice (based on list sizes as at 1 April 2020) assuming full delivery of all standards.

[#] Final balancing payment is subject to the delivery of all standards. A reclaim of the delivery payments made for all standards may be applied if all of the delivery requirements for each standard have not been met.

Data monitoring and reporting

The PCCF Monitoring Group has been established by the Primary Care Commissioning Committee (PCCC) to operationally oversee the commissioning, implementation, evaluation and re-commissioning of the PCCF.

The PCCF Monitoring Group will meet on a quarterly basis and will consist of the following members:

- Head of Primary Care (Chair)
- Head of Primary Care Contracts or Deputy
- Primary Care Development Manager (PCDM lead for PCCF)
- Senior Primary Care Accountant or Deputy
- Primary Care Quality Lead
- Business and Contract Performance Manager or Performance Analyst
- Senior Commissioning Engagement Manager.

The PCCF Monitoring Group will report into the PCCC and make recommendations for implementation, change and financial accounting.

Where a practice is found to not be delivering and/or achieving elements of the PCCF the group may make recommendations to the PCCC in respect of payments to practices.

During the year the CCG will monitor practices against the requirements within each standard. The methods used to support this are:

- Data Extracts
- Virtual Quarterly Support Visits
- Mystery Shopping

- Year End Submission
- Annual Validation Visits (25% of practices)
- Medicines Management Team Monitoring of Standard 9.

Monitoring process

Data Extracts

The CSU have developed data capture templates that have been imported into each clinical system. The templates utilise agreed read codes to ensure that practices are coding datasets consistently and accurately. Practices should ensure the accuracy of their coding both for payment and quality purposes.

On a quarterly basis the CSU perform a data extraction to obtain data from clinical systems which is transposed into a performance dashboard detailing practices' progress against targets and outcome measures set out within the PCCF.

Throughout the year this data is used to track progress, identify possible anomalies and ensure accuracy.

The final year end data extraction will take place in April of each year. This data extraction will be used by the Monitoring Group to assess achievement against targets and outcome measures.

Quarterly Support Visits

The individual practice performance dashboard will be provided to each practice on a quarterly basis, together with a PCN level dashboard.

Virtual quarterly progress calls will be undertaken at Primary Care Network Level by the designated Primary Care Development Manager (PCDM). The PCDM will review the dashboard at a Primary Care Network Level meeting to identify areas for improvement and/or concern to help practices within the network direct resources accordingly.

If, during the call the Primary Care Development Manager identifies an area of exception they will report back to the Monitoring Group.

Mystery Shopping

Practice opening hours may be checked throughout the year by a mystery shopping call.

Mystery shopping will be carried out by our team of mystery shoppers, supported by the CCG's Communications and Engagement Team.

Mystery shoppers will make calls at various times during the day, typically between 8am – 8.30am and 6.00pm – 6.30pm. Calls will also be made in the mid part of the day to check that requirements are still be met during lunch or on the

afternoons where practices have traditionally closed for half day.

Mystery shoppers will record their findings and report back to the Communications and Engagement Team.

A representative of the Communications and Engagement Team will present the findings to the Monitoring Group.

Year End Submission

There are some elements of the PCCF where practices are required to complete an annual audit or manually provide data which is not extractable and cannot be included in the quarterly dashboard reports.

For these elements practices will be required to complete and return electronic templates that will be provided by the CCG.

Templates must be submitted to the CCG by no later than 10 working days after 31st March. Failure to submit templates by this deadline will result in delayed payment.

Annual Validation Visits

Each year the CCG will select 25% of practices to receive a Validation Visit.

The purpose of the visit is to validate the elements of the PCCF which are not measurable by the other monitoring methods described above.

A visit template setting out all the requirements to be validated at the visit will be provided to practices by the CCG in advance of the visit.

At the visit, the practice will be expected to demonstrate compliance against each requirement within the visit template and provide evidence accordingly.

If, during the visit, the CCG Visit Team identifies an area of exception or a matter of concern which signifies non-compliance to the PCCF, the CCG visit team may take one or more of the following actions:

- Make a recommendation for action by the practice stating the timeframes in which it is to be met
- Report back to the Monitoring Group for discussion before deciding on the actions that will be taken should the findings be significant or the practice have failed to meet the timeframes for action/response.
- Make a recommendation to PCCC for decision.

Due to COVID 19 a decision will be made towards the end of the financial year as to whether it is appropriate to conduct the annual validation visits and if so, these will be undertaken via virtual means.

Standard 9 Medicines Management

Standard 9 is evaluated by the CCG's Medicines Management Team.

The team's Locality Pharmacists work with practices throughout the year to ensure that the delivery requirements are being met accordingly and that practices are undertaking the relevant audits as set out within the standard.

During the year if a Locality Pharmacist identifies a concern or issue it will be presented to the Monitoring Group with recommendations.

The data associated with this standard is not published until May/June which means that the outcome/output elements will be evaluated following the evaluation of all the other standards in April.

Due to the above, Standard 9 is treated differently and the Medicines Management Team makes year-end payment recommendations directly to PCCC in July once the standard has been fully evaluated. Practices will therefore receive payment for the outcome of this standard in July 2021.

Other sources of monitoring

At times other departments within the CCG, e.g. Time2Talk, may receive reports or discover instances where they believe the PCCF is not being adhered to.

In these situations the findings will be reported to the PCCF Monitoring Group and/or the Primary Care Operations Group for their discussion.

Exception reports

Where an issue/concern has been identified which has prevented or, may prevent the practice from fulfilling its obligations as part of the framework, the practice will be asked to complete an Exception Report. The Exception Report will be reviewed by the Monitoring Group.

In circumstances where the Exception Report identifies a short-term resolvable issue/concern that the practice is actively managing or has already managed, the PCCF Monitoring Group may ask for a monthly update until it is assured that the issue/concern has been fully resolved.

Where an issue/concern reported via an Exception Report will impact on a practice's ability to meet the requirements of the framework over a prolonged period of time, the group may make recommendations for remedial actions to

alleviate the problem and the practice will be supported to develop a remedial action plan.

The PCDMs will liaise with the practice and provide support in agreeing and developing the remedial action plan which will be reviewed by the Primary Care Operations Group and/or the PCCF Monitoring Group.

In circumstances where the practice may not be able to demonstrate that it is making progress against the remedial action plan, the issues will be escalated to the Primary Care Contracting Team who will formally contact the practice to confirm its responsibility to deliver the PCCF in full in order to continue to receive payment in accordance with the contractual terms.

The Primary Care Contracting Team may agree further remedial action(s) or an extension to timescales to ensure that the contractual requirements can be met.

Each Exception Report and any associated remedial action plans and response will be managed on a case by case basis depending on the individual circumstances of each case.

Should this process identify issues that may impact on any or all other practice(s) then the Monitoring Group may make recommendations for a CCG wide approach to manage that particular issue. In addition, the Monitoring Group may make recommendations for amendments to be made to the following year's PCCF Contract.

At any time during the period of exception reporting, the PCCF Monitoring Group may recommend to the Primary Care Commissioning Committee for payments to cease and/or for payment to be reclaimed where it is identified that a practice is not fulfilling the requirements of a particular standard(s).

Primary Care Commissioning Committee (PCCC)

Any issues that cause exceptional concern will be reported to PCCC.

Depending on the circumstances the Committee may be asked to make a decision based on one or a combination of the following recommendations:

- Practice is unable to deliver the full framework and all future payments must be ceased until the practice is in a position to deliver
- Reclaim payments already made (in exceptional circumstances and considered on a case by case basis)
- Offer continued support.

Submission dates

Any non-automated data submissions must be received by the CCG no later than 10 working days following the end of the quarter.

Submissions will be sense checked by the CCG for completeness. If there are any omissions, it will be the responsibility of the practice to correct and re-submit to the data return email address within the timescales requested as set out by the CCG.

Late submissions may be approved if there are extenuating circumstances. Any requests for late submission will be dealt with on an individual practice basis. Requests should be addressed to swbccgprimary.carecontracts@nhs.net, and must be received by the CCG before the monthly deadline.

Late submissions will only be accepted if prior approval has been granted.

Disputes

If practices wish to dispute decisions relating to the achievement of this scheme our Primary Care Dispute Resolution Policy will be enacted. Please note that disputes around coding errors will not be accepted.

Practices must provide all relevant evidence to support their dispute with the first stage of their appeal redacting any patient identifiable data. Any screenshots of searches included as evidence should be run prior to 1st April 2021 to be considered as part of the appeal.

GMC standards of practice

The General Medical Council (GMC) accepts that incentive schemes can be a legitimate way of influencing GPs' behaviour, when the aim is to improve quality and safety of care and encourage the responsible use of resources.

To implement the contract, we are applying the following core principles:

- Patient safety should not be compromised
- Patients should continue to receive clinical care, specific to their individual needs
- The incentives should not encourage a uniform or blanket approach to all patients with the same condition. GPs should continue to have the flexibility to meet the individual needs of their patients
- Incentives should be paid in relation to outcomes for large groups or populations of patients
- Incentives should not directly reward decisions relating to individual patients
- The new investment should largely be used to increase staffing capacity across primary care to enable quality improvement.

Standards of practice

We acknowledge and support the statutory obligations on GPs such as those set out in the NHS Constitution, GMC and other regulatory bodies.

Equality and diversity

An Equality Impact Assessment (EIA) screen has been undertaken on this contract.

Conflicts of interest

"CCGs manage conflicts of interest as part of their day-to-day activities. Effective handling of such conflict is crucial for the maintenance of public trust in the commissioning system. This assures patients, providers, the Government and taxpayers that commissioning decisions are robust, fair, transparent and offer value-for-money (NHS England, 2014)."

Our Conflicts of Interest Policy outlines our governance arrangements to manage conflicts of interest. All members, clinical directors, clinical leads and senior managers are bound by the policy and must familiarise themselves with it. The policy is available on our website.

All member GPs have a duty to identify, address and declare any conflict of interests that may arise from participation in this contract. The Board Secretary, on behalf of the Chair, will maintain a Register of Interests declared by all members. The Register can be accessed at:

https://sandwellandwestbhamccg.nhs.uk/publications/policies/ccg-corporate-policies/1809-managing-conflicts-of-interest

The register will be refreshed every three months and will be checked annually for accuracy. All interests declared in the register will be published in our annual report. GPs who identify conflict of interests are required to complete a Declaration of Interest Form and send it to Jodi Woodhouse, email: jodi.woodhouse@nhs.net for inclusion in the register.

In addition to the inclusion of interests onto the register, where GPs are present at committee meetings, we also require GPs to review meeting papers and identify any additional 'ad-hoc' conflicts of interest relevant to specific agenda items.

In relation to conflict of interests, we fully endorse the range of obligations set out in Good Medical Practice (GMC) (2013).

References

1. General Medical Council (GMC), (2013) G*ood medical practice Working with doctors Working for patients.* Available at: www.gmc-uk.org/guidance/good_medical_practice.asp
2. SWB CCG, (2018) *Conflict of Interests Policy*
3. NHS England (NHSE), (2014) *Managing Conflict of Interests: Statutory guidance for CCGs London*. Available at: www.england.nhs.uk/wp-content/uploads/2014/12/man-confl-int-guid-1214.pdf

Section Three: The Standards

Standard 1: Primary Care Access and Onward Referrals

Rationale	As a result of COVID 19 practices within their Primary Care Networks have come together to deliver a different model of access for patients. Primary Care has rapidly moved to a model of total triage with the vast majority of appointments being provided remotely via telephone, video or online consultations. Where face to face appointments are required these have been provided at place based red sites for COVID cases and network level amber/purple sites for unplanned or planned non-COVID patients. Patients have overnight experienced a fundamental change to the way in which they access primary care and we now have an opportunity to embed the positive changes that have been made possible through an enforced change to the way general practice works. For the remainder of this financial year the focus for practices around access will be to continue to operate a model of total triage, maximizing the opportunities for remote care and ensuring that where face to face care is required that this is undertaken in line with the national general practice standard operating procedure. Practices have a key role in ensuring patients have clear information on how to access primary care services and are confident about making appointments for current concerns. In addition, an integrated approach between general practitioners and hospital clinicians is essential to managing the flow of patients where onward referral is required. Practices have a key role to play in maximizing the use of Advice and Guidance and the Single Point of Access (SPA) service at SWBHT which provides a single referral hub for same day access emergency admissions (see Appendix 9). The SPA can often resolve GP queries on the phone either directly via the skilled nurses taking the calls or by facilitating a three-way conversation with a specialist clinician where necessary. The team can also ensure patients are directed to the service that will meet their needs by facilitating a booked appointment at a hot clinic or an attendance to an assessment unit at an agreed timeslot which offers a much more planned approach to managing care and is better for both patients and the clinicians treating them. Also, there is the added benefit that GPs know when and where their patients will receive the next step in their care rather than just sending them to A&E. SPA will make sure the patient is directed to the right hospital to prevent delays in clinical treatment and patient dissatisfaction.

Delivery	**Practices will be expected to:** 1. Be accessible by phone and virtual means to patients during core hours from 8.00am to 6.30pm, Monday to Friday. (OOH cover should not be used during core hours). Where federated arrangements are necessary to deliver this requirement practices must: • enable access to patient information and sharing of records • enable access to book appointments • ensure that patients are clearly informed on how to access the federated practices at times when their registered practice is not accessible. • obtain prior approval from the CCG before commencement 2. Ensure patients have clear information on how to access primary care services, including new digital access and are confident about making appointments for current concerns. 3. Accommodate changes in how patients want to seek healthcare including supporting patients with self-care and self-management. 4. Adopt a total triage model maximising the use of telephone, video and online consultations, ensuring appropriate access to same day consultations as clinically required, including same day clinical assessments for children under 5. 5. Ensure there is provision for face to face care when clinically required with appropriate pre-appointment screening for all face to face appointments. 6. Ensure a dedicated provision is in place for patients on the shielded patient list in order to manage their ongoing care needs safely. Those requiring face-to-face assessment should be seen by home visit unless an alternative care setting is clinically indicated. 7. Offer access to both male and female clinicians. Federated arrangements are acceptable to provide cover between practices. 8. Triage patients booked into nominal appointment slots by NHS 111, the COVID Clinical Assessment Service (CCAS) and A&E and arrange ongoing management based on the degree of urgency. 9. Facilitate rapid telephone access to a GP via a bypass number for ambulance crews and admission avoidance teams during practice opening hours. 10. Proactively contact parents who miss opportunities for routine child vaccinations to maximise uptake. 11. Undertake a review of patients discharged from intermediate care providers within 7 days of receipt of the discharge letter. The review should include monitoring the discharge summary, patients

	medication, care plan and diagnosis (see appendix 6 for the list of intermediate care providers). 12. Use the route2wellbeing portal and all other known channels (including public health services) to signpost patients and their carers to a range of wellbeing, preventative type and welfare services within the community. 13. Utilise the eRS advice and guidance service provided for each speciality by Sandwell and West Birmingham NHS Trust (using the SWBHT standard A&G referral form) and other Trusts, where available via eRS where it is unclear whether to refer or not. 14. Utilise the Single Point of Access (SPA) service at SWBHT which provides a single referral hub for same day access emergency admissions in accordance with Appendix 8.
CCG support	**We will**: 1. Share good practice from peers.
Outputs/ Outcomes	**Advice and Guidance** 1. An improvement in the % ratio of advice and guidance requests compared to e-RS referrals • If demonstrate a 5% ratio of advice and guidance requests compared to e-RS referrals – 15% payment **Single Point of Access (SPA)** 2. An improvement in the % ratio of SPA referrals compared to direct ED referrals. • If demonstrate a 70% ratio of SPA referrals compared to direct ED referrals – 15% payment
References	Advice on how to establish a remote 'total triage' model in general practice using online consultations https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0098-Total-triage-blueprint-April-2020-v2.pdf Principles of Safe Video Consulting in General Practice during COVID-19 https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0479-principles-of-safe-video-consulting-in-general-practice-updated-29-may.pdf Guidance and standard operating procedures General practice in the context of coronavirus (COVID-19) https://www.england.nhs.uk/coronavirus/primary-care/general-practice/

Standard 2: DMARD Management

Rationale	A key part of our vision is to bring care closer to home through enhancing and making more consistent the range, availability and quality of services in primary care.
Delivery	Disease modifying antirheumatic drugs (DMARDs) are prescribed for a range of inflammatory conditions including rheumatology, gastroenterology and dermatology indications. This standard applies to all conditions where an Effective Shared Care Agreement (ESCA) is available. There are currently ESCAs approved for Gastroenterology, Rheumatology and Dermatology indications. These drugs are clinically effective and accepted standard practice but require regular blood monitoring. Although uncommon, due to the mode of action, DMARDs can potentially cause serious adverse effects. Regular blood monitoring in line with guidelines ensures that DMARDs are safely prescribed. **Practices will be expected to:** 1. Provide via an effective shared care agreement, prescribing and blood monitoring for patients who have been prescribed any of the following drugs: a) Sulfasalazine b) Azathioprine c) Methotrexate d) Ciclosporin e) Leflunomide f) Mycophenolate (for CCG commissioned indications only) g) Mercaptopurine 2. Prescriptions issued for the drugs listed above should have a read code for shared care documented in the clinical system. 3. Ensure that all patients on DMARDs have appropriate blood monitoring. However, for the achievement of PCCF practices must ensure that 95% of DMARDs prescribed by the practice have a read code documented in the clinical system to confirm appropriate blood monitoring has been carried out in accordance with local/national guidelines (as per the ESCA)*. *During COVID-19 Patients should continue to be invited for their regular blood tests, and this should be read-coded in the clinical system. When patients are not willing to attend for blood monitoring, clinicians should undertake a risk assessment to review the appropriateness of ongoing treatment, documenting the outcome in the patient record. 4. Work in partnership with secondary care colleagues with regards to the following: a) Agree to shared care drug monitoring for DMARDs b) Implement a practice DMARD register c) Implement effective call and recall. Evidence of robust, systematic and responsive recall system for monitoring and review as laid down

	in the ESCA. Mechanisms to deal with non-attendees. d) Ensure each patient has an individual management plan (secondary care/GPwSI to provide) e) Implement accurate record keeping – prescribing and blood monitoring f) Read code when a patient has an annual review (the disease review is to be completed in secondary care) g) Ensure professional links and referral policies in place for secondary care providers other than SWBHT. Approved ESCAs are available from UHB/HEFT and Dudley Group NHS Foundation Trust. h) Practices must have robust written processes in place to ensure that appropriate monitoring has been carried out before each prescription is issued and to ensure that patients failing to attend for blood tests are identified and recalled.
CCG Support	**We will:** 1. Provide prescribing monitoring and guidance, where appropriate. 2. Provide read codes for documenting in the patient record. 3. Update practices on any relevant changes to national guidance.
Outputs / Outcomes	As per delivery requirements
References	1. *Standards of care for people with musculoskeletal conditions*, ARMA, January, 2004. 2. *The Musculoskeletal Framework, Department of Health*, July 2006. 3. *Perceptions of patients and professionals on rheumatoid arthritis care*, The Kings Fund, January 2009. 4. *Rheumatoid arthritis in adults: management*, NICE NG100, July 2018 https://www.nice.org.uk/guidance/ng100/chapter/Recommendations#initial-pharmacological-management. 5. *Services for people with Rheumatoid Arthritis*, National Audit Office, July 2009. 6. *British Society for Rheumatology BSR/BHPR guideline for disease-modifying anti-rheumatic drug (DMARD) therapy in consultation with the British Association of Dermatologists* (2008). 7. *Psoriasis: assessment and management*, NICE CG153, September 2017. https://www.nice.org.uk/guidance/cg153/chapter/1-guidance#systemic-therapy. 8. *Crohn's disease: management*, NICE CG152, May 2016 https://www.nice.org.uk/guidance/cg152/chapter/Recommendations#maintaining-remission-in-crohns-disease.

Standard 3: Access to multidisciplinary team (MDT)

Rationale	Integrated teams working together are key to improving outcomes for patients. A well-functioning MDT provides holistic, multi-disciplinary health and social care to its patients. Centrally coordinated care management ensures that the skills and competencies required to benefit patient care and outcomes are utilised in the right place at the right time. The patient's GP is central to the delivery of a successful MDT. Integrated working is a key priority in the NHS Long Term Plan. Locally, GP practices have been holding MDT meetings for some time through formal and informal mechanisms. This standard will further develop joint working, breaking down the divides between health and social care. At a national level the NHS Long Term plan emphasises that the NHS will need to dissolve the traditional boundaries that exist between primary care, community services and hospitals, recognising that this traditional divide is increasingly a barrier to the personalised and coordinated health services people need. The development of primary care networks will provide a practical way of achieving this vision as individual practices work more closely together to breakdown some of these barriers to ensure improved patient care. During COVID-19 Multidisciplinary care is ever more important to ensure that there is an agreed plan across providers for how best to manage an individual's care, reducing duplication and ensuring staff resources across the system are used in the most efficient way. Practices are encouraged to consider in light of COVID-19 those patients who are most vulnerable and would benefit from a multidisciplinary approach to their care, together with patients who are at risk of unplanned admissions.
Delivery	**Practices will be expected to:** **Identify patients suitable for Multidisciplinary Care** 1. Work with partner organisations to identify vulnerable individuals and those at risk of unplanned admissions for MDT discussion. 2. Consider End of Life patients, regardless of their position in the pathway / supportive care plan, not just newly diagnosed patients. Responsibility is on practices to review patients so that they know exactly where a patient is on their pathway / plan. In addition, unexpected deaths should be discussed at Primary Care MDTs to explore lessons learned. **Host well-functioning MDTs** 3. Identify a practice lead clinician who will host a well-functioning virtual MDT providing holistic, multi-disciplinary health and social care to the identified cohort of patients.

	4. Review individual patient care plans at each MDT and update as required. 5. For patients identified as being in the last 12 months of life, the MDT meeting should include the district and specialist palliative nurses in line with the Gold Standards Framework. Verbal consent should be obtained from the patient prior to them being added to the EOLC register. 6. Record in patient notes that identified patients have been reviewed at an MDT meeting and the agreed actions/outcomes **Regular Proactive Review** 7. Following the MDT, invite or facilitate a visit via the most appropriate health professional those at risk of unplanned admission for regular proactive virtual review with a clinician, where appropriate and jointly agree care plans.
CCG support	**We will:** 1. Support practices to resolve attendance issues from community, social and other teams as practices raise issues on DATIX. 2. Share best practice from successful MDTs.
Outputs / Outcomes	1. Provide evidence of 4 MDT meetings held and attendees at those meetings. 2. 75% of patients aged 50+ with a no cause fall OR sustained a fragility fracture in the last 12 months to be assessed for Osteoporosis using: • FRAX - can be used for people aged between 40 and 90 years, either with or without BMD values, as specified; **OR** • Qfracture - can be used for people aged between 30 and 84 years. BMD values cannot be incorporated into the risk algorithm; **OR** • By referring the patient to an Osteoporosis Service 3. All GPs to complete the RCGP Osteoporosis eLearning module (2 CPD points available): https://theros.org.uk/healthcare-professionals/courses-and-cpd/rcgp-osteoporosis-e-learning/
References	*MDT Development - Working toward an effective multidisciplinary/multiagency team* http://www.england.nhs.uk/wp-content/uploads/2015/01/mdt-dev-guid-flat-fin.pdf NHS Long Term Plan (2019) *https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf*

Standard 4: Carers given priority

Rationale	Nationally, the numbers of carers are rising by 2% per annum with an estimated 7 million unpaid carers in the UK. However, not enough carers are likely to be receiving the support they need or are entitled to. One of the main obstacles to carers getting the right support is identification – both self-identification and identification by health professionals. Self-identification can be problematic as many carers, understandably, see their relationship with the person they care for as one of being a parent, child, neighbour, friend or partner and don't recognise "carer" as a term they would use. This is why identification by health professionals becomes even more important. Estimates suggest carers save the economy £132 billion a year (Carers UK, 2019). Findings from a recent study highlight that 70% of carers come into contact with the NHS, yet only 10% of these are identified as a carer (Schonegevel, L. 2013). Healthcare staff are not proactive in signposting carers to relevant support or information, and when information is given, it comes from charities and support groups. (NHS England, 2014). There has been a growing emphasis in recent years on the need to provide more comprehensive support to carers, since they often face greater social deprivation, isolation and ill health. Also, they have fewer opportunities to do the things other people may take for granted, such as access to paid employment, learning opportunities or having quality time to spend on their own, or with friends. In terms of young carers, it can often compromise their education and social life, limiting their life chances (Carers UK, 2019). It is acknowledged that GPs are developing and improving their services for carers. However, the Royal College of General Practitioners (RCGP) (2014) highlights an urgent need to further embed the identification and support of carers within general practice. This will ensure carers are supported at an earlier stage, enabling real benefits for both carers and patients alike. Both Sandwell and Birmingham local authorities have carers' strategies, which highlight key issues and priorities for local carers. The burden on carers will be ever more present during COVID 19. Practices therefore have a key role to play in supporting carers during this period to ensure their own health needs are identified and addressed.
Delivery	**Practices will be expected to:** ***NB. The following applies to carers registered in the practice. Carers registered elsewhere should be signposted to their own practice.*** 1. Identify a carers' lead within the practice. 2. Create a carers' register, which is well maintained throughout the year. 3. Have an understanding of the support services available and use appropriate referral channels (including Route2Wellbeing website and

	public health services) to signpost carers. 4. Proactively contact carers to assess current needs and signpost to the appropriate support services or social prescribing. 5. Promote and offer a flu vaccination **to all** carers. 6. All practice staff are 'carer aware', (including the needs of young carers) and have an understanding of the health and well-being needs of carers, including their right to a carers' assessment by the local authority. 7. Provide information on the practice website to help carers identify themselves and to highlight available support and information. 8. Encourage carers to play an active role in patient participation groups which are operating virtually. 9. Assess carers mental health and appropriately refer to low level support services or IAPT. 10. Consider carers needs and include relevant people for MDT discussions.
CCG support	**We will:** 1. Use existing channels to highlight carers' news, networks and learning opportunities. 2. Promote the use of Route2Wellbeing to highlight local carers services.
Outputs / Outcomes	The following apply only to carers who are registered with the practice. 1. Demonstrate the addition of new carers to the register each year. 2. Evidence that 95% have been offered a flu vaccine. 3. Evidence that 70% of carers have been proactively contacted by the primary care team to assess current needs and signposted to appropriate support services or social prescribing.
References	*Identification of carers in GP practices* – a good practice document https://professionals.carers.org/sites/default/files/identificationofcarersingppractices.pdf *Carers UK, (2016) The State of Caring 2016* available at: https://www.carersuk.org/for-professionals/policy/policy-library/state-of-caring-2016 *Carers UK, (2014) Carers at Breaking Point* available at: www.carersuk.org/for-professionals/policy/policy-library/carers-at-breaking-point-report *NHS England (NHSE), (2014) Commitment to Carers* available at: www.england.nhs.uk/wp-content/uploads/2014/05/commitment-to-carers-may14.pdf Office for National Statistics (ONS), (2011) Carers data [Online] available at: https://cy.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/numbersofcarersintheuk *Royal College of General Practitioners, (2014) Supporting Carers*: An action guide for general practitioners and their teams available at: https://www.rcgp.org.uk/clinical-and-research/resources/a-to-z-clinical-

	resources/carers-support.aspx Schonegevel, L. (2013) Macmillan briefing on carers issues available at:https://www.macmillan.org.uk/documents/getinvolved/campaigns/mps/carersbriefingformpsoctober2013.pdf Carers UK – Coronavirus – Further Support https://www.carersuk.org/help-and-advice/coronavirus-covid-19/coronavirus-further-support?gclid=EAIaIQobChMI7Y-95sHo6QIVRLTtCh23QQDAEAAYAiAAEgJyEfD_BwE

Standard 5: Patient-centred care – Diabetes

Rationale	Diabetes mellitus is a major health problem in the UK. Type 2 diabetes is by far the commonest form of diabetes and is the form that mostly affects adults. People with diabetes are well known to be at high risk of developing major health problems earlier in life than those without diabetes. In 2019/20, 1,333 patients were added to the diabetes register, giving a total of 42,419 patients. NHS England estimates that the total number of people with diabetes in the SWBCCG area (including diagnosed and undiagnosed diabetes) is 50,123 patients. The **NHS Right Care Pathway: Diabetes** identifies areas to improve diabetes care and reduce variation amongst different areas across England. The report identifies seven priority areas, including type2 diabetes prevention, diagnosis, structured education, care planning, foot care, inpatient safety and specialist type 1 diabetes services. The Right Care pack highlights a number of opportunities including reducing non-elective admissions, cost effective primary care prescribing, increasing the numbers attending retinal screening and those attending education. Following analysis of Right Care opportunities, the CCG's key focus area is unwarranted variation in prescribing spend of £600k (factoring in the additional number of diagnosed diabetic patients compared to comparator CCGs). The CCG redesigned diabetes care with the introduction of Diabetes In Community Extension (DiCE) clinics in April 2014. The redesign aims to: 1. Improve collaboration and integration between acute, community and primary care services 2. Provide integration of care between specialist diabetes and primary care teams to optimise care of patients 3. Enable the 'Upskilling' of primary care to manage patients with more complex diabetes 4. Reduce acute inpatient admissions and outpatient activity - moving care closer to home 5. Improve appropriate prescribing and medication compliance for diabetic patients. High quality primary care is crucial for improving outcomes because it is where much prevention and most diagnosis and treatment is delivered. The diabetes PCCF standard aims to improve diabetes outcomes

	through: • Increasing uptake and referrals to the NHS Diabetes Prevention Programme (NDPP) - this is an evidence based programme aimed at reducing the incidence of type 2 diabetes • Identification of undiagnosed diabetic patients to ensure early management • Improving the number of diabetes patients achieving all 3 NICE recommended treatment targets (HbA1c, Total Serum Cholesterol and blood pressure) • Increasing the number of patients who receive all eight care processes (HbA1c, blood pressure, cholesterol, serum creatinine, urine albumin, foot surveillance, body mass index and smoking). Retinopathy Screening will become the 9th care process • Improving the uptake of newly diagnosed diabetes patients (less than a year) who attend a structured education course within 12-months of diagnosis in order to improve understanding, empowerment and self-management of diabetes, including specific support to patients with learning difficulties and language barriers • Increasing the number of patients who receive an annual care plan to ensure holistic approach to patient care • Adopting a personalised care approach, including a focus on nutritional advice, for people with diabetes to involve them in their decision-making process and support discussion about the outcomes that matter most to them and the best course of action to achieve these outcomes. • Improve care closer to home by upskilling primary care clinicians to enable them (where appropriate) to manage patients within the primary care setting through joint reviews with DiCE teams and CCG arranged training sessions, improving the clinical outcomes of complex diabetic patients.

Diabetes Nutrition and Personalised Care

Type 2 diabetes is a long-term condition that can be prevented, attenuated, and potentially put into remission through dietary measures, implemented with support from a healthcare team in a variety of ways. New approaches to working with patients are required to address the challenges associated with increasing patient confidence, decision-making, compliance and lifestyle change to improve health outcomes and reduce health care costs.

Some research, including Diabetes UK DiRECT trial, shows that low-calorie diets delivered as part of a weight management programme can put some people's Type 2 diabetes into remission.

Diabetes and COVID 19

https://www.england.nhs.uk/publication/type-1-and-type-2-diabetes-and-covid-19-related-mortality-in-england/

On 19th May a world leading study "Type 1 and Type 2 diabetes and COVID-19 related mortality in England: a cohort study in people with diabetes" reported that People living with type 1 diabetes are at three and a half times the risk, and people living with type 2 are at double the risk of dying in hospital with the virus, compared to people without diabetes.

Other findings showed that in both type 1 and type 2 diabetics:

- Higher blood glucose levels and obesity are linked to higher risk.
- Men, people of black or Asian ethnicity, and people living in more deprived communities, were at higher risk.
- Those with pre-existing kidney disease, heart failure and previous stroke, were also at higher risk.

Practices therefore have a key role to play in supporting their diabetic patients to optimise the management of their condition.

Those patients at high risk, with poor control/ frailty or multiple co-morbidities, are a priority for review and virtual contact, with necessary blood tests performed as clinically indicated.

https://www.diabetesonthenet.com/journals/issue/612/article-details/how-undertake-remote-diabetes-review

Please continue to refer to NDPP and OVIVA for education services as these are operating virtually.

Delivery	**Prevention** 1. Identify and refer patients eligible for the National Diabetes Prevention Programme (NDPP): • Actively encourage patient's attendance through raising awareness of the benefits of attending the NDPP • All referrals to be made via electronic referral template on clinical system – completing all relevant fields **Management** Improve the management of diabetes through focusing on: 2. The number of adult diabetes patients that have achieved all 3 of the NICE recommended treatment targets; as follows: • HbA1c <=58mmol/mol (7.5%), • Total Serum Cholesterol <5mmol/L and • Blood pressure <=140/80 mmHg (NB or <130/80 mmHg if there is kidney, eye or cerebrovascular damage). (NB patients with frailty and/or dementia will benefit from individualised targets for HbA1c & Blood pressure: NICE NG28) 3. The percentage of people diagnosed with diabetes who receive all eight care processes. 4. Actively encouraging patients to attend retinopathy screening as the 9th care process and engaging with the programme provider. 5. Providing initiation and ongoing management of GLP1 Receptor Agonists and Insulin Therapy for over 18 years in accordance with the requirements set out within Appendix 3, ensuring a minimum of 3 insulin initiations per annum* to maintain competency. * Initiations do not need to be the practice patients only and can be made up with new patient initiations, dose adjustments of existing patients and peer-review of case studies. Competence in initiation of insulin/GLP1 will be supported through the DiCE clinics. 6. Delivering enhanced diabetes care to all type 2 and stable type 1 patients in accordance with the requirements set out in Appendix 4. 7. When available arrange joint diabetes clinics with the DiCE team and read code DiCE activity. 8. Use the CCG risk stratification/patient segmentation (control of diabetes) tool to assist in identifying patients most appropriate for review with the practice or DiCE team: Level 1 – Health Care assistance / Practice Nurse Level 2 – Practice Nurse / GP/ DiCE Level 3 – Joint review with DiCE

9. Undertake the agreed recommendations including follow-up

Structured Education

10. Encourage patients that are newly diagnosed with diabetes (less than a year) to attend accredited Structured Education.

Individualised Care Planning

11. Patients with uncontrolled diabetes (HbA1c of 58mmol/mol (7.5%) and above) to have an annual care plan (using the CCG template) which identifies key areas for improvement in diabetes management to aid self-care support and personalised care.

Diabetes Nutrition and Personalised Care

12. Undertake coaching and personalised care conversations as part of routine practice, to support improving behaviour change.

13. Maximise any opportunity to engage with type 2 patients either 1-2-1 or in groups to undertake lifestyle/diet changes to reduce weight and the complications of diabetes.

14. Embed a personalised care support plan as part of existing care planning process.

15. Test patient activation measures to measure the levels of knowledge, skills and confidence of patient cohort to evaluate change in behaviour and understanding.

Training

16. Provide a named GP/clinician and Practice Nurse lead for Diabetes, at each site. The CCG must be notified if there is a change in the Diabetes Leads.

17. Ensure a minimum of 2 attendances at the virtual CCG quarterly diabetes training sessions (equivalent of a total minimum 6 CPD points a year) by at least one clinician from the practice.

18. Provide evidence of the recognised training undertaken by the Health Care Assistant/Practice Nurse in delivering the annual review including foot screening assessment training

19. Ensure one member of staff who leads on Diabetes care at the practice attends the CCG organised personalised care and nutrition advice virtual training for diabetes, incorporating:
    - coaching methods for behaviour change
    - personalised care approaches
    - shared decision making
    - a range of evidence-based dietary measures

	personalised to the individual and completes a post course evaluation.
CCG support	**We will:** • Provide templates for use compatible with all IT systems • Provide the training specified virtually to named Diabetes Leads • Provide a practice report on the performance of the 8 care processes • Share best practice from high performing practices • Provide all required 'Read codes' for delivery and outcome measures to be recorded.
Output / outcome	**Prevention (5%)** 1. Refer a minimum of 20% of patients (18 years and over) identified with a HbA1c between 42-47 (6-6.4%) mmols taken in the last 12 months who do not have an existing diagnosis of diabetes (excluding patients that have already attended) to the NDPP and read code accordingly. **Management (15%)** 1. Diabetes Management (10%): a) Improve the proportion of people diagnosed with diabetes (type 1 and type 2) who receive all eight care processes • If achieve 60% of diabetic patients – 7.5% payment • If achieve 55% of diabetic patients – 5% payment • If achieve 50% of diabetic patients – 2.5% payment b) Maintain the number of people achieving all 3 treatment targets from the 19/20 baseline - 2.5% payment 2. Audits (5%): (please note nil returned audits will not be paid) a) The practice must undertake a clinical audit and maintain a spreadsheet of all patients seen/reviewed within the DiCE clinics using table 1 in appendix 3. b) The practice to undertake a clinical audit for all patients that have had a hypoglycemia ambulance call-out, A&E attendance or hospital admission using table 2 in appendix 3. c) As part of Primary Care Upskilling the practice will complete and retain their Primary Care Development Plans using the template in Appendix 5 for each clinician working with the DiCE team.

	Structured Education (5%) 3. Improve the uptake of structured education (2 or more sessions as per NDA criteria also includes undertaking on-line digital programmes) within 12 months of diagnosis: • If achieve 7.5% attendance – 5% payment. • If achieve 5% attendance – 2.5% payment **Individualised care planning (5%)** 4. Patients with a HbA1c of 58mmol/mol (7.5%) and above must have an annual care plan in place using the CCG template. Care plans should be undertaken remotely with patients. • If achieve 70% of patients with care plans in place – 5% payment • If achieve 60% of patients with care plans in place – 2.5% payment
References	Lean, ME et al. Primary care-led weight management for remission of type 2 diabetes (DiRECT): an open-label, cluster-randomised trial. Lancet 2018, volume 391, Issue 10120, P541-551 Thomas D, Elliott EJ. Low glycaemic index, or low glycaemic load, diets for diabetesmellitus. Cochrane Database of Systematic Reviews 2009, Issue 1. Art. No.: CD006296. DOI: 10.1002/14651858.CD006296.pub2. Unwin D, Haslam D, Livesey G. It is the glycaemic response to, not the carbohydrate content of food that matters in diabetes and obesity: The glycaemic index revisited. Journal of Insulin Resistance. 2016;1(1), a8. http://dx.doi.org/10.4102/jir. v1i1.8 DOI: 10.1002/14651858.CD006296.pub2. Murdoch C, et al. Adapting diabetes medication for low carbohydrate management of type 2 diabetes: a practical guide. BJGP 2019; 69 (684):360-361 NHS Oversight Framework 2019/20 https://www.england.nhs.uk/wp-content/uploads/2019/10/nhs-oversight-framework-rev-oct19.pdf National Diabetes Audit https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-diabetes-audit#latest-reports NICE Diabetes Standards

Standard 6: Cardiovascular Disease

Rationale	Cardiovascular disease (CVD) is a national clinical priority reflected in the NHS Long Term Plan. RightCare data highlights opportunities to improve health outcomes for people and deliver efficiencies. https://www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/better-care-for-major-health-conditions/cardiovascular-disease/ CVD causes a quarter of all deaths in UK and is the largest cause of premature mortality in deprived areas. This is the single biggest area where the NHS can save lives over the next 10 years. The NHS Long Term Plan aims to address major causes of CVD by focusing on addressing atrial fibrillation (AF), hypertension (high blood pressure) and high cholesterol: • 85% of expected number of people with AF are detected by 2029 • 90% of patients with AF who are already known to be at high risk to be adequately anticoagulated by 2029 • 80% of the expected number of people with high BP are detected by 2029 • 80% of the total number of people already diagnosed with high blood pressure are treated to target as per NICE guidance by 2029 • 75% of people aged 40-74 have received a formal validated CVD risk assessment & cholesterol reading recorded on the primary care data system in the last 5 years by 2029 • 45% of people aged 40 to 74 identified as having a 20% or greater 10-year risk of developing CVD in primary care are treated with statins by 2029 • 25% of people with Familial Hypercholesterolemia (FH) are diagnosed and treated optimally according to NICE FH guideline by 2024 CVD is largely preventable, through lifestyle changes and a combination of public health and NHS action on smoking and tobacco addiction, obesity, tackling alcohol misuse and food reformulation; and secondly through treatment of the high-risk conditions such as atrial fibrillation, high blood pressure and high cholesterol that cause heart attack, stroke and other cardiovascular conditions. Early detection and preventative treatment of CVD can help patients live longer, healthier lives. Too many people are still living with undetected and sub-optimally treated high-risk conditions such as AF, Familial Hypercholesterolemia (FH), Heart Failure (HF) and high blood pressure. This standard encompasses the CCGs vision to reduce mortality for under 75s and improve detection and management of conditions that

cause stroke and heart disease. Alongside this activity, the CCG will work with local authority partners to develop prevention activities to encourage good population health.

Cardiovascular disease causes more than a quarter (26%) of all deaths in the UK; approximately 160,000 deaths each year. Most premature deaths from CVD (<75 years old) are preventable. Two thirds of premature deaths could be avoided through improved prevention, earlier detection and better treatment.

There are around 7 million people living with cardiovascular disease in the UK and an ageing and growing population along with improved survival rates from cardiovascular events could see these numbers rise further still.

Sandwell and West Birmingham has the highest rates of morbidity and mortality from preventable cardiovascular disease (CVD). There is a great opportunity to have an impact at primary care level to reduce this burden of disease. Through this standard we will work towards people routinely knowing their 'ABC' numbers – (AF, blood pressure and cholesterol).

Hypertension

Hypertension is one of the leading risk factors for premature death and disability. At least half of all heart attacks and strokes are caused by high blood pressure and it is a major risk factor for chronic kidney disease and cognitive decline. Treatment is very effective – every 10mmHg reduction in systolic blood pressure lowers risk of heart attack and stroke by 20%. Despite this 4 out of 10 adults with hypertension, remain undiagnosed. The majority of patients should be diagnosed and managed in primary care and hence its pivotal there is an impact on new diagnosis and established cases.

There are estimated to be approximately 76,000 people living with hypertension in SWBCCG and approximately 47% are yet to be diagnosed. The range of observed to expected hypertension prevalence across member practices is 14% to 114%, with an average achievement ratio of 53%.

Atrial Fibrillation (AF)

Stroke is one of the leading causes of premature death and disability. Atrial fibrillation increases the risk of stroke by a factor of 5, and strokes caused by AF are often more severe, with higher mortality and greater disability. AF is underdiagnosed and under treated: up to a third of people with AF are unaware they have the condition and even when diagnosed inadequate treatment is common. There is an unmet need in prevalence, risk stratification and anti-coagulation.

It is estimated that there are 10,576 people with undiagnosed atrial fibrillation in NHS Sandwell and West Birmingham CCG. The range of observed to expected atrial fibrillation prevalence across member practices is 20 to 90%, with an average achievement ratio of 60%. The NOAC drugs have shown to provide superior efficacy in stroke

prevention but with the added caveat reviews are needed for renal dose optimization and adverse bleeding.

When prescribing warfarin, clinicians should ensure patients have had their INRs checked and recorded on clinical systems. They should also reassess anticoagulation in those with poor control, indicated by any of the following:

- 2 INR values higher than 5, or 1 INR value higher than 8 within the past 6 months.
- 2 INR values less than 1.5 within the past 6 months.
- Time in therapeutic range (TTR) is less than 65%.

Practices are expected to take due regard to the CCG's process for continuing prescribing of oral anticoagulation in primary care.

Cholesterol

High cholesterol (Hypercholesterolemia) is when there is too much cholesterol in the blood. It's mainly caused by eating fatty food, not exercising enough, being overweight, smoking and drinking alcohol. Hypercholesterolemia increases the risk of cardiovascular disease and impacts on mortality.

Patients can lower their cholesterol by eating healthily and getting more exercise. The most widely used medicine to lower cholesterol is a statin, but there are other medicines available too and some may only be prescribed in a specialist lipid clinic.

Familial Hypercholesterolaemia (FH) is a common genetic condition that causes a high cholesterol concentration in the blood, leading to an increased risk of premature coronary heart disease and/or early death. Although management of FH with lipid-lowering therapy, e.g. statins, is highly effective, more than 85% of people with FH in the UK are unaware that they have the condition and are therefore untreated.

Untreated, people aged 20-39 with FH have a 100-fold increased risk of death from heart disease compared to those of a similar age without FH. Early identification of FH is important because if treatment is started early enough, it will give patients a life expectancy similar to the general population.

Systematic searching of GP records to find those at high risk of FH is an important method of identifying affected individuals and allows us to cascade test relatives. Cascade testing is the process of systematically offering DNA testing to the relatives of affected individuals because someone with FH has a 50:50 chance of passing the condition on to their children.

The benefits of cascade testing are early treatment and the avoidance of heart disease. The West Midlands Familial Hypercholesterolaemia Service (WMFHS) was launched in November 2017. To date, over 240 patients have genetically confirmed FH and hundreds of family members including

young children are now eligible for cascade testing. There is a designated FH specialist nurse for The Black Country CCG's and the service is delivered from multiple GP practices across the area. Patients can be referred opportunistically or following a systematic search of GP records.

Heart Failure

80% of heart failure is currently diagnosed in hospital, despite 40% of patients having symptoms that should have triggered an earlier assessment (Bottle et al (2018). Good links and access to community heart failure nurses ensure patients receive specialist care and advice. Better, personalised planning for patients helps reduce nights spent in hospital and drug spend. Rapid access to echocardiography in primary care helps improve the investigation of those with breathlessness, and the early detection of heart failure and valve disease.

Heart failure is a common and important complication of coronary heart disease and other conditions. Untreated it has a high mortality rate. Early diagnosis is key in preventing mortality and worsening morbidity. Appropriate treatment with ace inhibitors beta blockers and Spironolactone in HF can significantly improve survival, symptom control and quality of life. Despite this, around a quarter of people with heart failure are undetected and untreated.
With the introduction of proNT-BNP test and direct access for transthoracic echo, diagnosis of heart failure has been made easier. The optimisation of medication can also have impact on the disease trajectory with great impact towards palliative care in end stage disease.

Practices are expected to participate in education sessions provided to support GP staff to detect heart failure, and to use the PCCF template provided to support the management of heart failure. High quality primary care is crucial for improving outcomes because it is where most diagnosis and appropriate treatment is delivered.

12 Lead ECG Recording and Interpretation

The provision of a 12-lead stable patient ECG interpretation service in primary care will help to prevent unnecessary referrals into hospital for routine 12 lead ECGs and will reduce delays in their interpretation.

The aim of the 12 Lead ECG Recording & Interpretation service is to support patient diagnosis and the ongoing assessment, monitoring and management of patients with a previously diagnosed condition in primary care.

CVD and COVID 19
Anyone with a heart condition is considered at increased risk of more severe complications of Covid-19 coronavirus. As such the CVD standard for the remainder of 20/21 will focus on optimising treatment for patients with an existing diagnosis. Practices should consider how they can deliver this care remotely, only bringing in patients face to face where it is clinically necessary.

Delivery	**Practices are expected to:** **Training and education** 1. Provide a named GP and Practice Nurse lead for CVD for their practice. 2. Ensure attendance at virtual CVD educational workshops provided by the CCG – minimum of one GP and one Nurse per practice attending two workshops equivalent to 4 CPD points during 2020/21 **Appropriately manage those with AF** 3. Run CHA_2DS_2-VASc to identify anyone with a CHA_2DS_2-VASc of greater or equal to 1 using automated template. Offer anti-coagulant where appropriate. Utilise HAS-BLED and patient decision aid to help make this decision. 4. Review those on the AF register to ensure appropriate management using the CCG AF template. **Manage those with hypertension** 5. Carry out a QRISK2 assessment on patients on the hypertensive register aged 25-84 and offer statins where QRISK2 is 10 % in patients aged < 84 years. 6. Review those on anti-hypertensives to ensure proper management of hypertension: o Aim for target clinic blood pressure in patients under 80 at <140/90 or <130/80 if Diabetic o Aim for target clinic blood pressure in patients >80 years at <150/90 o Remember to measure sitting and standing BP in patients with diabetes, those with postural hypotension and patients > 80 years 7. Refer patients with HTN under the age of 40 to secondary care for further management, if this is clinically appropriate. **Cholesterol** 8. Ensure people clinically appropriate at high risk (QRISK2 score of 10% or more) of developing CVD in the next 10 years are offered/treated with lipid lowering medication. 9. Implement systematic searching of GP records to find those at high risk of FH to identify affected individuals. For those patients with Cholesterol greater than or equal to 9 mmol/L that meet the West Midlands Familial Hypercholesterolaemia Service referral criteria practices should ensure onward referral (the CCG will develop a search criteria to identify 10% of this cohort of patients for onward referral to manage service capacity and planning). **ECG** 10. Practices will provide a non-urgent 12 lead ECG recording and interpreting service for primary care-initiated requests to all registered patients over the age of 18 years. 11. Practices should be able to demonstrate that they have a process in place for agreed follow up (where required) and to inform the patient

	of findings, usually within 5 working days 12. It is a mandatory requirement for continued service delivery that practices provide annual evidence to the CCG that clinicians delivering the interpretation service have received an update (either through face to face, online or other CCG approved learning) within the last 12 months so that they remain accredited to deliver the service. 13. Practices should provide 12 lead resting ECGs for registered patients: o All newly diagnosed patients since 1st April 2020 with an irregular pulse should have a primary care ECG (NICE guidance CG180) and onward referral to specialists is only needed if treatment fails to control symptoms. o All newly diagnosed hypertension cases since 1st April 2020 should have a primary care ECG (NICE guidance CG127) to assess cardiovascular risk and look for end organ damage. o All patients newly diagnosed with HF on or after 1 April 2020 should have an ECG before or within 12 months of being entered on the register. This can determine patients with wide QRS complex who may require non-pharmacological treatments. o Provide ECGs for other clinically relevant conditions. o Practices should adherence to the Appendix Two criteria. o Practices are only required to perform an ECG if one has not been previously performed (e.g. where diagnosis has been made by the acute trust and an ECG performed as part of this diagnosis) or it becomes clinically appropriate to repeat. Previous ECGs need to be appropriately electronically coded in patients' notes. **Heart Failure** 14. Current patients with HF should have a yearly review as per QOF using the PCCF template. 15. All patients with a current diagnosis of heart failure should be on maximally tolerated doses of ACEi, Betablocker (that is licenced for heart failure) and Spironolactone. 16. Patient with a confirmed diagnosis of heart failure, who would benefit from assessment and support by the community heart failure nursing team should be referred appropriately. 17. Referral to Cardiac rehabilitation as recommended by NICE will save lives, improve quality of life and reduce hospital readmissions. 18. Patient education and self-care advice should be initiated as part of the patient assessment and diagnosis.
CCG support	**We will:** 1. Develop and provide a continual rolling programme of education for CVD with supporting tools to support the primary care team 2. Provide prescribing monitoring and guidance, where appropriate 3. Provide read codes for documenting in the patient record 4. Update practices on any relevant changes to national guidance.

Output / outcome	Standard	Outcome	Payment
	Hypertension (7.5%)	Practices are required to carry out a QRISK2 assessment for patients on the hypertension register aged 25-84 years.	a) 70% of patients aged 25-84 years on the hypertensive register have a QRISK2 score = 7.5% payment b) 60% of patients aged 25-84 years on the hypertensive register have a QRISK2 score = 5% payment
	Atrial Fibrillation (7.5%)	Achievement of the recording of CHA2DS2-VASc score and treatment for AF (using measurable Read or SNOMED CT code to be provided by CCG).	a) 90% people with AF and a record of CHA2DS2-VASc score of 2 or more are offered/treated with anticoagulation drug therapy = 4.5% payment b) 80% people with AF and a record of CHA2DS2-VASc score of 2 or more are offered/treated with anticoagulation drug therapy = 3% payment
		Practices are required to conduct a warfarin patient safety audit using the template in appendix 7 to ensure optimal TTR for patients on warfarin. For those where this is suboptimal with no justifiable cause to warrant variation, consider pragmatic approach to offer alternative anticoagulants not withstanding ascertaining the risk of bleeding and utilising creatinine clearance to offer NOAC as an option	a) Evidence of audit completion for CCG assurance = 3% payment

	Cholesterol (7.5%)	Achievement of appropriate treatment for patients with high cholesterol.	a) 90% of patients on the practice register with a high risk of CVD (QRISK2 score of 10% or more) are offered/treated with lipid lowering medication = 3.5% payment
		Referral of patients to the FH service for genetic screening, diagnosis and appropriate management (using CCG search criteria embedded within clinical system)	a) 10% of patients with Cholesterol greater than or equal to 9 mmol/L that meet the West Midlands Familial Hyper-cholesterolaemia Service referral criteria are referred to the FH service for diagnosis = 4% payment
	Heart Failure (7.5%)	Evidence of Heart Failure patient review and treatment using the **CCGs HF clinical template** (using measurable Read or SNOMED CT code 'annual heart failure review and 'max tolerated dose').	a) 65% of HF patients have been reviewed and treatment optimised as clinically appropriate using the PCCF HF clinical template = 7.5% payment b) 55% of HF patients have been reviewed and treatment optimised as clinically appropriate using the PCCF HF template = 5% payment

References

Bottle, A., Kim, D., Aylin, P., Cowie, M., Majeed, A. & Hayhoe, B. (2018) Routes to diagnosis of heart failure: observational study using linked data in England. Heart. 104 (7), 600-605. Available from: https://doi.org/10.1136/heartjnl-2017-312183

NICE (NG136) Hypertension in Adults: Diagnosis and Treatment https://www.nice.org.uk/guidance/ng136/resources/visual-summary-pdf-6899919517

Public Health England (2017) Cardiovascular intelligence pack. NHS Sandwell and West Birmingham CCG. Available at: https://assets.publishing.service.gov.uk/government/uploads/syste

	m/uploads/attachment_data/file/623447/NHS_Sandwell_and_West_Birmingham_CCG_CVD_intelligence_pack.pdf

Standard 7: Mental health

Rationale	People with mental illness are at increased risk of the top 5 killers: heart disease, stroke, liver disease, respiratory disease and some cancers. This will require a holistic approach; tackling poor physical health at the same time as addressing mental health disorders. Average life expectancy in England is 79 for men and 83 for women. However, for people with mental ill health, average life expectancy is 68 and 73 respectively (Office for National Statistics (ONS), 2012). Primary care has a key role to play in achieving parity of esteem for physical health and mental health. This should support improved health outcomes, through annual health checks and screening, enhanced patient and carer experience, and a reduction in health inequalities (NHSE, 2013). Health promotion advice is particularly important for service users with serious mental illness, although evidence suggests that they are less likely than other members of the general population to be offered blood pressure checks and cholesterol screening if they have concurrent coronary heart disease, for example. Services should be provided that address diet, nutrition, exercise, alcohol consumption, drug misuse and sexual health in ways that are responsive to the needs of service users. This also includes access to smoking cessation clinics, free dental and optical examinations and flu vaccinations.
Delivery	Practices are expected to offer personal annual physical and mental health checks, based on the Lester cardiometabolic toolkit and NICE guidelines to all serious mental illness (SMI) patients. This includes patients who have a diagnosis of schizophrenia, psychosis, bipolar disorder or are taking anti-psychotic medication. Practices must demonstrate that they have offered appropriate health promotion advice. As a minimum an appropriately trained and competent clinician is required to perform a core physical health check consisting of all 6 key elements: 1. A measurement of weight (BMI or BMI + Waist circumference) 2. A blood pressure and pulse check (diastolic and systolic blood pressure recording + pulse rate) (QOF) 3. A blood lipid including cholesterol test (cholesterol measurement or QRISK measurement) 4. A blood glucose test (blood glucose or HbA1c measurement) 5. An assessment of alcohol consumption (QoF) 6. An assessment of smoking status In addition, NICE guidance best practice states as part of a comprehensive health check the following elements should also be undertaken: 7. An assessment of nutritional status, diet and level of physical activity 8. An assessment of use of illicit substance/non prescribed drugs 9. Access to relevant national screenings

	10. Medicines reconciliation and review 11. General physical health enquiry into sexual health and oral health 12. Indicated follow-up interventions including referral to NICE recommended interventions, personalised care planning (as per QOF) and psychosocial support Where a patient declines an aspect of the physical health check this must be exception reported within the clinical template. A copy of the care plan should be given to the patient and emailed securely to secondary care where appropriate and following patient consent. Practices must offer an annual appointment to **all** patients on the SMI register. The offer must be made for each patient on at least three occasions using at least two different methods of communication All the above information is to be recorded in the patient record using the provided template and the GP informed (if not performed by a GP) if further investigation is required. Practices are also expected to: a) Have an identified mental health clinical lead within the practice b) Ensure all GPs within the practice complete 3 short mental health learning modules per annum as part of their ongoing professional development.
CCG Support	**We will:** Supply an appropriate template to form the basis of the enhanced health check and action plan. This will be integrated into current IT clinical systems.
Output / outcome	Percentage of **total** SMI register who **actually receive** an annual physical and mental health check in accordance with the delivery requirements identified below (excludes exception reported patients) Payment will be made on achievement of the core physical health check consisting of all 6 key elements: • If achieve 60% of register = 30% payment • If achieve 50% of register = 20% payment
References	1. NICE CG178. Psychosis and schizophrenia in adults: treatment and management. 2014. http://www.nice.org.uk/guidance/CG178 2. 112 NICE CG185. Bipolar disorder. *The assessment and management of bipolar disorder in adults, children and young people, in primary and secondary care.* 2014. http://www.nice.org.uk/guidance/CG185 3. Mackin P, Bishop D, Watkinson H et al. *Metabolic disease and cardiovascular risk in people treated with antipsychotics in the community.* 2007. BJP 191: 23-9.

Standard 8: Cancers

Rationale	Sandwell and West Birmingham CCG (SWBCCG) has a reported cancer prevalence of 1.7% (2017/18) which is similar to the majority of comparator CCGs apart from Wolverhampton (2.3%) and Bradford (2.5%). The cancers workstream became an organisational 'must do' for SWBCCG in 2015, following publication of the National Cancer Strategy and subsequently, the 'Five Year Forward View' and the Improvement Assessment Framework (2016/17). Cancer was highlighted as an area at 'greatest need of improvement' for SWBCCG, in the Improvement Assessment Framework NHS England cancer ratings. There were 4 key areas that the CCG were monitored on: the percentage of cancers diagnosed at an early stage; the percentage of people referred urgently by their GP having definitive treatment for cancer within 62 days of referral; 1 year survival rates from all cancer; and cancer patient experience. Cancers was also highlighted as a Right Care priority in 2017. Comparison to the 10 most similar CCGs revealed scope for improvement, in particular • The proportion of the eligible population taking up cancer screening (breast, cervical and bowel) • The percentage of people diagnosed through the emergency route • The percentage of people diagnosed at early stages (stages 1 and 2) • The high mortality rates • The poor primary care patient experience feedback Cancer Research UK highlights the importance of local screening programmes, which are proven to increase the chances of spotting cancers early, saving thousands of lives every year. Whilst screening programmes are effective at targeting and inviting the right people, there are still large numbers of patients who do not take up the opportunity to be screened. The NHS Cancer Screening Programme (NHSCSP) (2014) suggests that more could be done at a local level to improve uptake. Pignone (2001) suggests that staff in a Primary Care setting, can encourage patients who are faced with screening decisions, to make informed choices, by providing up-to-date information about the options available. There is some evidence to suggest that GP endorsement letters, enhanced patient leaflets and enhanced reminder letters improve uptake (Cancer Research, 2017).

Breast screening
Breast screening aims to detect cancer at a very early stage, when any changes in the breast would be too small to feel. For women diagnosed early in England, the chance of surviving for three years is better than 99%. However, for those diagnosed at a late stage, this drops to just 27.9% (Cancer Research, 2014).

The latest figures for Sandwell and West Birmingham show that average breast screening coverage was 67.2% in 2018/19 (PHE Fingertips). This is a slight increase compared to the previous year. However, uptake is still considerably lower than the England average of 71.6% (PHE Fingertips 2018/19).

The NHS Breast Screening Programme offers screening every three years to all women aged 50 to 70 years.

Bowel screening
The Bowel Cancer Screening Programme (BCSP) aims to reduce bowel cancer mortality by detecting and treating bowel cancer or pre-cancerous growths early. More than 90% of people will live for at least five years when it is detected early. However, when found late less than 7% survive for the same period (Cancer Research, 2014). It is estimated that the BCSP will save more than 2,000 lives each year by 2025 (NHSE, 2014).

The screening uptake rate for those aged 60-74 years in Sandwell and West Birmingham was 48.4% in 2018/19 (PHE Fingertips) and overall this appears to have increased slightly in the past 4 years. Uptake is variable across practices, with particularly low uptake in the most deprived ethnic communities (NHSE, 2014). The England Average for 2018/19 was 60.5%.

The NHS Bowel Cancer Screening Programme offers screening every two years to all men and women aged 60 to 74 years.

Cervical screening
This programme aims to reduce the incidence, and associated mortality, of invasive cervical cancer. If an overall coverage of 80% can be achieved, a reduction in death rates of around 95% is possible in the long term (HSCIC, 2010).

The NHS Cervical Cancer Screening Programme offers screening by Primary Care to all women aged 25 to 64 years at varying intervals depending on age, allowing the process to be targeted effectively (Sasieni et al, 2003).

The screening uptake in 2018/19 was 65.9% across Sandwell and West Birmingham, which is significantly lower than the national average of 72.6%. Uptake has steadily fallen for the past 5 years.

Delivery	**Practices will be expected to:** **Awareness and Education** 1. Proactively raise awareness in their own patient population of the common signs and symptoms of common cancers. To achieve this practices should: • Have a named Clinical Cancer Lead and Cancer Champion • Ensure at least one member of staff (clinical) receives/attends 1 cancer education session per annum. This can be achieved through teleconference approaches or other mechanisms as identified by the Cancer Steering Group • Have a 'cancer information area' which is regularly maintained and includes information on screening. **Screening** 2. Promote the importance of the three national screening programmes: **Breast, Cervical and Bowel**. In particular, attending screening as soon as possible after being invited. 3. Agree and ensure ongoing sign up to a register for GP practice endorsement of correspondence from screening hubs. 4. Sign up to 'e-Comms' in line with the paperless approach to receive results electronically, including information on patients that did not attend (DNAs) etc. 5. Read Code DNAs and create an alert on the patient medical record. 6. Actively follow up identified DNAs to encourage screening uptake. 7. Work with the Cancer Research UK Facilitator to explore Cancer data for their own practice and to support early diagnosis initiatives. 8. Sign-up to the automated bowel screening kit request programme as it is rolled out across SWBCCG **Referrals** 9. All referrals will be made on agreed 2 week wait forms. The appropriate forms will be uploaded to GP clinical systems. 10. All 2 week wait referrals should be made via eRS 11. All 2 week wait patients will be provided with a 2 week wait patient information leaflet and will be informed of the importance of attending their appointment and will be asked about their availability in the next 2 weeks. 12. Cancer patients identified as being in the last 12 months of life to be offered a referral to Connected Palliative Care. **Living with and Beyond Cancer** 13. Ensure those patients diagnosed or living with or surviving cancer are signposted to the new Living with Cancer and Beyond Team at Sandwell and West Birmingham Hospitals NHS Trust (SWBHT) as

	appropriate (swbh.livingwithandbeyondcancer@nhs.net) and to the 'Directory of Services' for those living with and beyond cancer. 14. Ensure the newly agreed Cancer Care Review template is used to complete the Cancer Care Reviews undertaken remotely within 6 months of diagnosis for QOF.
CCG support	**We will:** • Provide ongoing Cancer education as appropriate • Support practices to obtain information for the information boards • Facilitate sign-up to endorsement and e-Comms opportunities • Work with Cancer Research UK to ensure Facilitator support to practices and share good practice/learning • Provide practices with ongoing data as received • Provide the latest and appropriate 2 week wait forms • Provide the 2 week wait patient information leaflets • Monitor screening uptake figures • Provide information on living with and beyond, including the 'Directory of Services • Provide any updated Cancer Care Review templates for completion
Outputs / outcomes	The percentage of patients who DNA screening who are followed up: **Breast** If 80% of DNAs are followed up – 10% payment If 70% of DNAs are followed up – 5% payment **Bowel** If 80% of DNAs are followed up – 10% payment If 70% of DNAs are followed up – 5% payment **Cervical** If 80% of DNAs are followed up – 10% payment If 70% of DNAs are followed up – 5% payment
References	Cancer Research, (2014) statistics available at: www.cancerresearchuk.org Cancer Research (2017) Evidence on screening Uptake available at: www.cancerresearchuk.org/health-professional/screening Department of Health (DH), (2011) *Improving Outcomes: a strategy for cancer* London Foot, C, Harrison, T, (2011) *How to improve cancer survival London*: The King's Fund Health & Social Care Information Centre (HSCIC), (2014) [Online] available at: www.hscic.gov.uk/catalogue/PUB10339/bres-scre-prog-eng-2011-12-rep.pdf Public Health England (PHE), (2014) NHS Cancer Screening Programmes [Online] Available at: www.cancerscreening.nhs.uk/

	Pignone, M., (2001) *Cancer Screening in Primary Care Are we communicating?* Journal of General Intern Medicine Vol: 10 p.867 Sasieni, P., Adams, J., Cuzick, J. (2003) *Benefits of cervical screening at different ages: evidence from the UK audit of screening histories*, British Journal of Cancer

Standard 9: Medicines Management

Rationale	Standard 9 supports the national prescribing QIPP programme and will include the following areas: • **Self-care and Low Value Medicines** • **Diabetes – Deprescribing and frailty reviews** • **Respiratory – COPD formulary review** • **Antibiotic Stewardship** • **Medication Safety – NOAC monitoring** Practices are to meet virtually, on a **quarterly basis** with their PCN Medicines Quality team, to discuss PCCF requirements and achievements, at individual practice or at PCN level. **COVID and Vulnerable/Shielded patients** As our practices have adapted patient consultations from face-to-face to virtual/ telephone appointments, the reviews required in Standard 9 have been developed and adapted. The majority of the work may be undertaken without the need for a face-to-face review. Where a face-to-face review may be required, such as changing an inhaler device, the likelihood is that a patient already in a more vulnerable/ shielded patient will benefit, i.e. diabetic/ COPD and elderly. **SELF-CARE AND LOW VALUE MEDICINES** **Self-Care** The CCG has saved over £500k in the last 18 months on medicines for self-care. However, data still shows that we have potential savings to realise of £2.7million (ePACT2). SWBCCG still have one of the highest spends nationally for prescribing medicines that may be bought over the counter (OTC). We are endeavouring to minimise further the prescribing and dispensing of medicines paid for by the NHS which are subsequently not effective, not appropriate or not taken by patients. This will continue to build on the work from 19/20. This effort should not be construed in any way as an initiative not to prescribe medicines which patients need, or just to reduce spend. In line with national efforts, the aim is to develop a culture of cost-effective prescribing and promote self-care where clinically appropriate to do so. **Low Value Medicines (LVMs)** The CCG has reduced spend in this area from in excess of £1m in 2016, to £530k in 2019. These medicines have limited clinical or cost effectiveness. De-prescribing of drugs of limited value or switching to cost effective medicine may reduce waste and realise savings that can be invested in improved patient care.

In November 2018, the national scope of LVMs was extended to these following areas (Part 2):

Aliskiren	Amiodarone	Dronedarone	Silk garments
Bath and shower emollients	Minocycline in acne	Diabetic Needles	

This year, we will be continuing the work from last year, as well as looking at Part 2 of LVMs (above).

DIABETES

Deprescribing – Blood Glucose Test Strips and Dipeptidylpeptidase-4 inhibitors (Gliptins/DPP4i's) and Glucagon-like peptide-1 receptor agonists (GLP1-RAs)

Blood Glucose Test Strips

This work will build upon PCCF 19/20, whereby practices were incentivised to issue diabetes meters (and therefore the testing strips) in line with the Pan-Birmingham guidance – ***Blood Glucose Monitoring: Guidelines for the choice of blood glucose meters, test strips and lancets in diabetes.***

Recent data (Q1/Q2 2019/20) revealed that SWBCCG are amongst the top 10 CCGs in the country for co-prescription of blood glucose testing strips (BGTS) for patients prescribed metformin without insulin (ePACT2). Practices will be incentivised to reduce the number of test strips issued to those patients that do not require self-monitoring according to the Pan-Birmingham and review of quantities of test strips issued for patients on sulphonylureas as per the table below:

Blood Glucose Monitoring Guidance:

Treatment Group	**Testing Frequency**	**Rationale**	**Prescriptions requirements per month (or as specified)**
Type 2 Diabetes, Diet and exercise alone with/without: Metformin, pioglitazone, DPP4 inhibitor, GLP-1 mimetic, SGLT-2 inhibitor (or any combination of the above)	SMBG **not routinely recommended** as part of routine care.	-No hypo risk, monitor glycaemia via HbA1c -Motivated patients may wish to monitor effects of changes in diet/exercise (up to once a day, 2-4 times a week is sufficient) or if on steroids/unwell.	Issued only as clinically required with patient education

Dipeptidylpeptidase-4 inhibitors (Gliptins/DPP4i's) and Glucagon-like peptide-1 receptor agonists (GLP1-RAs)

The new Pan-Birmingham Type 2 Diabetes Mellitus Guideline recommends the following:

- Never prescribe DPP4i's and GLP1-RAs together

The aim is to implement this guidance into practice.

Frailty Reviews

There is increasing evidence that tight control of glucose and blood pressure in frail elderly people with diabetes can be harmful. This group are less likely to benefit from the long-term microvascular outcomes of good glycaemic control and have a marked increase in risk of hospital admissions. There is a need to avoid over-treatment of both blood pressure and glycaemic control. Glycaemic control will be reviewed for this indicator*. A target range of 53-58mmol/mol seems appropriate for people who are functioning well, but in people with features of moderate to severe frailty, a more appropriate HbA1c target is >58mmol/mol. The QOF diabetes indicators for primary care in 19/20 changed to allow people with moderate to severe frailty to now be excluded from tighter HbA1c and BP control (DM020, DM021 and DM019).

Functional category	General HbA1c target
Functionally independent elderly	7 - 7.5% / 53 - 59 mmol/mol
Functionally dependent elderly • Frail • Dementia	7 – 8% / 53 – 64 mmol/mol Up to 8.5% / 70 mmol/mol Up to 8.5% / 70 mmol/mol
End of life	Avoid symptomatic hyperglycaemia

*Glycaemic targets should be individualised taking into account functional status, comorbidities, especially the presence of established CVD, history and risk of hypoglycaemia and presence of microvascular complications.

RESPIRATORY

COPD

Although the CCG's prevalence of prescribing a ICS-LABA-LAMA combination for patients with a chronic respiratory illness is lower than the England average, the aim of this indicator is to assure that prescribing of inhalers in patients with COPD is in line with the ***Black Country and West Birmingham COPD guidance***, with a shift from ICS-LABA to LABA-LAMA or ICS-LABA-LAMA combinations.

Seretide Evohaler is licensed for asthma but is one such ICS-LABA combination widely used, off-license, for COPD treatment. Therefore, one aspect of this domain focusses on reducing Seretide Evohaler prescribing in COPD patients.

ANTIBIOTIC STEWARDSHIP

There are two strands to this year's scheme:

- Adoption of and adherence to the Primary Care Antimicrobial Guidelines to ensure appropriate prescribing of antibiotics.
- The total volume of antibiotics prescribed will be monitored, to ensure that practices are observing good general principles of antimicrobial stewardship and achieving the National NHSE/I target for total volume antibiotic prescribing, currently set at 0.965 items/STAR-PU.

	MEDICATION SAFETY **NOACs– Novel (Direct) Oral AntiCoagulants** Dosing and monitoring of NOACs is not as straightforward as envisaged when NOACs were first launched. The dose of NOAC can vary depending on indication, age, body weight and renal function. Monitoring requirements need to be tailored, based on calculated creatinine clearance using the Cockcroft & Gault equation (**not eGFR**) as per NOAC prescribing licenses. (www.medicines.org.uk/emc/). The aim of this indicator is to assure that the prescribing and monitoring of NOACs is undertaken in line with best practice guidance and prevent avoidable harm to the patient.
Delivery	**Practices are expected to demonstrate:** **SELF-CARE** • Adoption of the CCG Policy on ***'Conditions for which over the counter (OTC) medicines should NOT be routinely prescribed in Primary Care' policy,*** to encourage patients to self-care and purchase OTC medicines for treatment of minor, self-limiting illnesses. • Practices need to reduce cost per 1000 patients to the 30th percentile of practices within the CCG. Target is £4375 per 1000 patients. • An e-learning on self-care needs to be completed by all prescribers by Q3 of 2020/21. Practices should electronically send their certificate of completion once they have passed the **HEE e-Learning for Health 'Successful Self Care Aware Consultations.**' • Practices will need to upload self-care advice to their practice websites to signpost patients to available resources, e.g. NHS Choices, the CCG Minor Ailment Scheme. Practices should send a screenshot/link of the practice website's self-care section to the Medicines Quality Team by **30th November 2020.** Practices will achieve an additional 5% reward if the **average** spend across the PCN meets the target. By end of Quarter 3, if the PCN is not predicted to achieve the target, a PCN level action plan (minimum 3 action points) should be formulated. Medicines Quality staff can help to facilitate these discussions. • Practices will get **2%** for submission of the Action Plan by 15th January 2021. • Practices who can demonstrate **achievement** against the action plan will be awarded **3%** • Practices demonstrating **improvement** against their action plan from the Q3 position will receive a partial award of **1.5%.** **LOW VALUE MEDICINES (LVMs)** • Adoption of the CCG Policy on ***'Items which should NOT be routinely prescribed in Primary Care'*** policy. • For Low Value Medicines (Part 1), practices who achieved targets in 2019/2020 need to **maintain the total actual cost** of all LVMs prescribed (by comparing

Q4 19/20 with Q4 20/21 data).

- Practices who did not meet last year's targets, will need to reduce to a **Total Spend of £2000 by Q4 20/21**.
- Practices should develop processes to prevent new initiations of any LVMs, including involving the medicines quality team.
- Report any exceptions in line with the guidelines, on the appropriate document to the Medicine's Quality Team in Q4 2021.
- For new additions to Low Value Medicines (Part 2), practices will be expected to demonstrate a **minimum 40% reduction in total actual cost** of LVMs Part 2 prescribed to qualify for payment.

Practices will achieve an additional 5% reward if the **average PCN performance** meets the targets for both Part 1 and 2.

DIABETES
As with previous years, audit templates and SOPs will be provided to support practices to achieve against this year's scheme indicators.

Deprescribing Blood Glucose Testing Strips

Practices will be sent a list of patients and SOP to review, with an aim to deprescribe, blood glucose test strips or reduce quantities of strips prescribed that are not prescribed in line with the ***Pan-Birmingham Blood Glucose Test Strip Guidance.***

Deprescribing DPP4i's and GLP1-RAs

Searches will be run and sent to practices by the Medicine's Quality Team:

- Never prescribe DPP4i's and GLP1-RA's together, as there is no pharmacological basis for this combination. Also note there is an increased risk of side effects.

Frailty

Type 2 diabetic elderly patients on sulfonylureas and insulin will be identified through a search, and where assessed/coded will have a frailty or dementia code within the audit template. Patients should be assessed for frailty and coded as appropriate.

Where patients are identified as having moderate to severe frailty (indicated by having a frailty index score of between 0.25 – 0.36 for moderate, severe being any score above 0.36), and those assessed/coded to have dementia should be reviewed as part of an structured medication review between 1st July 2020 and 31st March 2021 and set an individualised HbA1c target. The aim is to deprescribe therapy in this cohort of patients to reduce harm in line with the ***Pan-Birmingham Type 2 Diabetes Mellitus Guidance*** and supporting SOP.

RESPIRATORY
As with previous years, audit templates and SOPs will be provided to support our practices to achieve against the scheme indicators.

COPD

- Patient COPD treatment should be reviewed in line with **Black Country and West Birmingham COPD treatment guidelines**, with at least 80% formulary compliance.
- To encourage compliance, patients prescribed ICS-LABA, or ICS-LABA-LAMA in single or dual inhalers, should be offered treatment consolidation by using combination formulary inhalers, minimising the number of devices being used.
- Seretide Evohalers (and generic equivalents) are not licensed for COPD, so this cohort should be one of the key groups to prioritise for review.

ANTIBIOTIC STEWARDSHIP

For practices <u>above</u> the target of 0.965 items/STAR-PU:

- Practice to conduct an audit, review and action plan, and share any learning across the practice.
- The audit and action plan must be sent for review to the Medicines Quality team by 1st January 2021.
- The action plan and supporting evidence of completed actions should be sent to the Medicines Quality team by 31st March 2021.
- Practices must demonstrate a reduction in antibiotic prescribing to NHSE/I target.
- Attendance at webinar would also be recommended for all prescribers in these practices.

For practices <u>at or below</u> the target of 0.965 items/STAR-PU:

- The total volume of antibiotics prescribed must be at 0.965 items/STAR-PU or below (subject to change, if updated by NHSE/I).
- All prescribers must attend a webinar organised by SWB CCG by 31/12/20 (details to follow).

MEDICATION SAFETY

NOACs

- Check concordance to NOACs regularly, and at least annually at medication reviews.
- Ensure monitoring for NOACs is up to date (annual FBC and LFTs. Renal function checked every 3, 6 or 12 months, depending on creatinine clearance calculated using the Cockcroft & Gault equation) and assess the risk-benefit of anticoagulation in patients with AF by reviewing the CHA□DS□-VASc/HAS-BLED score.
- HAS-BLED scores need to be repeated at least annually.
- Thereafter, ensure a robust recall process is set up to ensure NOAC monitoring and dose checks remain up to date.
- Ensure drug dose is correct based on indication, and individual parameters.
- Ensure patients have been appropriately counselled on NOACs.
- Review any other antiplatelet medication co-prescribed with NOACs.

Practices will be required to complete a template on prescribing systems to demonstrate the above has been done by 31st March 2021.

<table>
<tr><td>CCG support</td><td>We will:
Support the practice and prescribers to review trends in prescribing, including support to identify non-adherence and waste.
Support our practices in detail regarding Standard 9 requirements 20/21, including searches, SOPs and audits as required and relevant policies, procedures and guidelines.
Supply the practice with relevant prescribing data to identify medication that may need de-prescribing or switching to alternative cost and clinically effective medication.
Provide practices with quarterly updates on progress, including performance at PCN level.</td></tr>
<tr><td>Outputs/ outcomes</td><td>
<table>
<tr><th colspan="3">Reduce prescribing of Over The Counter medicines/ promote Self-Care (20%)</th></tr>
<tr><th>Measure</th><th>Target Reduction</th><th>% of award</th></tr>
<tr><td rowspan="2">Practice needs to reduce cost per 1000 patients to the 30th percentile of practices - £4375

Award will be based on comparing Q4 19/20 baseline with Q4 20/21 data</td><td colspan="2">Percentage of the award is stratified according to achievement of reduction in cost per 1000 PU from baseline
<table>
<tr><th>Prescribing spend
Cost per 1000 patients</th><th>% of award</th></tr>
<tr><td>£4375</td><td>12.5%</td></tr>
<tr><td>£4750 (40th percentile)</td><td>10%</td></tr>
<tr><td>£5250 (median)</td><td>7.5%</td></tr>
<tr><td>£6000</td><td>5%</td></tr>
<tr><td>£7000</td><td>2.5%</td></tr>
</table></td></tr>
<tr><td colspan="2">Practices who have already achieved ≤ £4375 per 1000pts at baseline need to reduce or maintain prescribing spend</td></tr>
<tr><td colspan="3">All practices need to update their websites with self-care signposting advice by 30th November 2020</td></tr>
<tr><td>PCNs need to reduce their average cost per 1000 patients to the 30th percentile of practices</td><td>The average PCN spend is ≤ £4375 cost per 1000 patients</td><td>5%</td></tr>
<tr><td colspan="3">OR</td></tr>
<tr><td rowspan="3">PCNs not predicted to achieve the target by Q3 will need to formulate a PCN-level action plan (minimum 3 QI points)</td><td>Completion of action plan and submission to Meds Quality team by 15th January 2021</td><td>2%</td></tr>
<tr><td>Full achievement of the action plan</td><td>3%</td></tr>
<tr><td>Partial achievement of the action plan</td><td>1.5%</td></tr>
<tr><td colspan="2">All prescribing clinicians should demonstrate completion of HEE e-learning for Health ‘Successful Self Care Aware Consultations’ by Quarter 3 20/21</td><td>2.5%</td></tr>
</table>
</td></tr>
</table>

Implement Low Value Medicines Policy (20%)		
Measure	**Target**	**% of award**
Practices who achieved targets in 2019/2020 need to maintain the total actual cost of all LVMs prescribed (by comparing Q4 19/20 with Q4 20/21 data). Practices who did not meet last year's targets, will need to reduce to the median spend for 19/20	Reduce **or at least maintain total actual cost** (comparing Q4 19/20 with Q4 20/21 data) **OR** Reduce total actual cost to £2000 by Q4 20/21	5%
Practice needs to reduce total actual cost of LVM (Part 2) prescribed.	Minimum 40% reduction (comparing total cost from Q4 19/20 with 20/21 PrescQIPP data)	10%
If Part 1 and Part 2 targets attained across the **PCN**, the practice will receive a bonus award of 5%.		5%
Diabetes Quality Improvement Programme (20%)		
Measure	**Target**	**% award**
Reduction in prescribing of blood glucose testing strips (BGTS) for patients who do not meet criteria for self-monitoring and quantity review for those on SUs	At least 80% of patients who are inappropriately prescribed BGTS on/ after 1st April 2020 should be stopped Review quantities of test strips issued to patients on SUs in line with guidance	7.5%
Never co-prescribe: DPP4i's and GLP1-RA's	At least 80% of patients who are inappropriately prescribed BGTS on/ after 1st April 2020 should be stopped Review quantities of test strips issued to patients on SUs in line with guidance	2.5%
T2DM Patients over the age of 65 on sulphonylureas or insulin with moderate to severe frailty have personalised HbA1c targets	All patients in this cohort (identified on/ after 1st July 2020) will receive a structured medication review between 1st July 2020 and 31st March 2021. At least 50% of this cohort of patients will have a relaxed HbA1c target (ie >58 mmol/mol)	10%

Respiratory (15%)		
Measure	**Target**	**% of award**
COPD Patients on single or dual combinations of ICS-LABA-LAMA	All patients should receive an annual review, to include ongoing appropriateness of existing treatment and with a view to consolidate to dual/triple therapy devices. This will improve patient compliance and avoid the requirement for multiple inhalers. All pts **reviewed** should be on a formulary approved inhaler. At least 80% of inhalers prescribed for COPD patients must be in line with the **Black Country Guidelines,** prioritising review of patients on Seretide Evohaler and equivalents (unlicensed use)	15%
Antimicrobial stewardship (10%)		
Measure	**Target**	**Proposed payment**
Audit – Submission of snapshot audit of antibiotic prescribing in all practices where total volume antibiotic prescribing is above the National target at baseline (annualised to March 2020) **Education -** Complete SWB CCG antimicrobial webinar (details TBC)	**Practices above national target at baseline** Practices to complete audit and action plan then submit to MQ team for review and any feedback. Shared learning to be demonstrated at practice level. Attendance at webinar would also be recommended for these practices **Practices below national target at baseline** All prescribers to complete webinar by December 2020.	5%
National Target as per NHSE/I (currently ≤0.965 items per STAR-PU) for year ending 2020/21	Total volume antibiotic prescribing target ≤0.965 items/ STAR PU (TBC) by March 2021.	5%

Medication Safety (15%) - NOACs		
Measure	**Target**	**Proposed payment**
Appropriate monitoring of NOACs is carried out ie: - -annual LFT and FBC, -serum creatinine (frequency based on patient's calculated creatinine clearance)	Practices can evidence a robust recall system to ensure drug dose and monitoring is in place for NOAC patients Details of the recall system should be included in the submission	5%
For patients with AF: assess the risk benefits of anticoagulation by reviewing the HASBLED/ CHA_2DS_2-VASc score. HASBLED should be repeated annually.	Templates on clinical system to be completed indicating all patients prescribed NOACs at baseline (on or after 1st April 2020, prescribed in the last 4 months) have had: • Drug monitoring • Dose check • Compliance check • Patient counselling • Concurrent antiplatelet review • CHA_2DS_2-VASc and HASBLED score reviewed	10%
Patients are prescribed the correct dose of NOAC as per indication and renal function (plus age/ weight if applicable) Review any other antiplatelet medication co-prescribed with NOACs		

Standard 10: Respiratory

Rationale	Respiratory disease continues to be a major cause of disability and premature mortality in the United Kingdom. It affects 1 in 5 people and is the third leading cause of death in England. The annual economic burden of asthma and chronic obstructive pulmonary disease (COPD) on the NHS in the UK is estimated as £3 billion and £1.9 billion respectively. In total, lung conditions (including lung cancer) directly cost the NHS in the UK £11 billion each year.[1] Respiratory conditions are a significant driver of poor health in Sandwell and West Birmingham, with under-75 mortality due to respiratory causes being 38.1 per 100,000 population (England 28.1)[2]. Health care use for respiratory conditions is also higher in SWB than in comparable CCGs, with SWB CCG spending approximately £1.4 million per year more on respiratory conditions, than comparable CCGs (2018/19). The differences are likely due to multiple factors, including population (higher smoking prevalence than England, higher levels of comparative deprivation), environment (historically industrial area with employment in smoky conditions and poor air quality with Sandwell and Birmingham designated as Air Quality Management Areas), and health care delivery (practices and pathways used by health care staff). Diagnosis of respiratory conditions can also be problematic, with difficulty identifying those with COPD, for example. Data suggests that in SWB CCG, only 8,313 out of an estimated 17,900 people with COPD have been identified (46.4%). This may be partly due to COPD not being considered for diagnosis, and a lack of quality assured spirometry to help identify patients. During this unprecedented time during the Coronavirus pandemic, Spirometry, internationally, has been halted because of the high risks to clinical staff performing the test and potential cross contamination between patients and equipment. However, as COPD and Asthma are largely clinically diagnosed on a good history, we feel patients will still present with possible symptoms and should be treated in accordance with National Guidelines. Patients presenting with possible respiratory cancers, must still be referred into the two-week-wait system. There is high-quality evidence that the treatments for COPD and asthma – generally these are inhaled therapies – can reduce symptoms, improve quality of life, and reduce health care use[3]. These therapies must be provided only once a confirmation of diagnosis has been made. PCCF requires practices consider the use (and potential overuse) of inhaled therapy, as part of the medicines management and respiratory standards. In particular, those with COPD and a FEV1 of >50% should be reviewed and considered to have inhaled

[1] British Lung Foundation https://www.blf.org.uk/policy/economic-burden
[2] https://data.england.nhs.uk/dataset/nhsof-1-6-under-75-mortality-rates-from-respiratory-disease.
[3] http://www.sciencedirect.com/science/article/pii/S0954611113001340

	steroid therapy stepped down and stopped, as per current local step wise guidance. Asthma and COPD are currently included in the National QOF, which requires minimum levels of care in order to be achieved. QOF is not holistic and does not elaborate on the quality of the care provided to patients. The PCCF criteria for 2020/21 may help practices demonstrate more holistic care for those with COPD and asthma. In particular, the requirement for a more detailed annual review, using a template provided by the CCG, will enable adequate data capture for this enhanced dataset. The templates will include all current QOF requirements to avoid unnecessary duplication. Annual reviews for COPD and asthma can also continue virtually & are also opportune times to provide written patient-held management plans (promoting patient self-help through promoting smart phone and computer apps recommended by NHS England), so that they have greater control and ability to manage their own health . This medium is also awash with videos and instructions on inhaler techniques and the use of video consultations means inhaler technique can still be checked in the majority. A standard personalised care plan, provided to appropriate patients with asthma, and for COPD, will help guide at risk patients should they have an exacerbation, which can be sent via e-mail or posted. Evidence shows that accessing Pulmonary Rehabilitation (PR) programs improves people's ability to walk further and helps them feel less tired and breathless when carrying out day-to-day activities. 90 per cent of patients who complete a PR program have higher activity and exercise levels and report an improved quality of life. PR has been shown to support better self-management and reduction in exacerbations, reduction in numbers of acute and emergency admissions and reduction in primary care appointments. It is anticipated that these measures will help reduce COPD and asthma admissions and outpatient attendances. Practices must use the clinical codes provided in order to qualify for payments.
Delivery	**Practices will be expected to:** **Training and Education** 1. Provide a named GP/clinician and Practice Nurse lead (unless none in post) for Respiratory, at each site registered to the GP/Practice. The CCG must be notified of any changes to the lead clinicians. 2. Provide evidence of the Respiratory Leads' attendance at one of the CCG virtual adult asthma and/or COPD virtual training sessions.

Multidisciplinary Meetings (MDTs)

3. The CCG has developed specialist respiratory multi-disciplinary teams (MDTs) made up of a respiratory Specialist Nurse/Physiotherapist and Consultant jointly reviewing patients with GP/Practice Nurse, called PRISMM (Programme for Respiratory Integration in the Midland Metropolitan area). MDTs aim to reduce the future burden of respiratory disease through supporting diagnosis, education, and responding to the holistic needs of people at risk of or with lung conditions.

4. When PRISMM is available Practices and PCNs are expected to:

    a. Engage in undertaking PRISMM MDTs; reviewing patients whose COPD or Asthma is not adequately controlled resulting in frequent exacerbations and/or hospitalisation. PRISMM MDT sessions will be undertaken jointly with the respiratory specialist nurses, physiotherapists, and consultants; either face-to-face with patients or through case notes review (virtual).
    b. Code the number of patients discussed at PRISMM MDTs
    c. Increase the use Advice and Guidance for respiratory conditions to support integration between primary and secondary care services.

Suspected COPD

5. Where COPD is suspected practices should clinically assess patients remotely, arranging investigations and treatment as per guidelines. These patients should be coded as suspected and a waiting list for spirometry created.

Asthma screening and diagnosis

6. The practice should have a register for “Suspected Asthma” patients. This register should also incorporate all children who are known ‘’wheezers’’ or ‘’viral induced wheezers’’. Many children can become wheezy and do not develop asthma, but some do and are often receiving repeated un-monitored inhaler use and no diagnosis.

7. Identified patients should be followed-up where appropriate to establish diagnosis. Any patients remaining unproven should remain on the suspected register for future awareness. All patients should have ‘follow-up’ code within 12 months and at least annually.

8. Expected outcomes:
    a. Maintain a register of patients for suspected asthma, wheeze and viral wheeze
    b. All patients should be recalled and reviewed annually (a follow-up code should be added if appropriate)
    c. Correct diagnosis of asthma patients and increasing register
    d. Reduction in the prescription of unnecessary inhalers to undiagnosed asthma patients

During COVID-19 practices should continue their suspected asthma register and treat all high probability asthmatics. Practices can diagnose asthma with the issue of home PEFR and diaries to confirm DUV and or reversibility to Treatment, creating a waiting list for Spirometry if needed.

Holistic assessment and management of COPD and unstable asthmatics at risk of exacerbations

9. The most effective treatment for COPD or asthma is a partnership between the patient and his or her clinician. Practices are encouraged to undertake holistic assessment and management through supporting patients to undertake self-management of COPD or asthma.

10. Practices should develop a holistic assessment for all severe and very severe COPD and unstable asthmatics at risk of exacerbations using the CCG provided COPD and Asthma clinical templates and self-management plans. This should include patients who still seem symptomatic and have had at least one exacerbation within the last 12 months despite optimised treatment and patients at risk of exacerbations due to co-morbidities, complications from frequent steroid use or other long-term treatment:
    a. By coding all patients that have a completed COPD and Asthma Annual Review, using the more detailed clinical templates
    b. By coding all patients that have been issued with a completed self-management plan

11. Practices should offer enhanced support to patients during and after acute exacerbations, whether in-house or hospitalised, embedding empowerment through robust management planning, self-management, rescue packs and better communication between patients, GP practice staff and the Community Respiratory Services.

12. Practices are encouraged where appropriate to signpost patients to other services or resources as they are stood back up:
    - Community Respiratory Service:
    - Home Oxygen Assessment and Review services (criteria for referral: Oxygen saturation < 92% on room air and at rest, polycythaemia, pulmonary hypertension and peripheral oedema, <94%)
    - Pulmonary Rehabilitation (evidence-based intervention reducing mortality, improving quality of life, reducing hospital admissions, reducing re-admissions, reducing number of home visits and reducing Length of stay).
    - Route2wellbeing / other services as appropriate.
    - Advise use of electronic self-management options such as App's recommended by NHSE; 'Manage your Health' and 'RightBreathe

Spirometry

13. Practices not currently qualified to ARTP standard should register to undertake full ARTP accredited spirometry in preparation for this being provided in primary care during 2021/22.

COVID 19 Follow Up

14. In order to take a proactive approach to managing the ongoing care and support needs of patients following discharge for a COVID 19 related admission a CCG template has been developed to provide a consistent method of follow up within five working days of discharge notification.

CCG support

The CCG will:

1. Provide baseline statistics for all proposed outcomes.
2. Provide approved clinical templates and signpost to recommended on-line apps.
3. Provide management plans for primary care use
4. Provide educational and workshop training relevant to the PCCF standard, practices will be responsible for funding any ARTP accreditation registration fees and training for their staff.
5. Share The London Respiratory Network (LRN) COPD Value Pyramid - Widely used for its impactful message about the comparative value of interventions fo COPD that rebalances the value accorded to flu vaccination, stop smoking as a treatment, pulmonary rehabilitation, inhaled medicines and telemedicine using cost per quality adjusted life year (QALY) https://thorax.bmj.com/content/thoraxjnl/69/11/973/F1.large.jpg
6. Provide all required relevant searches & clinical codes for delivery and outcome measures to be recorded.

Outputs / outcomes

Standard	Outcome	Payment (30%)
COPD clinical template	Patients on the COPD register to receive annual reviews (to match QOF) but using the CCG COPD clinical template. This will include: • A record of Depression screening questions (there are 2 questions) • Recognition of depression/anxiety can reduce hospitalisation. Practices should use tools such as PHQ-9 or GAD7 questionnaire's to screen for depression or anxiety & refer on accordingly	a) 50% achievement = 2.5% payment b) 80% achievement = 5% payment
COPD care planning	Patients on the COPD register to receive a written individualised COPD Management Plan (MP) following annual review, which is also stored in the electronic patient record. • Priority given to patients deemed to be at risk of exacerbations. [As QOF has removed annual	a) 30% achievement = 2.5% payment b) 50% achievement = 5% payment

		spirometry, severity score using recent FEV_1 is difficult to rely on. Use frequent exacerbations, patients with a CAT score of 20 or more or frequent attenders as you feel is appropriate].	
	Asthma management planning	Registered Asthma patients, who have • had a hospital admission in the past 12m; OR • been given oral steroids (4 or more courses) for a flare up within 12m; OR • been given nebulised/rescue bronchodilator in surgery within 12m are considered to be at high risk of exacerbations Receive: • a written individualised Management Plan (MP) which is also stored in the electronic patient record, to include Home Peak flow monitoring, • are recommended to use self-help apps	a) 50% achievement = 2.5% payment b) 90% achievement = 5% of payment
	Exacerbations	• All patients who are admitted following an exacerbation are reviewed within 14 days of discharge • Update management plan accordingly	a) 50% achievement = 2.5% of payment b) 80% achievement = 5% of payment
	COVID 19 Follow up	Patients who are discharged following acute admission for COVID-19 are followed up by the practice within five working days of receipt of the discharge notification using the CCG developed COVID19 discharge template. (See appendix 9 for discharge pathway)	a) 75% of patients receive a follow up = 2.5% payment b) 90% of patients receive a follow up = 5% payment

	Paediatrics – Asthma AND viral Wheeze care planning	Patients aged 0-18 with or without a diagnosis of asthma who have 3 or more courses of oral steroids in the last 12 months should be reviewed (including assessment of adherence, assessment of inhaler technique/spacer use and issued a personalised asthma/wheeze management plan).	a) 50 % of patients receive a review/follow up = 2.5% payment b) 75% of patients receive a review/follow -up = 5% payment
References	• Association of Respiratory Technologists & Physiologists. Website for Spirometry; https://www.clinicalscience.org.uk/national-artp-spirometry-programme/ • Editorial comparing NICE and BTS Guidelines 2017.Available at http://blogs.bmj.com/thorax/files/2017/12/BTS-SIGN-and-NICE-Asthma-guidelines.pdf • BTS/SIGN British Guideline for the management of asthma, 2019, SIGN 158. https://www.brit-thoracic.org.uk/quality-improvement/guidelines/asthma/ • GINA (2019) Global Strategy for the Asthma Management and prevention. https://ginasthma.org/ • GOLD (2019) Global Strategy for the Diagnosis, Management and prevention of COPD; https://goldcopd.org/ • NRAD (2014) *Why Asthma still kills*. https://www.rcplondon.ac.uk/projects/outputs/why-asthma-still-kills • *Asthma: diagnosis, monitoring and chronic asthma management,* NICE NG80, November 2017; https://www.nice.org.uk/guidance/ng80/resources/asthma-diagnosis-monitoring-and-chronic-asthma-management-pdf-1837687975621 • Birmingham, Sandwell, Solihull and environs APC Formulary 2019; http://www.birminghamandsurroundsformulary.nhs.uk/ • Respiratory Clinical Network COPD guideline 2017 http://www.birminghamandsurroundsformulary.nhs.uk/docs/acg/Pan%20Birmingham%20Respiratory%20Clinical%20Network%20COPD%20guideline%20v2%20approved%202017.pdf?uid=983659955&uid2=201796123249189	

Standard 11: Dementia

Rationale	Dementia is a term used to describe a group of cognitive and behavioural symptoms that can include memory loss, problems with reasoning and communication, a change in personality and a reduction in a person's ability to carry out daily activities, such as shopping, washing, dressing and cooking. Dementia is a progressive condition, which means that the symptoms will gradually get worse with progression. People may often have some of the same general symptoms, but the degree to which these affect each person and their carers will vary. Based upon the Alzheimer's Society's report[1], a major study on the social and economic impact of dementia in the UK in the autumn of 2014, one in six people over the age of 80 has dementia (with the number set to double within 30 years) and 70% of people in care homes have dementia or severe memory problems. Looking after people with Dementia and their carers incurs significant health and social care costs, with 25% of all hospital beds occupied by people with Dementia[2] and their average hospital stay being an average one week longer compared to others. The condition is rarely present by itself, with 80% of people with dementia have another long term condition. **Local Context** According to the latest estimates produced by NHS England (September 2019) there are 4,526 people across SWB CCG GP over the age of 65 years living with Dementia. Of these 2,829 (62.5%) have a confirmed diagnosis with a ratio based on their gender of 2:1, female to male. 62% are described as having Alzheimer's Disease (AD); 17% vascular dementia; 10%, a mix of AD and vascular dementia; 4% Lewy Bodies; 2% Parkinson's Disease; 2% front-temporal dementia and the other, remaining 3%, which are undefined[3]. **Key Drivers for Action** The *NHSE Next Steps on the Five Year Forward View*[4], the Department of Health's *Prime Minister's Challenge on Dementia 2020*[5] and the *Long Term Plan*[6] all highlight the importance of good care and support for people with dementia, their carers and their families, as well as a focus upon prevention, information/awareness and research. All policy publications share the view that GPs have a lead role in ensuring coordination and continuity of care for people with Dementia and their carers, supported by partners from secondary care, social care and the voluntary sector. From prevention, early identification, diagnosis (in primary care and specialist settings) and referral to post-diagnosis care and support GPs have a pivotal role in ensuring people with Dementia can live independently in their own homes, crisis-free, for as long as possible and thereby avoid unnecessary admissions to hospital. Every person with Dementia should have meaningful care consistent with National Institute for Health and Care Excellence (NICE) guideline NG97[7] and quality standards[8]. Advance care planning (ACP) should be offered at the earliest opportunity allowing people with Dementia to put their affairs in order to ensure that the right decisions about their care and treatment will be made in the future, even

	if they lack capacity to make that decision themselves. Guidance indicates the ACP: • be co-produced with the patient and carers as early as possible after diagnosis, given in writing and reviewed at least annually • should cover an individual's preferences, wishes, beliefs and values about future care and guide future best interest decisions in the event the individual loses capacity to make decisions • may lead to making: an advance care statement, an Advance Decision to Refuse Treatment, 'A Do Not Attempt Cardiopulmonary Resuscitation' decision and other types of decisions, such as appointing a Lasting Power of Attorney and preference for place of death • should be shared with and known by relatives and those providing services such as hospital, primary care and community services. Every person diagnosed with Dementia should have an identified coordinator of care who will: • facilitate choice, independence and person-centred care, including where appropriate seeking informed decision making and valid consent through use of advance directives and the Mental Capacity Act 2005 • signpost people with Dementia and their carers to local support services and ensure continuity of care • jointly develop and review the care plan with the person and the carer, at least every 12 months, to ensure it is still applicable, and • ensure the person's physical and mental health is monitored and that they can access appropriate treatment. Primary care are expected to: • Contribute towards people being better informed about dementia and being supported to reduce their personal risk of developing the condition • Only refer to specialist memory assessment services where the diagnosis cannot be appropriately made in primary care • Ensure earliest intervention through the life course of the disease • Ensure all patients with Dementia are on the appropriate medication • Contribute to increasing the number of people with Dementia that die in the place of their choice • Create a more aware, educated and trained primary care workforce, including receptionists • Play its part in creating dementia-friendly local communities.
Delivery	**Practices will be expected to:** **1. BECOME DEMENTIA FRIENDLY** Continue to ensure that a minimum of 80% of staff (clinical and non-clinical) have attended a virtual Dementia Friends training event provided by the Alzheimer's' Society (AS). This can be organised directly by the practice staff, or as part of a PCN initiative. Details of how to access these are available via the Alzheimer's Society website (https://www.alzheimers.org.uk) Where applicable, staff can also opt to attend one of the CCG arranged virtual events.

2. PREVENT WELL

Apply 'Make every contact count' principles in relation to dementia awareness, risk reduction and identification, discussing the links to Dementia with suitable patients presenting with the risk factors of: smoking, depression, physical inactivity, social isolation, hypertension, cardiovascular disease, obesity and diabetes.

Interventions to reduce dementia risk include:

- refer to smoking cessation services
- treat depression (talking therapies or antidepressants)
- advise aerobic exercise minimum 40 minutes/week
- encourage social activity
- aim for BP <140/90
- advise weight loss if BMI>30

This will also include a locally agreed means of identifying patients identified 'at risk' of developing Dementia.

3. DIAGNOSE WELL

a. Screen (as outlined below) those deemed to be at high risk of developing Dementia, in particular those with a history of heart attacks, strokes or mini strokes, those who have Parkinson's Disease and people with Downs Syndrome etc.

b. Assess patients presenting with signs and symptoms of Demenia and Mild Cognitive Impairment

- Screen using an accredited tool e.g. Mini Cog, GP Cog, 6 Item CIT, Montreal Cognitive Examination, RUDAS
- Where the diagnosis cannot be made in primary care, refer patients for specialist memory assessment at the earliest opportunity i.e. patients under 75 years where depression and infection are excluded
- Provide a follow up appointment to the patient and their carer after the initial diagnosis to confirm their understanding of the condition and ensure they have been signposted to an appropriate identified coordinator of care
- Place the patient on the Practice QOF Dementia register

b. Gain consent from the patient for their next of kin (or preferred person) to receive GP/memory assessment service communications at the point of diagnosis if made in primary care OR at the point the GP confirms a referral to specialist services with the patient

c. Use the DiaDem tool for all patients in a care home setting without a previous diagnosis of dementia who have been identified as at risk of

dementia by care home staff and / or others (e.g. Dementia Navigators) using the dearGPtool.

d. Undertake bi-annual data cleansing exercise (May and November) to ensure Dementia Registers are robust.

4. SUPPORTING AND LIVING WELL

Good Dementia care ensures that the patient and their carer have access to personalised ongoing care coordination and support from diagnosis to end of life. GPs are expected to ensure that advanced care planning is offered to all patients diagnosed with Dementia, with patients and their carer/families given the opportunity to be involved in creating their personalised advanced care plan. For all patients diagnosed with dementia:

a. All existing and newly diagnosed Dementia patients to have an identified, named coordinator of care (this should be someone based in primary care with the default position being the patient's GP because of his/her access to their clinical notes)

b. The nominated care coordinator will complete an annual review for each patient with a confirmed Dementia diagnosis. A review of this plan will be completed with the identified patient and their main carer (subject to the agreement of the patient), or where a patient who lacks capacity, in his/her best interests, in line with the provisions of the Mental Capacity Act 2005

c. The expectation will be that an Advanced Care Plan (ACP) will be offered to every diagnosed patient with Dementia. This will be reviewed and confirmed at an MDT within 3 months of the diagnosis and annually thereafter (as a minimum – a change in symptoms may necessitate an earlier review of a patient's plan). The newly agreed Treatment Escalation and Resuscitation Form should be used for Advance Care Planning.

d. All carers of people with Dementia are placed on the Carers register

e. Safer dementia medications are prescribed at post diagnostic review as there is a clear link between cognition and anticholinergic drug treatment which can cause sedation, confusion, delirium and falls. Further information is available via the Anticholinergic Burden eLearning module (PDS, 2018-19), Medichec and the Medicines Quality Team.

5. DYING WELL

Where the patient has indicated their preferred place of care and death, this is recorded in their care plan, through the Treatment Escalation and Resuscitation Form. Patients in the last 12 months of life (where this is known) to commence on the End of Life care pathway and referred to Connected Palliative Care.

CCG Support	**We will:** 1. Continue to deliver on the Dementia Strategy for Sandwell with the Local Authority and ensure implementation through the re-focussed Sandwell Dementia Action Alliance. 2. Continue to strategically engage with Birmingham and Solihull CCG and ensure parity of Dementia care and provision. 3. Within the strategy, roll out a clear series of outcome-focused, strategic priorities that link and highlight the short, medium and long term goals that will achieve optimal dementia care pathways aligned to the Well pathway. Any new plans and decisions for change will be based on evidential data, and co-produced with key statutory and non-statutory partners, service users and the wider public. 4. Ensure commissioned behaviour change services include educating and raising awareness of the link between lifestyle factors and Dementia 5. Commission sufficient imaging and specialist diagnostic service capacity to enable every patient to have an initial assessment within 6 weeks following a referral from a GP by March 2020 6. Jointly commission with the Local Authority locally available pre- and post-diagnostic care and on-going support to meet the forecast demand by people with dementia and their carers, in order to ensure NICE guidance and other standards can be met consistently and sustainably 7. Support Primary Care Networks to achieve Dementia Community Friendly status and ensure the whole primary care team is trained to contribute to delivery of Dementia care founded on early identification and intervention. This will be enabled by suitably accredited service providers approved by the local Dementia Action Alliance. 8. Provide training for primary care to enable delivery of this standard.
Outputs / outcomes	**1. Dementia diagnosis (10%)** Local GP QOF Registers should be systematically updated to reflect the numbers of patients diagnosed with Dementia, in line with the minimum 67% of estimated prevalence of people aged 65 years and older, to consistently be achieved across the PCN / CCG Achievement of the actual to expected prevalence ratios for Dementia will attract the following payments: • 67% of patients with a confirmed diagnosis of dementia - 5% payment. • An additional 5% payment will be made to practices where their PCN achieves an overall rate of 67% of patients with a confirmed diagnosis of dementia.

	2. Advanced Care Planning Training (10%) At least one registered healthcare professional will be required to complete the CCG's virtual training on Advanced Care Planning (ACP). **3. Advanced Care Plans (10%)** Diagnosed patients will have Advanced Care Plan (ACP) in place using the agreed CCG template – the Treatment Escalation and Resuscitation Status Form: • 65% of all diagnosed patients have an ACP in place – 5% payment. • A further 5% payment will be payable to practices where their PCN collectively achieves 65% of all diagnosed patients with an ACP in place.
References	1 Dementia 2014: Opportunity for Change, Alzheimer's Society, September 2014 2 Counting the Cost – Caring for people with dementia on hospital wards, Alzheimer's Society 2009 3 NHS Digital monthly return December 2018 4 Next Steps on the NHS Five Year Forward View (March 2017) 5 Prime Minister's challenge on dementia 2020 (February 2015) 6 The NHS Long Term Plan (January 2019) 7 National Institute for Health and Care Excellence https://www.nice.org.uk/guidance/ng97 8 Dementia NICE quality standard - Draft for consultation https://www.nice.org.uk/guidance/GID-QS10079/documents/draft-quality-standard **Other useful sources of information:** NHS England Dementia Well pathway (March 2016) https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/03/dementia-well-pathway.pdf NHS England Dementia: Good Care Planning https://www.england.nhs.uk/wp-content/uploads/2017/11/dementia-good-care-planning-v2.pdf https://www.alzheimers.org.uk/get-involved/dementia-friendly-communities/how-to-become-dementia-friendly-community

Appendix One: DMARD Monitoring

Service description/care pathway
Effective Shared Care Agreements (ESCA) will be implemented for all the DMARDs included in this standard. DMARDs are prescribed for a range of inflammatory conditions including rheumatology, gastroenterology and dermatology indications. This standard applies to all conditions where an ESCA is available. There are currently ESCAs approved for gastroenterology, rheumatology and dermatology indications. In Sandwell and West Birmingham CCG DMARDs are classified as AMBER drugs i.e. considered suitable for GP prescribing following specialist initiation of therapy and patient stabilisation, with specific long term monitoring for toxicity needing on going specialist support. Prescribing responsibility will only be transferred when it is agreed by the consultant and the patient's GP that the patient's condition is stable or predictable. Disease monitoring remains within the remit of the specialist team, however concerns about individual patients can always be raised by GPs to secondary care. As part of the ESCA for DMARDs, GP practices are expected to work in partnership with secondary care colleagues with regards to the following: 13. Agree to a shared care drug monitoring for DMARDs 14. Implement a practice DMARD register 15. Implement an effective call and recall. *Evidence of robust, systematic and responsive recall system for monitoring and review as laid down in the ESCA (Effective Shared Care Arrangement). Mechanisms to deal with non-attendees.* 16. Ensure each patient has an individual management plan (secondary care/GPwSI to provide) 17. Implement accurate record keeping – prescribing and blood monitoring 18. Attend appropriate training 19. Read code when a patient has an annual review (the disease review is to be completed in secondary care) 20. Ensure professional links and referral policies in place for secondary care providers other than SWBHT. Approved ESCAs are available from UHB/HEFT and Dudley Group NHS Foundation Trust 21. Practices must have robust written processes in place to ensure that appropriate monitoring has been carried out before each prescription is issues and to ensure that patients failing to attend for blood tests are identified and recalled. All prescriptions for high-risk drugs and DMARDs should only be issued if regular biological testing is undertaken as relevant. As part of CQC inspections of GP practice, the CQC can review the prescribing of DMARDs and request to see if associated ESCAs are in place. For all prescriptions

issued for the drugs included in the list below there is a requirement that 80% have a read-code for shared care documented in the clinical system.

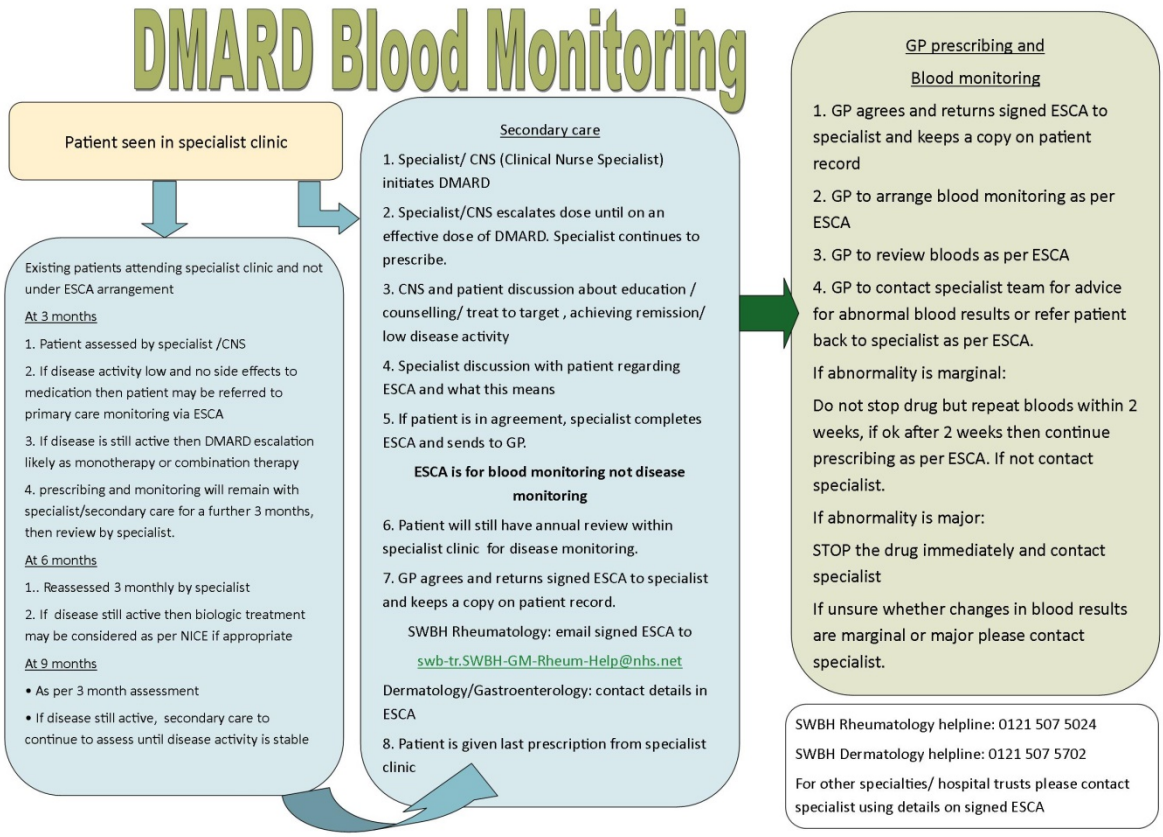
a) Sulfasalazine
b) Azathioprine
c) Methotrexate
d) Ciclosporin
e) Leflunomide
f) Mycophenolate (for CCG commissioned indications only)
g) Mercaptopurine

Table 1: All patients receiving treatment under an ESCA need to be appropriately Read Coded.

GP Prescribing System	Read Code	Description	Template Heading
EMIS Web	8BM5	Shared care prescribing	PCCF DMARD Management
SystmOne	XaK6z	Shared care prescribing	PCCF DMARD Management blood view

The list of ESCAs approved by the Birmingham, Sandwell, Solihull and environs (BSSE) Area Prescribing Committee (APC) are available using this link: http://www.birminghamandsurroundsformulary.nhs.uk/docs/ESCA/

Rheumatology, Gastroenterology and Dermatology ESCA pathway and responsibilities at SWBH



Other trusts may have different pathways. If any doubt, contact the specialist using the details provided on the ESCA.

Dudley Group of Hospitals has repatriated prescribing and blood monitoring of all DMARDs back to primary care. They provide ESCAs in line with the policy available here: http://www.dudleyformulary.nhs.uk/page/51/10-musculoskeletal-and-joint-diseases-shared-care.

Appendix Two: 12 Lead Resting ECGs

Service description
Providers of 12 Lead Resting ECGs will undertake the following: **Infection prevention and control** Appropriate infection, prevention and control measures are taken. **Accreditation** All staff involved in the provision of ECG within primary care must be appropriately trained and competent. Guidance can be found on the Skills for Health website. **Review and audit** The provider should perform an internal annual review of the ECG service that they provide. The audit is to include a review of the service throughout the year, staff development and training, any problems encountered and how they were resolved and how the protocols and local agreements have been implemented and monitored. This needs to include a clinical review of a sample of ECGs performed by all staff. The audit is to include 10 ECG reviews per individual practitioner performing ECGs.

Appendix Three: Diabetes Injectable Therapies Initiation and on-going Management

Service description/care pathway

This service will be provided in accordance with NICE Clinical Guidelines, NICE Technology Appraisals, locally agreed pathways and Health Economy Formulary with responsibility sitting with the prescribing clinician.

Patients will be discharged from the Specialist Diabetes Service and receive all ongoing diabetes care from the practice in accordance with the locally agreed pathways. The practice will be responsible for communicating with the patient and liaising with the Specialist Diabetes Team to ensure a smooth and appropriate transition of care.

The ongoing management of patients on injectable therapies will be in line with locally agreed pathways.

GLP-1 receptor agonists

GLP-1 receptor agonists must be used in line with the current marketing authorisation and Health Economy Formulary guidance.

Triple Therapy Regimens

GLP-1 receptor agonists in triple therapy regimens (that is, in combination with metformin and a sulphonylurea, or metformin and a pioglitazone are recommended as a treatment options for people with type 2 diabetes when control of blood glucose remains or becomes inadequate (HbA1c ≥59 mmol/mol or other higher level agreed with the individual), and the person has:

- A body mass index (BMI) ≥ 35 kg/m2 in those of European family origin (with appropriate adjustment for other ethnic groups) and specific psychological or medical problems associated with high body weight **or**
- A BMI < 35 kg/m2, and therapy with insulin would have significant occupational implications or weight loss would benefit other significant obesity-related comorbidities.

Continuation of treatment

All patients on GLP-1 receptor agonists will be reviewed every six months to determine whether it is appropriate to continue with the current therapy regimen. Where appropriate treatment should be stopped if not proving effective as detailed below.

Treatment with GLP-1 receptor agonists in triple therapy regimen should only be continued if a beneficial metabolic response has been shown (defined as a reduction of at least 1 percentage point in HbA1c [11 mmol/mol] and a weight loss of at least 3% of initial body weight) at six months

Insulin therapy

Discuss the benefits and risks of insulin therapy when control of blood glucose remains or becomes inadequate (HbA1c ≥ 58 mmol/mol or other higher level agreed with the individual) with other measures. Start insulin therapy if the person agrees.

For a person on dual therapy who is markedly hyperglycemic, consider starting insulin therapy in preference to adding other drugs to control blood glucose unless there is strong justification not to. When starting insulin, a structured programme employing active insulin dose titration should be used that encompasses:

- Education
- Continuing telephone support
- Frequent self-monitoring
- Dose titration to target
- Dietary understanding
- Management of hypoglycemia
- Management of acute changes in plasma glucose control
- Support from an appropriately trained and experienced healthcare professional.

The education programme, undertaken by practice staff should cover:

- Aims of insulin therapy
- Delivery of insulin, including injection techniques
- Care of injection sites
- Self-monitoring techniques and use of devices
- Dietary advice
- Physical activity advice
- Detection and management of hypoglycemia
- Sick day rules and driving regulations
- Complications.

Initiate insulin therapy from a choice of a number of insulin types and regimens. Begin with a human NPH insulin included in the Health Economy Formulary injected at bed-time or twice daily according to need.

Consider, as an alternative, using a long-acting insulin analogue (insulin glargine or Biosimilar) if:

1) The person needs assistance from a carer or healthcare professional to inject insulin, and use of a long-acting insulin analogue (insulin glargine or Biosimilar) would reduce the frequency of injections from twice to once daily, or
2) The person's lifestyle is restricted by recurrent symptomatic hypoglycemic episodes, or
3) The person would otherwise need twice-daily NPH insulin injections in combination with oral glucose-lowering drugs, or
4) The person cannot use the device to inject NPH insulin.

Consider twice-daily pre-mixed (biphasic) human insulin included in the Health Economy Formulary (particularly if HbA1c ≥ 75mmol/mol). A once- daily regimen may be an option.

Consider pre-mixed preparations that include short-acting insulin analogues, rather than pre-mixed preparations that include short-acting human insulin preparations, if:

- A person prefers injecting insulin immediately before a meal, or
- Hypoglycemia is a problem, or
- Blood glucose levels rise markedly after meals.

Consider switching to a long-acting insulin analogue (insulin detemir, insulin glargine or biosimilars) from NPH insulin in people:

1. Who do not reach their target HbA1c because of significant hypoglycemia, or
2. Who experience significant hypoglycemia on NPH insulin irrespective of the level of HbA1c reached, or
3. Who cannot use the device needed to inject NPH insulin but who could administer their own insulin safely and accurately if a switch to a long-acting insulin analogue were made, or
4. Who need help from a carer or healthcare professional to administer insulin injections and for whom switching to a long-acting insulin analogue would reduce the number of daily injections.

Monitor a person on a basal insulin regimen (NPH insulin or a long-acting insulin analogue (insulin glargine) for the need for short-acting insulin before meals (or a pre-mixed insulin preparation).

Monitor a person who is using pre-mixed insulin once or twice daily for the need for a further injection of short-acting insulin before meals or for a change to a regimen of mealtime plus basal insulin, based on NPH insulin or long-acting insulin analogues (insulin glargine), if blood glucose control remains inadequate.

Accreditation
All GPs and practice nurses who are providing this service must:

1. Complete a GLP1 Initiation and management training programme before delivering this service
2. Complete injectable therapies initiation and management training programmes and be formally assessed as competent before delivering this service. This can include joint consultations with the DICE team.
3. Clinicians that have previously not delivered insulin initiation and ongoing management must be able to demonstrate that they have successfully completed an insulin initiation and management course and been formally assessed as competent through the post course accreditation process before they can start delivering this service
4. Clinicians that are already delivering insulin initiations and ongoing management under previous arrangements must demonstrate their competence through providing details of:
    a. The courses they have successfully completed (including dates).
    b. The date they were formally assessed as competent
    c. The name of the professional that assessed them to be competent. This can be a member of the DICE team through a joint consultation.
    d. The number of insulin initiations they have completed over the past 12 months.
5. Undertake a minimum of 3 insulin initiations per annum to maintain competency (the initiations do not need to be the practice patients only). NB. Initiations can be made up with new patient initiations, dose adjustments of existing patients and

peer-review of case studies. These can be documented on the audit in Appendix 3 in Table 2 or on a separate audit sheet to demonstrate competence for insulin initiations.

Evaluation/ audit

The template at the end of this document should be completed and submitted for review by the medicines management team at the end of each year. Please note that a nil return audit will not be paid.

Any acceptance and exclusion criteria and thresholds

This service only applies to those over school leaving age.

Onward referrals should be made for structured patient education or to the following clinics where appropriate:

1. Diabetic renal clinics
2. Diabetic pregnancy clinics
3. Diabetic foot clinics (for complex foot care)
4. Young people's diabetic clinics
5. Insulin pump clinics
6. Dietician clinics (for complex dietary support).

Table 1 – DiCE Clinic Audit (April 20 to March 21)

To be completed by Practice prior to DiCE Clinic								To be completed in DiCE or post DiCE Clinic			
Patient ID	**Date Seen and type of clinic*** *** F2F=**Face to face consultation**;** **VOS=**Virtual On Site –DiCE team MDT at practice; **VT**= Virtual Telephone/Skype/Off site.	**Diagnosis** ***Type 1/ Type 2/ Other***	**HbA1c** *prior to DiCE clinic and date*	**Individualised Care Plan completed** **Y / N**	**Receiving all 8 care process** **Y / N** *If N stipulate number e.g. 6/8 complete*	**Antidiabetic Medications prior to DICE Clinic**	**List any allergies/ intolerances/ ineffective antidiabetic medication**	**Actions taken on Oral Hypoglycaemic Agents** **- Titrated or added, (please state specific actions)?** **Y / N**	**Insulin started/ titrated?** **Y / N / NA**	**GLP-1 started/ titrated?** **Y / N / NA**	**Any Comments** *e.g. Number of hospital admissions – Hypo or DKA in last 12months, improvement in HbA1C?, other co-morbidities impacting targets, other specialist referral required, compliance, individualised target achieved etc.* **Please state:**

Table 2 – Diabetic related hypoglycaemic audit (following ambulance call-out/ A&E attendance/ hospital admission)

SANDWELL AND WEST BIRMINGHAM CCG

Practice MCODE	
Practice Name	

Standard 5: Patient-Centred Care - Diabetes
Diabetic related hypoglycaemic audit (following ambulance call-out/ A&E attendance/ hospital admission)

Patient ID	Coded on clinical system? Y/N	Follow-up/ Review What action was taken to stop or to reduce future occurrence?

Appendix Four: Enhanced Diabetes Care

Scope

Objectives

- To improve the knowledge and confidence of primary care clinicians to treat and manage diabetic patients in their own practice with the aim of reaching a point where 95% of the diabetes care for type 2 and stable type 1 diabetics occurs within the practice without the need for onward referral.
- DiCE specialist to provide supervision and training to primary care clinicians.
- DiCE specialists to facilitate competence of primary care clinicians to initiate insulin/GLP1.
- To achieve a year on year increase in the number of patients completing education programmes (e.g. DAFNE, XPERT, Conversation Maps etc.) through improved accessibility at practice level.
- To provide cost effective prescribing with the addition of diet and lifestyle intervention.
- To improve formulary compliance with blood glucose test strips achieving better value for money and aiming to meet or exceed the West Midlands target.
- To move towards the National QIPP targets for Type 2 Diabetes:
    - Number of prescription items for metformin as a percentage of the total number of prescription items for all antidiabetic drugs
    - Number of prescription items for long acting human analogue insulins detemir and glargine or biosimilars as a percentage of the total number of prescription items for all long acting and intermediate acting insulins excluding biphasic insulins.
- To achieve a year on year reduction in emergency admissions/A&E attendance from specific diabetes related complications
- To achieve a reduction in the number of amputations, renal dialysis and blindness arising in people with diabetes
- All patients will receive a service which encourages partnership in decision-making, supports them in managing their diabetes and helps them to adopt and maintain a healthy lifestyle. This will be reflected in an agreed and shared care plan in an appropriate format and language. Where appropriate, parents and carers should be fully engaged in this process

- All patients will have an individualised agreed shared care plan detailing HbA1c target, diet and exercise programme, medication management plan, cholesterol level, BMI and blood pressure together with the agreed approach the patient will take to meeting these targets. A written record of these targets and plan will be given to the patient in written form and a copy kept in the patient's records

- Savings made as improvements in primary care and community services lead to a reduction in the need for hospital based care.

Service description/care pathway

Enhanced diabetes care

The practice will be responsible for providing diabetes management for adults of its type 2 and stable type 1 patients at a practice level with the support of a specific named Diabetes Community Care Extension (DiCE) team (Diabetes Consultant and Diabetes Specialist Nurse).

The aim is to reach a point where 95% of the care for type 2 and stable type 1 diabetics occurs within the practice without the need for onward referral.

Each practice will have named DiCE Team. As you begin working together, the detail and type of support your practice and patients require can be readily established. Some of the examples of the support DiCE teams offer include:

- **Advice and guidance:** via telephone, video conferencing or email during normal working hours. Wherever possible telephone and email enquiries will be dealt with on the same day, with a maximum turnaround time for non- urgent enquiries of two working days. It is expected that working together you will establish mechanisms to share clinical information electronically with your DiCE team (e.g. by providing access through SystmOne, EmisWeb or similar)
- **Joint meetings between DiCE and the practice diabetes team:** e.g. for activities including case note reviews, with DiCE teams offering advice/support and reviewing management plans
- **Specific diabetes related education and training:** at a practice level
- **Joint consultation clinics within the practice:** for cases where it is optimal that primary care clinicians and DiCE clinicians see patients together at the practice (the organisation and administration of these clinics will be the responsibility of the practice, including organising interpreters where required).

Joint consultation clinics will be the first stage of stepped up care from a routine diabetes appointment with a practice clinician. This will assist in identifying patients with complex or severe diabetic presentations. Once the issues presenting are resolved the practice can continue the person's care in their routine appointments (in line with a jointly agreed care plan).

Individualised care planning

Consultations under this service will be managed through an individualised care planning approach, using a standard template which is accessible through your clinical system.

In line with NICE guidance, at the initial appointment, a target will be agreed between clinician and patient/carer of the HbA1c level that will jointly be pursued. A target HbA1c is expected to be agreed for at least 98% of patients.
Other relevant targets will be jointly agreed at this initial consultation covering areas such as medication management, cholesterol level, BMI, blood pressure, weight loss, diet, exercise etc. A jointly agreed plan will also be agreed as to how to achieve these targets. A written record of these targets and plan will be given to the patient in written form and a copy kept in the patient's records.

At subsequent appointments, this plan and associated targets will be jointly reviewed by patients/carers and clinicians and updated as necessary. Any amendments made will be recorded as above, with copies given to the patient and retained in the patient's record. Frequency of appointments will be jointly determined by the patient, carer and clinician.

This set of targets and plan of care will be used as the benchmark to determine the timing of the patients discharge from the joint clinics back to routine primary care. Once these targets are met or the patient decides or the patient's GP agrees, discharge will take place.

Care plans can be used for audit/quality assurance/training purposes.

Accreditation

In order to participate providers must meet the following requirements:

- At least one GP and practice nurse/second GP must have attained the Certificate in Diabetes Care accredited by Warwick University; or an equivalent course recognised by the CCG; or provide evidence of CPD which must be accepted by the CCG as equivalent
- All clinicians providing enhanced diabetes care to attend a minimum of six hours of diabetes direct learning (6 CPD credits) per year. The CCG reserves the right to review the clinician's CPD portfolio.
- The practice must participate in the National Diabetes Audit and the local CCG Diabetes Audit annually and give consent for the CCG to access practice level data and to share this data with their DiCE Team and other CCG member practices.

Evaluation/ audit

The practice will participate in evaluation/audit as detailed in the PCCF diabetes standard.

In addition practices will be monitored against the following indicators:

- Number of outpatient referrals for diabetes
- Emergency admissions for diabetic complications including episodes of hypoglycaemia
- A&E attendances for diabetic complications
- Number of amputations occurring as a result of diabetes complications
- Number of diabetic patients on renal dialysis
- Number of diabetic patients who have lost their sight due to diabetes complications
- Number of prescription items for long acting human analogue insulins detemir and glargine or biosimilars as a percentage of the total number of prescription items for all long acting and intermediate acting insulins excluding biphasic insulins
- National Diabetes Audit care processes and Treatment targets
- QOF achievement.

Any acceptance and exclusion criteria and thresholds

This service only applies to those over school leaving age.

Onward referrals should be made for structured patient education or to the following clinics where appropriate:

- Diabetic renal clinics
- Diabetic pregnancy clinics
- Diabetic foot clinics (for complex foot care)
- Young people's diabetic clinics
- Insulin pump clinics
- Dietician clinics (for complex dietary support).

Appendix Five: Diabetes Clinical Performance Development Plan

A separate plan is to be completed by each clinician/s working with DiCE team: -

Lead Diabetes Clinician Name (GP)		**Lead Diabetes Clinician Name (Nurse)**	
DicE Practice Support Consultant		**DicE Practice Support DSN**	
PDP Submission Date		**Submitted By**	

Continued Professional Development and Primary Care upskilling is a key objective in the Diabetes PCCF Standard and joint responsibility between you supported by your DiCE team. This enables more complex Diabetes cases to be controlled more effectively in Primary Care and offer a holistic approach to managing patients in general practice.

As part of the 2020/21 Diabetes PCCF you will be required to submit a Clinical Performance Development Plan for each clinician working with the DiCE team. Please note: Your DiCE Team will need to review your objectives with you and confirm engagement and indicate they will be able to support your development in these areas.

Objective Settings

5 Objectives will need to be identified initially, and the first section of the plan completed no later than the 31st October 2020. The plan can be retained within the Practice.

Key learning and Year End Review

The second section of the plan will need to be completed at the end of the year which will require submission to the following email address **swbccgprimary.carecontracts@nhs.net** as part of the end of year return.

Practice Development Plan – Objective Setting

This section is to identify what objectives you wish to focus on jointly with your DiCE team in your practice over the next 12 months for your Diabetes Development.

Please choose 5 subject areas your practice wishes to focus on from the below list and add them to the table: -

Screening, prevention and early detection of type 2 diabetes
Promoting self-care
Nutrition
Urine glucose and ketone monitoring
Blood glucose and ketone monitoring
Oral therapies
Injectable therapies
Hypoglycaemia
Hyperglycaemia
Intercurrent illness
Pregnancy
Cardiovascular disease
Neuropathy
Nephropathy
Retinopathy
Other – Please Clarify

Then tick a box for each objective to show your level of confidence currently in that objective.

	Learning Objectives ***To be completed by Oct 2020***	How confident are you at this objective (Please tick one box in each subject) ***To be completed by 31st October 2020***	Please highlight what you did to achieve your learning objective e.g. *Case based discussion leading to improved management and outcome i.e. HbA1c, complications of Diabetes, complex cases. *Use a case where joint working has improved outcome * Use DICE clinic experience/ training workshop to prepare a practice based audit. ***To be completed in April 2021***	How confident are you at this objective (Please tick one box in each subject) ***To be completed in April 2021***
1		Very Confident ☐ Somewhat Confident ☐ Ok ☐ Not that Confident ☐ Not at all Confident ☐		Very Confident ☐ Somewhat Confident ☐ Ok ☐ Not that Confident ☐ Not at all Confident ☐
2		Very Confident ☐ Somewhat Confident ☐ Ok ☐ Not that Confident ☐ Not at all Confident ☐		Very Confident ☐ Somewhat Confident ☐ Ok ☐ Not that Confident ☐ Not at all Confident ☐
3		Very Confident ☐ Somewhat Confident ☐ Ok ☐ Not that Confident ☐ Not at all Confident ☐		Very Confident ☐ Somewhat Confident ☐ Ok ☐ Not that Confident ☐ Not at all Confident ☐

4		Very Confident ☐ Somewhat Confident ☐ Ok ☐ Not that Confident ☐ Not at all Confident ☐		Very Confident ☐ Somewhat Confident ☐ Ok ☐ Not that Confident ☐ Not at all Confident ☐
5		Very Confident ☐ Somewhat Confident ☐ Ok ☐ Not that Confident ☐ Not at all Confident ☐		Very Confident ☐ Somewhat Confident ☐ Ok ☐ Not that Confident ☐ Not at all Confident ☐

Year End Review – To be completed April 2021

Practice Clinician Feedback – Additional Thought

DiCE Clinician Feedback – Additional Thought

Date of Year End Review	
Submitted By	

Appendix Six: Intermediate Care Providers

Own bed instead (home based intermediate care)

Leasowes

D47 (ward at City Hospital)

Henderson (ward at Rowley Hospital)

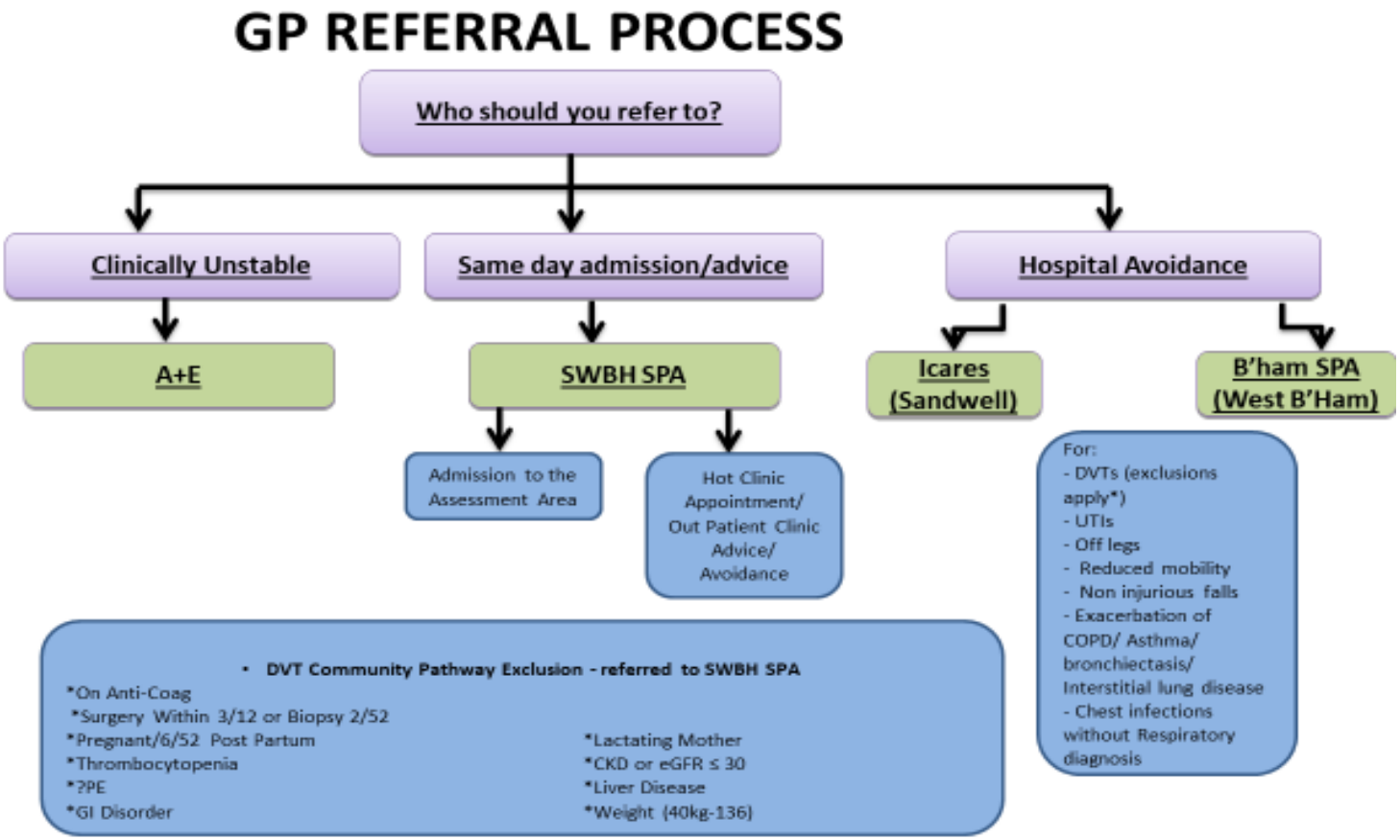
Waterside Care Home

Ryland View

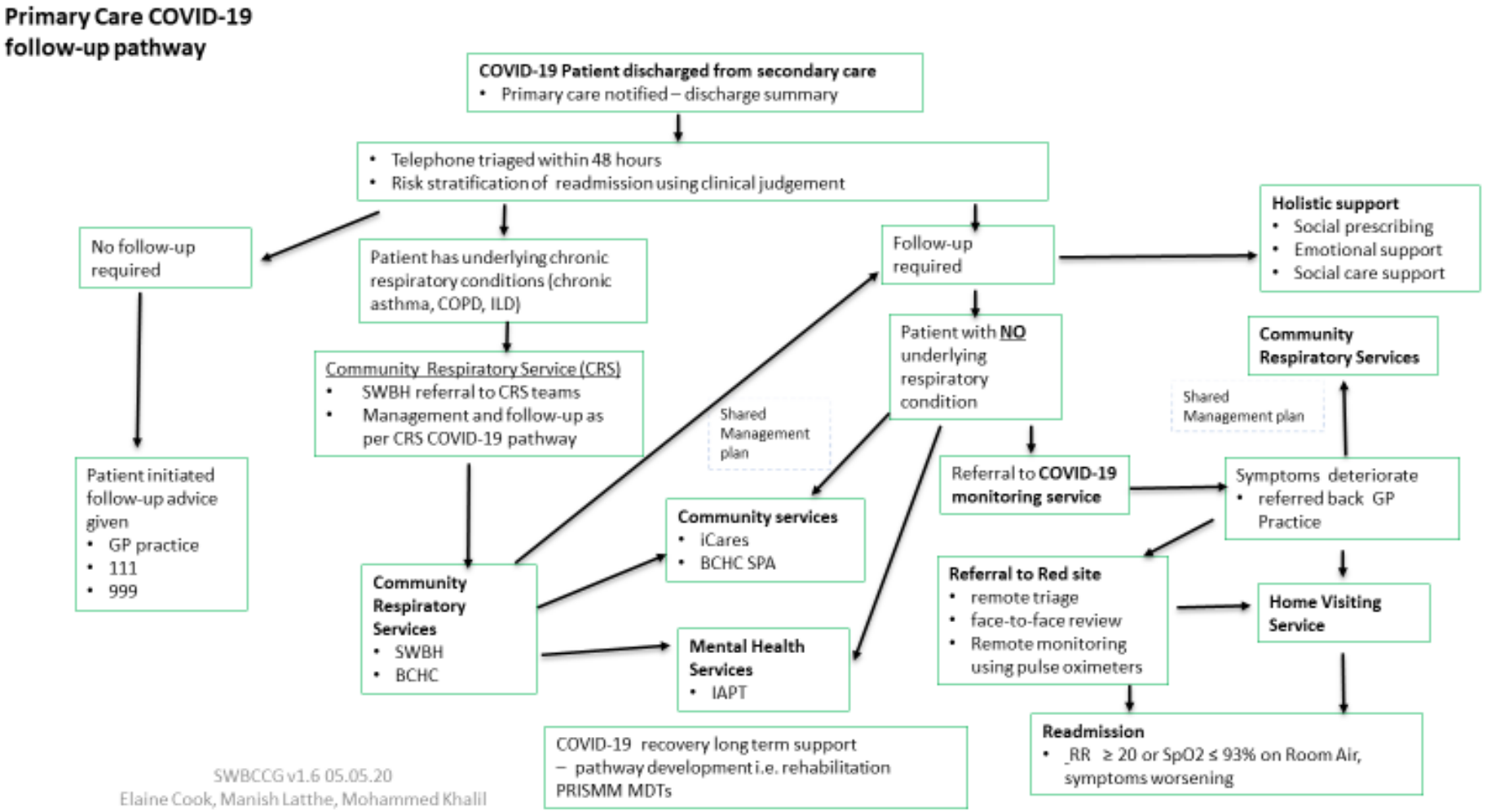
Appendix Seven: Warfarin audit

Patient ID	Indication for warfarin	Target INR	Continued appropriately? Y/N	Date warfarin issued in the last 6 months	INR recorded on clinical systems in the last 6 months (enter values)	Current TTR (read code INR % TTR on Emis 0R Xaa68 on SystmOne)	TTR <65% in last 6 months & actions taken

Appendix Eight: SPA GP Referral Process



Appendix Nine – COVID 19 Primary Care Follow Up Pathway



Digital Report

PRIMARY CARE COMMISSIONING COMMITTEES IN COMMON

DATE OF MEETING: Tuesday 23rd June 2020

AGENDA ITEM: 7.1

Title of Report:	Digital Report
Purpose of Report:	To provide the Committees with an update regarding a review of digital changes implemented as a result of covid 19 across Primary Care, Acute and Mental Health Services.
Author of Report:	Mike Hasting - Director of Technology and Operations Black Country & West Birmingham CCGs
Management Lead/Signed off by:	Mike Hasting - Director of Technology and Operations Black Country & West Birmingham CCGs
Public or Private:	Public
Key Points:	• Phase one is a high level review • Phase 2 which is due in July which will go into more detail • Phase 3 will be proposals for consolidation of digital services
Recommendation:	To note that this piece of work will be managed by the STP digital board.
Conflicts of Interest:	n/a
Links to Corporate Objectives:	
Action Required:	✔ Assurance Decision
Implications:	
Financial	N/A
Assurance Framework	N/A
Risks and Legal Obligations	N/A
Equality & Diversity	N/A
Other	N/A

Working together for healthier futures

Digital Report

NHS Dudley Clinical Commissioning Group
NHS Sandwell and West Birmingham Clinical Commissioning Group
NHS Walsall Clinical Commissioning Group
NHS Wolverhampton Clinical Commissioning Group

1 Introduction

The ‘apps’ covered in this report range from the following:

Online Consultations as part of the NHS England ‘Total Triage Model’

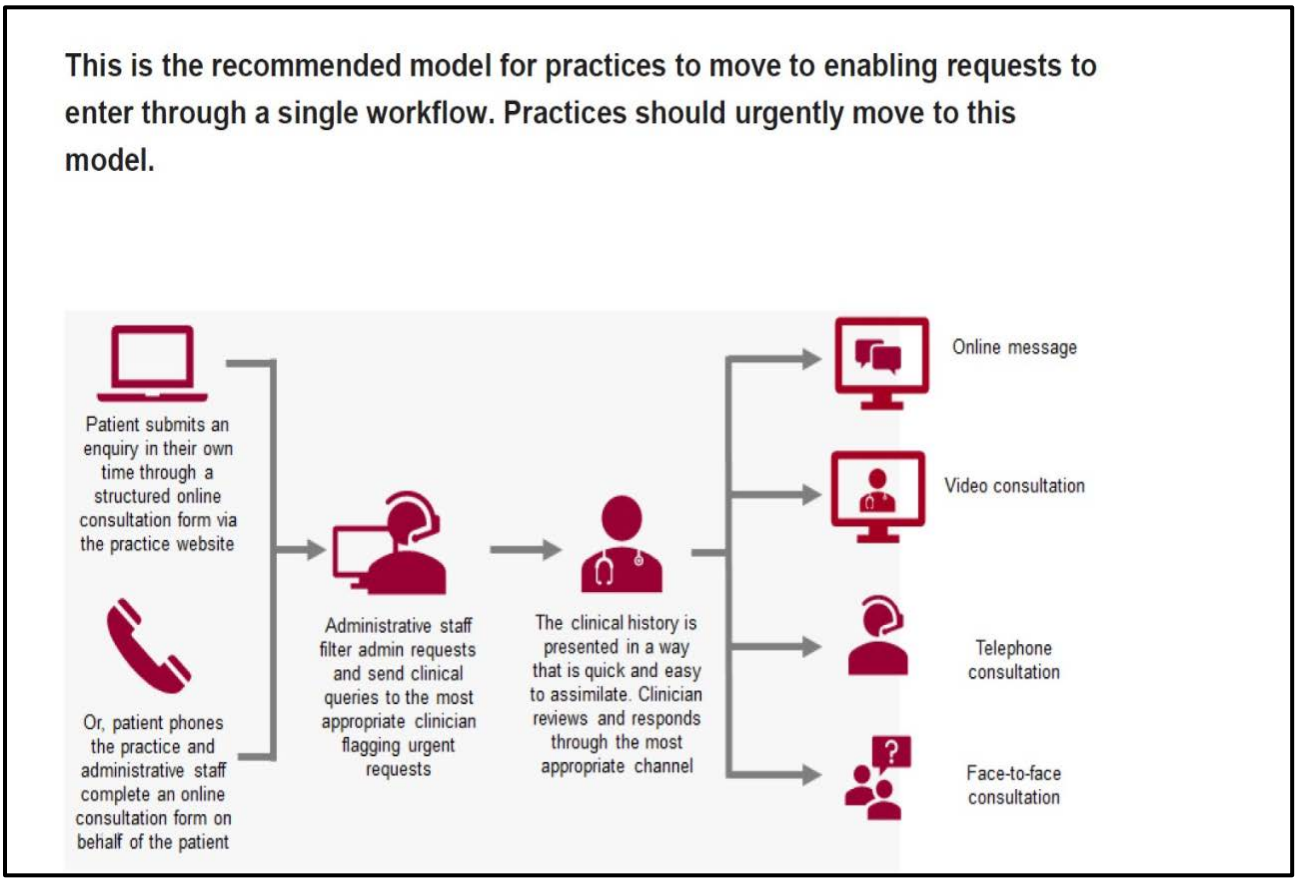
Video Consultations (primary and secondary)

Other symptom checker APP’s (secondary care, national NHS APP)

The solutions captured and illustrated in this briefing are from an initial data capture exercise over a 3-week period.

2 Online Consultations as part of the NHS England ‘Total Triage Model’

Across the STP within Primary Care, NHS England mandated that all practices adopt a Total Triage Model as part of Covid-19 by 30th April 2020. To help with this enablement, an Online Consultation accelerator framework was made available which funded any solution from that framework to be centrally funded for 12 months.



(taken from NHS England’s Remote Triage Blueprint published on 27th March 2020)

As the STP had already procured solutions from suppliers from the DPS Framework, the following solutions were either already deployed or were in deployment phase before covid-19. The solutions outlined were also included in the newly available 'Online Consultation accelerator framework'.

Name of 'Place':

Wolverhampton CCG

Date since solution was procured:

2018

Procured solution:

EMIS Online Triage

Registered patients that can use it:

25,439 patients registered to use it

Patient utilisation:

25 patients in the last month which included also a video consultation

Cost of solution per year:

approx. £70k

Name of 'Place':

Walsall CCG

Date since solution was procured:

2018 (an initial pilot took place first across 10 sites and deployment was accelerated in the past month as part of the NHS England deadline)

Procured solution:

eConsult

Registered patients that can use it:

270,000

Patient utilisation:

-10,492 eConsults submitted to practices

-972 patients have received or looked up self-help

-344 patients were given pharmacy self-help advice

-Estimated 6,025 appointments have been saved

Cost of solution per year:

approx. £60k

Name of 'Place':

Dudley CCG

Date since solution was procured:

2018

Procured solution:

Ask NHS (sense.ly)

Registered patients that can use it:

10,195

Patient utilisation:

-1993 patients have used the symptom checker ever

-8 patient appointments have been booked in total with 42 call backs

-A total of 930 patients have received self-care advice via the APP

-563 patients have had queries triaged by the practice administrative team

Cost of solution: approx.

£100k

Name of 'Place':

Sandwell & West Birmingham CCG

Date since solution was procured:

2019 (an initial pilot was in place across 15 sites before covid-19)

Procured solution:

Substrakt Patient Pack

Registered patients that can use it:

4,000 since February 2020 across 15 practices part of the pilot

Patient utilisation:

The implementation has just been scaled up in the past 3 weeks as part of the NHS England deadline and therefore utilisation is currently unavailable until 30th May.

Cost of solution: approx.

£450k

Summary of solutions, cost and VFM

CCG	Solution	Cost	VFM based on current usage
Wolverhampton	EMIS Online Triage	70k	No
Walsall	eConsult	60k	'Potential/Positive'
Dudley	Ask NHS (sens.ly)	100k	No
Sandwell & West Birmingham	Substrakt Patient Pack	470k	TBD

Video Consultations

Primary Care

The single biggest success that has been achieved via digital during covid-19 has quite easily been the adoption and use of video consultations across healthcare. Although the technology to do this has been around for some time, there has been a huge behavioural shift in the confidence to use technology such as this to see and treat patients. There has also been a significant shift towards telephone consultations.

Within primary care, AccuRx has been offered to be used free, funded by NHS England in response to Covid-19. Although other solutions were also available fully funded by the national team during covid-19, AccuRx was the first to release and easiest to adopt. Feedback from across primary care and the secondary care providers that have used it is that it has been a success and working very well.

Utilisation of AccuRx across primary care during covid-19

Wolverhampton CCG – 3,131

Walsall CCG – 3,536

Dudley CCG – 3,510

Sandwell & West Birmingham CCG – 6,649

Total of primary care video consultations across BC&WB STP – 16,826

As AccuRx is funded nationally during covid-19, costs to maintain this service as an STP are not available. Therefore, value for money cannot be fully quantified unless this is compared to the number of overall consultations that have been carried out in primary care since covid-19 was declared a national incident.

Secondary Care

Across secondary care, video consultations have also been rapidly deployed and enabled for first outpatient appointments and follow up's.

Black Country Healthcare NHS Foundation Trust – 'AccuRx' is used for all specialities with the ability to include an interpreter and/ or other family member/healthcare professional. BCHFT are also using and 'Jitsi Meet' for Group Therapies however they are also investigating other alternatives.

Sandwell and West Birmingham Hospital Trust – 'Visionable' has been deployed with currently 250 clinicians trained across all specialities. In total over 300 hours of video consultations have been carried out.

Dudley Group Hospitals – The nationally funded 'Attend Anywhere' has been adopted in DGH however no utilisation or information on adoption is available or been provided at this moment in time.

Walsall Hospitals Trust – 'eClinic' has been deployed however again no utilisation or information on adoption is available or been provided at this moment in time.

Royal Wolverhampton Trust – 'AccuRx' is being used for first patient appointments and no further information on adoption has been made available.

On Thursday 7th May, during a call with the hospital providers Chief Information Officers, and respective Heads of IT etc, it was resoundingly commented that consultants overall thought video consultations would be maintained and used post covid-19, although there is further analysis required within their organisations. Therefore, from a secondary care provider perspective, these solutions are value for money and working very well.

3 Other symptom checker APP's (secondary care, national NHS APP)

The 2 APPs that are known within this category are the 'National NHS APP' and the 'Ask A&E Covid-19 Care (Babylon) APP'. The national APP is available to all patients and uses the 111-symptom checker. However, 'Ask A&E 'is available only to residents in certain postcodes in Wolverhampton (via Royal Wolverhampton Trust) and residents in certain postcode's within West Birmingham (via University Hospitals Birmingham).

Neither of these APPs allow the patient to book a telephone and/or video consultation within primary care, and don't fit within the criteria from NHS England for a Total Triage model.

The Ask A&E Covid-19 Care Assistant APP from Babylon via Royal Wolverhampton and University Hospital Birmingham, does allow though for patients to be seen by a consultant in the hospitals once they have spoken to a Babylon call handler/care assistant if an appointment has been deemed necessary via the APP Symptom checker. No information on utilisation, cost or adoption is available and therefore this cannot be evaluated against value for money.

4 Next Steps

Following this initial data capture (phase 1) there will be further work carried out across 2 more phases delivered via Midlands & Lancashire CSU.

Phase 1 – Initial Data Capture – **Completed**

Phase 2 - Analysis of technology / APPs deployed and include evaluation of effectiveness and perceived and measured value (by 26th June)

Sample Output:

- Analysis of utilisation and opportunities to optimise
- Identify strengths, weakness and opportunities with relation to applications deployed.
- Focus on identifying solutions which have clearly offered significant benefit; identify opportunities to scale these deployments across a wider footprint
- Identify opportunities to further exploit capability and optimise value & benefit to the STP

Phase 3 - Technical options and feasibility to deliver a citizen facing 'single front door'; with access to the array of local applications provided by individual providers (by 24th July)

Sample Output:

- Initial analysis to establish the range of solutions deployed across the STP (across all providers).
- Requirements gathering exercise across the STP to establish latent need and in turn to inform the technical 'ask' to support the 'digital front door'.
- Technical evaluation to understand technical requirements to support the 'digital front' door aspiration.

Working together for healthier futures

Digital Report

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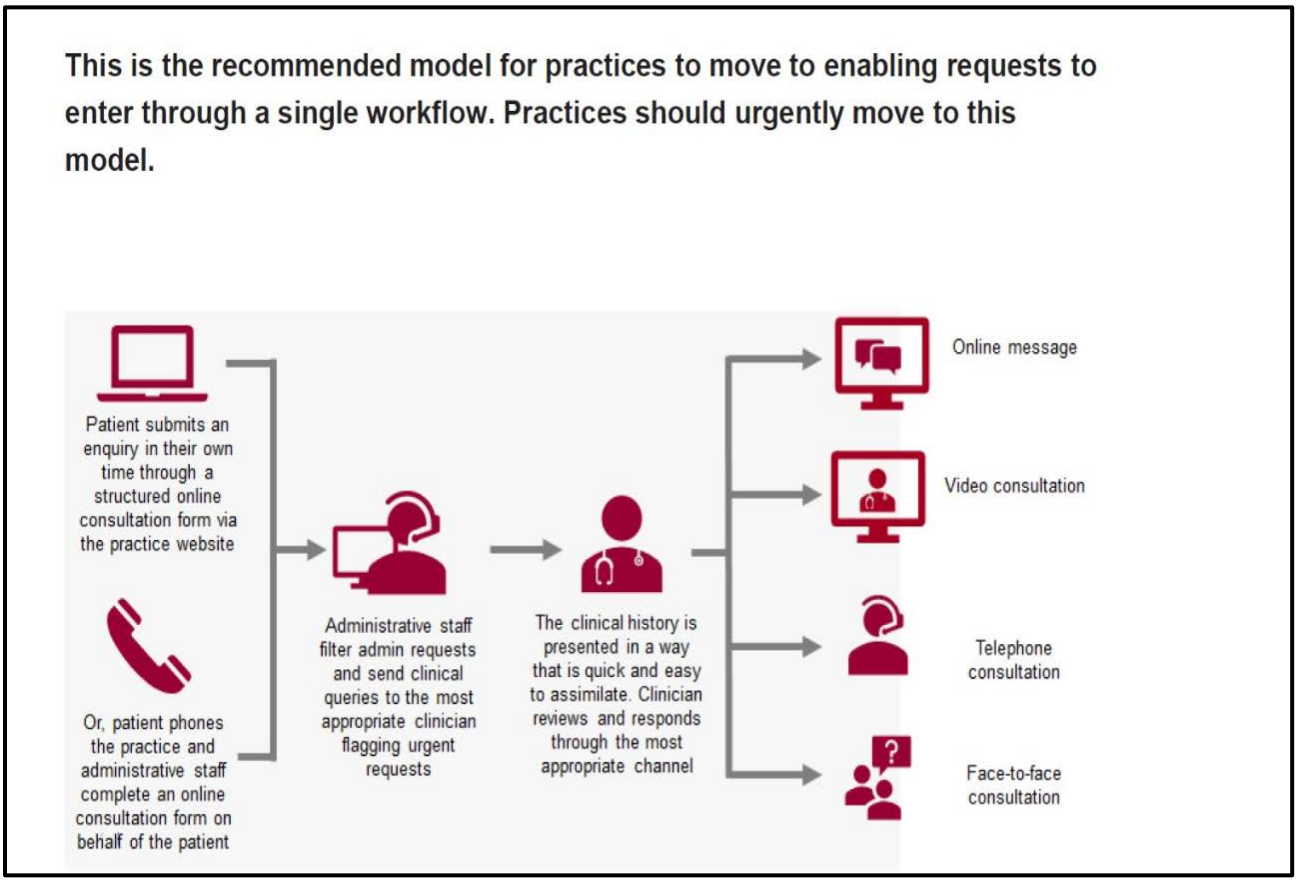

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Cost of solution per year:

approx. £70k

Value for money?

Based on current usage/utilisation, there is no evidence that this solution currently offers value for money. However, the product is competitively priced.

Name of 'Place':

Walsall CCG

Date since solution was procured:

2018 (an initial pilot took place first across 10 sites and deployment was accelerated in the past month as part of the NHS England deadline)

Procured solution:

eConsult

Registered patients that can use it:

270,000

Patient utilisation:

-10,492 eConsults submitted to practices

-972 patients have received or looked up self-help

-344 patients were given pharmacy self-help advice

-Estimated 6,025 appointments have been saved

Cost of solution per year:

approx. £60k

Value for money?

Due to the recent rapid deployment across all sites in Walsall, further utilisation is required to quantify the full value for money. However, the product is completely priced and is showing signs of good value for money.

Name of 'Place':

Dudley CCG

Date since solution was procured:

2018

Procured solution:

Ask NHS (sense.ly)

Registered patients that can use it:

10,195

Patient utilisation:

-1993 patients have used the symptom checker ever

-8 patient appointments have been booked in total with 42 call backs

-A total of 930 patients have received self-care advice via the APP

-563 patients have had queries triaged by the practice administrative team

Cost of solution: approx.

£100k

Value for money?

Based on current usage/utilisation, there is no evidence that this solution currently offers value for money. However, the product is competitively priced.

Name of 'Place':

Sandwell & West Birmingham CCG

Date since solution was procured:

2019 (an initial pilot was in place across 15 sites before covid-19)

Procured solution:

Substrakt Patient Pack

Registered patients that can use it:

4,000 since February 2020 across 15 practices part of the pilot

Patient utilisation:

The implementation has just been scaled up in the past 3 weeks as part of the NHS England deadline and therefore utilisation is currently unavailable until 30th May.

Cost of solution: approx.

£450k

Value for money?

Further information on utilisation is required to quantify any value for money. However, the product is not as competitively priced as other products on the framework.

Summary of solutions, cost and VFM

CCG	Solution	Cost	VFM based on current usage
Wolverhampton	EMIS Online Triage	70k	No
Walsall	eConsult	60k	'Potential/Positive'
Dudley	Ask NHS (sens.ly)	100k	No
Sandwell & West Birmingham	Substrakt Patient Pack	470k	TBD

Video Consultations

Primary Care

The single biggest success that has been achieved via digital during covid-19 has quite easily been the adoption and use of video consultations across healthcare. Although the technology to do this has been around for some time, there has been a huge behavioural shift in the confidence to use technology such as this to see and treat patients. There has also been a significant shift towards telephone consultations.

Within primary care, AccuRx has been offered to be used free, funded by NHS England in response to Covid-19. Although other solutions were also available fully funded by the national team during covid-19, AccuRx was the first to release and easiest to adopt. Feedback from across primary care and the secondary care providers that have used it is that it has been a success and working very well.

Utilisation of AccuRx across primary care during covid-19

Wolverhampton CCG – 3,131

Walsall CCG – 3,536

Dudley CCG – 3,510

Sandwell & West Birmingham CCG – 6,649

Total of primary care video consultations across BC&WB STP – 16,826

As AccuRx is funded nationally during covid-19, costs to maintain this service as an STP are not available. Therefore, value for money cannot be fully quantified unless this is compared to the number of overall consultations that have been carried out in primary care since covid-19 was declared a national incident.

Secondary Care

Across secondary care, video consultations have also been rapidly deployed and enabled for first outpatient appointments and follow up's.

Black Country Healthcare NHS Foundation Trust – 'AccuRx' is used for all specialities with the ability to include an interpreter and/ or other family member/healthcare professional. BCHFT are also using and 'Jitsi Meet' for Group Therapies however they are also investigating other alternatives.

Sandwell and West Birmingham Hospital Trust – 'Visionable' has been deployed with currently 250 clinicians trained across all specialities. In total over 300 hours of video consultations have been carried out.

Dudley Group Hospitals – The nationally funded 'Attend Anywhere' has been adopted in DGH however no utilisation or information on adoption is available or been provided at this moment in time.

Walsall Hospitals Trust – 'eClinic' has been deployed however again no utilisation or information on adoption is available or been provided at this moment in time.

Royal Wolverhampton Trust – 'AccuRx' is being used for first patient appointments and no further information on adoption has been made available.

On Thursday 7th May, during a call with the hospital providers Chief Information Officers, and respective Heads of IT etc, it was resoundingly commented that consultants overall thought video consultations would be maintained and used post covid-19, although there is further analysis required within their organisations. Therefore, from a secondary care provider perspective, these solutions are value for money and working very well.

3 Other symptom checker APP's (secondary care, national NHS APP)

The 2 APPs that are known within this category are the 'National NHS APP' and the 'Ask A&E Covid-19 Care (Babylon) APP'. The national APP is available to all patients and uses the 111-symptom checker. However, 'Ask A&E 'is available only to residents in certain postcodes in Wolverhampton (via Royal Wolverhampton Trust) and residents in certain postcode's within West Birmingham (via University Hospitals Birmingham).

Neither of these APPs allow the patient to book a telephone and/or video consultation within primary care, and don't fit within the criteria from NHS England for a Total Triage model.

The Ask A&E Covid-19 Care Assistant APP from Babylon via Royal Wolverhampton and University Hospital Birmingham, does allow though for patients to be seen by a consultant in the hospitals once they have spoken to a Babylon call handler/care assistant if an appointment has been deemed necessary via the APP Symptom checker. No information on utilisation, cost or adoption is available and therefore this cannot be evaluated against value for money.

4 Next Steps

Following this initial data capture (phase 1) there will be further work carried out across 2 more phases delivered via Midlands & Lancashire CSU.

Phase 1 – Initial Data Capture – **Completed**

Phase 2 - Analysis of technology / APPs deployed and include evaluation of effectiveness and perceived and measured value (by 26th June)

Sample Output:

- Analysis of utilisation and opportunities to optimise
- Identify strengths, weakness and opportunities with relation to applications deployed.
- Focus on identifying solutions which have clearly offered significant benefit; identify opportunities to scale these deployments across a wider footprint
- Identify opportunities to further exploit capability and optimise value & benefit to the STP

1.

Phase 3 - Technical options and feasibility to deliver a citizen facing 'single front door'; with access to the array of local applications provided by individual providers (by 24th July)

Sample Output:

- Initial analysis to establish the range of solutions deployed across the STP (across all providers).
- Requirements gathering exercise across the STP to establish latent need and in turn to inform the technical 'ask' to support the 'digital front door'.
- Technical evaluation to understand technical requirements to support the 'digital front' door aspiration.

Finance Briefing Report– 2019/20 Period

Period ending 31st March 2020 (Month 12)

PRIMARY CARE COMMISSIONING COMMITTEES IN COMMON

DATE OF MEETING: Tuesday 23rd June 2020

AGENDA ITEM: 7.2

Title of Report:	Finance Briefing Report – 2019/20 Period ending 31st March 2020 (Month 12)
Purpose of Report:	To provide information to the committees on the financial expenditure of the Black Country and West Birmingham CCGs' delegated primary care resource for the 2019/20 financial year.
Author of Report:	Phil Cowley – Senior Finance Manager – Primary Care, Dudley CCG Carly Sheldon – Senior Primary Care Accountant, Sandwell and West Birmingham CCG Lorraine Gilbert – Head of Finance, Walsall CCG Jonathan Mason – Senior Finance Manager – Wolverhampton CCG
Management Lead/Signed off by:	James Green - Chief Finance Officer
Public or Private:	Public
Key Points:	• This report is formed from the four individual CCG's reported position • The Black Country and West Birmingham CCGs' overall primary care co-commissioning delegated resource for 2019/20 was £204m. • The total GPFV allocation was £12m Other Primary Care Funding totalled £63,446m (Please note the budget lines reported are not consistent between CCGs)
Recommendation:	Members of the Primary Care Commissioning Committees are asked to: 1. Discuss the contents of the report; 2. Approve the contents of the report and the financial position for the year 2019/20 and 2020/21. Note the residual risks identified in this report.
Conflicts of Interest:	n/a
Links to Corporate Objectives:	
Action Required:	✔ Assurance ✔ Decision
Implications:	
Financial	N/A
Assurance Framework	N/A

Risks and Legal Obligations	N/A
Equality & Diversity	N/A
Other	N/A

1. Executive Summary – Assurance Overview for 2019/20

The financial duties for delegated primary care allocations are consistent with the NHS business rules.

The CCG's performance against key indicators is as follows:

Key Financial Duties (Business Rules)						
No.	Indicator	BCWB CCG's	Dudley CCG	SWB CCG	Walsall CCG	Wolverhampton CCG
1	Ensure a breakeven position on the 2019/20 delegated allocation					
2	Invest additional funding allocations as per the GP Forward View					
3	Contingencies and reserves held in accordance with the CCG business rules					
	The key indicators:					

Commentary/ Key Points to Note

• The finance position for delegated primary care was expected to operate within its allocated resource. The overperformance at Sandwell and West Birmingham CCG was funded using the CCG core allocation.

• Contingencies, recurrent and non-recurrent reserves were held in accordance with the NHSE business rules. In 2019/20 all contingencies have been utilised.

• No surplus was required against the delegated resource in 2019/20.

• Non recurrent funding allocations for the GPFV have been committed before the 31st March 2020.

• Capital expenditure in respect of primary care has not been delegated to the CCG.

2. Financial Position as at March 2020 (Month 12)

	Dudley CCG		SWB CCG		Walsall CCG		Wolverhampton CCG		Total 2019/20		
	Plan £000s	Actual £000s	Plan £000s	Actual £000s	Plan £000s	Actual £000s	Plan £000s	Actual £000s	Plan £000s	Final Outturn £000s	Fav / (Adv) Variance £000s
Primary Care Co-commissioning											
General Practice - GMS	27,842	27,842	52,107	51,387	21,450	21,452	22,491	22,491	123,890	123,172	718
General Practice - PMS	-	-	701	691	-	-	1,650	1,650	2,351	2,341	11
Other List-Based Services (APMS incl.)	554	554	5,266	6,003	4,450	4,607	1,744	1,613	12,014	12,777	(764)
Premises cost reimbursements	3,116	3,113	9,249	9,232	2,356	2,485	1,793	1,793	16,514	16,623	(110)
Primary Care NHS Property Services Costs - GP	1,587	1,550	-	-	4,749	3,734	940	940	7,276	6,224	1,052
Other premises costs	19	87	50	63	35	47	48	48	152	245	(93)
Enhanced services	7,964	7,820	9,724	10,872	2,999	2,747	1,916	1,497	22,603	22,936	(333)
QOF	140	140	7,305	6,950	4,083	4,078	3,927	3,327	15,455	14,495	960
Other - GP Services	1,725	1,861	(2,440)	(2,745)	1,087	1,144	3,064	3,250	3,436	3,510	(74)
Delegated Contingency	20	-	-	-	207	-	572	-	799	-	799
Total Primary Care Co-commissioning	42,967	42,967	81,961	82,453	41,416	40,294	38,145	36,609	204,489	202,323	2,166

Delegated Primary Care

- As at 31st March 2020 the final outturn position for 2019/20 for the Black Country and West Birmingham CCGs is a £2m underspend.

- The key points to note for each individual CCG at month 12 are:

Dudley CCG

- The final position for Dudley CCG is breakeven at the end of 2019/20
- Sandwell and West Birmingham CCG (SWBCCG)
- The final position for SWBCCG is an overspend of £492k.
- The position moved by £366k from month 11 due to increased estimates for PCCF and Premises reimbursements

Walsall CCG

- The final position for Walsall CCG is an underspend of £1,122k.
- This underspend has arisen due to a review of charges for the occupation of NHS Property Service buildings which resulted in a reduction in costs of approximately £900k
- An underspend has been reported against Additional Roles Reimbursement Scheme as a result of delays in recruitment by the PCN's – the CCG received late notification from NHS England that this funding would not be clawed back.

Wolverhampton CCG

- The final position for Wolverhampton CCG is an underspend of £1,536k.
- This is due to slippage in planned developments during the year and a reduction in locum sickness charges.

GP Forward View

The table below summarises the financial position of the GP forward view allocations and other primary care related expenditure.

	Dudley CCG		SWB CCG		Walsall CCG		Wolverhampton CCG		2019/20		
	Plan £000s	Actual £000s	Plan £000s	Actual £000s	Plan £000s	Actual £000s	Plan £000s	Actual £000s	Plan £000s	Forecast Outturn £000s	Fav / (Adv) Variance £000s
GP Forward View											
Access	1,933	1,933	3,746	3,746	1,788	1,788	1,744	1,706	9,211	9,173	38
PCN Development	184	184	334	334	165	165	421	421	1,104	1,104	-
Online Consultation	87	87	157	148	77	77	79	79	400	391	9
Reception & Clerical Training	23	25	123	123	-	-	105	105	251	253	(2)
Practice Resilience Programme	10	10	79	79	157	157	274	274	520	520	-
GP Retention	-	-	-	-	39	39	281	194	320	233	87
Training Hub	-	-	71	68	-	-	120	120	191	188	3
Fellowships - Core Offer	-	-	-	-	-	-	20	20	20	20	-
Fellowships - Aspiring Leaders	-	-	-	-	-	-	291	291	291	291	-
International Recruitment	-	-	-	-	-	-	6	4	6	4	2
GPN Nurse Champions	34	34	71	71	-	-	-	-	105	105	-
Care Navigators	-	-	-	-	12	12	-	-	12	12	-
Total GP Forward View	2,271	2,273	4,581	4,569	2,238	2,238	3,341	3,214	12,431	12,294	137

- The final outturn position for GPFV for 2019/20 for the Black Country and West Birmingham CCG's was a small underspend of £137k.

- The main reason for this underspend is due to a benefit carried forward from 2018/19 not being fully utilised.

- In 2019/20 funding for the GPFV programmes was allocated to each STP as one allocation, rather than to individual CCG's, the lead CCG for the Black Country and West Birmingham was Wolverhampton CCG.

Other Primary Care

The table below summarises the other areas of Primary Care related funding that are reported to individual CCG's. Throughout 2020/21 these areas will need to be reviewed to ensure consistency across the Black Country and West Birmingham.

	Dudley CCG		SWB CCG		Walsall CCG		Wolverhampton CCG		2019/20		
	Plan £000s	Actual £000s	Plan £000s	Actual £000s	Plan £000s	Actual £000s	Plan £000s	Actual £000s	Plan £000s	Forecast Outturn £000s	Fav / (Adv) Variance £000s
Other Primary Care											
Local Enhanced Services	2,006	1,511	-	-	3,627	3,640	873	760	6,506	5,911	595
Primary Care Investments	1,298	1,062	-	-	-	-	-	-	1,298	1,062	236
Primary Care Development	-	-	-	-	67	127	455	455	522	582	(60)
Primary Care IT	-	-	-	-	1,177	975	1,893	1,893	3,070	2,868	202
Out of Hours	-	-	-	-	1,672	1,645	2,632	2,595	4,304	4,240	64
Collaborative Commissioning	-	-	-	-	16	14	167	169	183	183	1
Prescribing	-	-	-	-	-	-	47,051	46,706	47,051	46,706	345
Prescribing Incentive Scheme	-	-	-	-	-	-	450	400	450	400	50
NHS 111	-	-	-	-	-	-	897	874	897	874	23
Transformation	-	-	863	863	-	-	-	-	863	863	-
Asylum Seekers	-	-	622	777	-	-	-		622	777	(155)
Commissioning Schemes	-	-	-	-	-	-	2,012	1,721	2,012	1,721	291
Total Other Primary Care	3,304	2,573	1,485	1,640	6,559	6,401	56,430	55,573	67,778	66,187	1,591

The key points to note are:

<u>Dudley CCG</u>

- An underspend against Primary Care Investments is reported due to the lower than anticipated spend against the Prescription Ordering Direct (POD) service.

<u>Sandwell and West Birmingham CCG (SWBCCG)</u>

- The allocation for the asylum seeker service for 2019/20 was £622k.
- An over performance of £155k is reported against this allocation due to a number of invoices relating to premises that had not previously been sent to the CCG plus an extension to the Bethel Doula contract.

<u>Walsall CCG</u>

- An underspend against Primary IT has been reported this is mainly due to the re-negotiation of the SLA with Walsall Healthcare Trust.

<u>Wolverhampton CCG</u>

- There has been a significant movement against the Prescribing budget from the last reported position this has moved from an overspend of £353k to an underspend of £345k.
- This is due to the Prescribing budget not seeing the surge anticipated for COVID-19 in March

3. Update to 2020/21 Financial Plan

The table below identifies the top-level summary of each CCG's 2020/21 financial plan originally notified to the CGG's prior to the current response to the COVID-19 pandemic. This identifies that in Dudley CCG and SWBCCG there has been a cost pressure identified as part of budget setting. Although a cost pressure has not been identified in Walsall CCG and Wolverhampton CCG there is an underlying recurrent risk across all CCG's, which has arisen due to the changes made to the GP contract in 2019/20.

	2020-21 Financial Plan		
	Allocation £000s	Planned Spend £000s	Variance £000s
Dudley CCG	44,566	45,323	(757)
Sandwell & West Birmingham CCG	85,330	87,214	(1,884)
Walsall CCG	43,172	43,172	-
Wolverhampton CCG	40,021	40,021	-
	213,089	215,730	(2,641)

During the current COVID-19 initial response phase an alternative financial regime is in place which ensures a short-term break-even position across these budgets, but this regime is currently only in place until the end of July. After this point these cost pressures must be addressed.

Next Steps

- Development of a management plan at the Primary Care Operations Group to:
  - Review spend in all areas
  - Review income and future allocations
  - No new investment
  - Use of contingency (if required)

4. COVID-19 Primary Care Reimbursement Update

- Financial arrangements for practices have been subject to a number of changes in response to the COVID-19 outbreak, in line with guidance from NHSE to protect practice income and reimburse genuine additional costs incurred by practices.

- All changes have been agreed by the Incident Room as part of the emergency response a detailed in the report from the Primary Care Operations Group (PCOG)

- A cross-BCWB COVID-19 primary care scheme has been implemented to allow practices to claim reimbursement for genuine additional costs incurred by practices as a result of the outbreak. This scheme is being co-ordinated across the 4 CCGs and includes reimbursement for Bank Holiday opening as per NHS England guidance.
- A high level summary of the claims received to date is shown below. Any reasonable additional costs incurred as a result of COVID-19 will be recoverable from NHS England via a central CCG template and may not result in costs to the CCG.

	Covid Reimbursments	
	Mar-20 £000s	Apr-20 £000s
Dudley CCG	92	259
Sandwell & West Birmingham CCG	114	304
Walsall CCG	25	20
Wolverhampton CCG	32	126
	264	709

5. Risks and Flexibilities

A number of risks and flexibilities within the primary care financial position have been identified and will monitored appropriately throughout the year. The financial risks have now been resolved for the 2019/20 financial year.

However there remains a recurrent financial risk against the delegated resource for 2020/21 this will need to managed by implementing the management plan.

6. Conclusion

In conclusion, the key points to note from this report are:-

- The total Black Country and West Birmingham CCG's reported position for 2019/20:

	£000's		
	Plan	Actual	Variance
Delegated Primary Care	204,489	202,323	2,166
GP Forward View	12,431	12,294	137
Other	67,778	66,187	1,591
	284,698	280,804	3,894

- Broken down by each individual CCG:

	£000's		
	Plan	Actual	Variance
Dudley CCG	48,542	47,813	729
Sandwell & West Birmingham	88,027	88,662	(635)
Walsall CCG	50,213	48,933	1,280
Wolverhampton CCG	97,916	95,396	2,520
	284,698	280,804	3,894

For 2020/21 there is an underlying recurrent financial risk. While this is mitigated in the short term by the temporary financial regime in place during the initial phase of the COVID-19 pandemic, it will need to be managed via a management plan at the Primary Care Operations Group.

7. Recommendations

Members of the Primary Care Commissioning Committees are asked to:

- Discuss the contents of the report;
- Approve the contents of the report and the financial position for the year 2019/20;
- Note 2020/21 financial plan update;
- Note the risks identified in this report.

Contact Officers
Phil Cowley – Senior Finance Manager – Primary Care, Dudley CCG
Carly Sheldon – Senior Primary Care Accountant, Sandwell and West Birmingham CCG
Lorraine Gilbert – Senior Finance Manager, Walsall CCG
Jonathan Mason – Senior Finance Manager – Wolverhampton CCG

NHS Wolverhampton Clinical Commissioning Group
NHS Sandwell and West Birmingham Clinical Commissioning Group
NHS Walsall Clinical Commissioning Group
NHS Dudley Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEES IN COMMON

DATE OF MEETING:
AGENDA ITEM:

Title of Report:	**Primary Care Quality Report**
Purpose of Report:	**To provide assurance to the committees on the core quality and safety activities relating to primary care during the reporting period April 2020-June 2020**
Author of Report:	**Primary Care Quality Leads**
Management Lead/Signed off by:	**Sally Roberts, Chief Nursing Officer, Black Country and West Birmingham CCGs**
Public or Private:	**Public**
Key Points:	In order to fully discharge the statutory duties, each CCG has submitted a detailed report in accordance with its usual reporting mechanisms. This suite of documents can be found at the appendices; • Dudley CCG (Appendix 1) • Sandwell and West Birmingham CCG (Appendix 2) • Walsall CCG (Appendix 3) • Wolverhampton CCG (Appendix 4) An over-arching report has also been submitted which provides detail across the on the key areas of • Care Quality Commission Inspections • Health Protection: PPE, Infection Prevention and Control and Immunisations • Patient Experience: Friends and Family Test, Complaints and Patient Concerns and Serious Incidents
Recommendation:	To receive the report for assurance and support the monitoring arrangements and actions taken
Conflicts of Interest:	N/A
Links to Corporate Objectives:	
Action Required:	☐ Assurance X Approval ☐ For Information
Implications:	
Financial	
Assurance Framework	X
Risks and Legal Obligations	
Equality & Diversity	
Other	

1. Introduction

It is the responsibility of each CCG to have an established Primary Care Commissioning Committee to discharge the powers delegated to the CCG by NHS England. This report provides an overarching update to the committee of the key areas of escalation and assurance relating to the quality and safety of services in Primary Care across the Black Country and West Birmingham CCGs. This over-arching report focusses on the key areas of:

- Care Quality Commission Inspections
- Health Protection: PPE, Infection Prevention and Control and Immunisations
- Patient Experience: Friends and Family Test, Complaints and Patient Concerns and Serious Incidents

In order to fully discharge the statutory duties, each CCG has submitted a detailed report in accordance with its usual reporting mechanisms. This suite of documents can be found at the appendices;

- Dudley CCG (Appendix 1)
- Sandwell and West Birmingham CCG (Appendix 2)
- Walsall CCG (Appendix 3)
- Wolverhampton CCG (Appendix 4)

2. Care Quality Commission (CQC) Inspections

Due to the covid-19 pandemic the CQC paused routine inspections (effective 16th March 2020 to date) and developed an Emergency Support Framework to follow during the pandemic.

The interim approach has a number of elements:

- Using and sharing information to target support where it's needed most
- Having open and honest conversations
- Taking action to keep people safe and to protect people's human rights
- Capturing and sharing actions taken.

2.1 CQC Inadequate Rated Practices

The table below highlights the practices rated as inadequate by the CQC and the date of publication. It is worth noting the lists were dispersed of two inadequate rated practices within Sandwell and West Birmingham CCG (Fiveways and Bloomsbury) on 31st March 2020 following CQC enforcement action. Forrester St (Walsall CCG) was subject to a re-inspection on 4th February 2020 as a **'***Special Measures'* practice**.** Improvements were noted. The CQC published the report on 13th April 2020, with the practice rated as 'Requires Improvement'.

CCG	Practice	Date of publication
Dudley CCG	Dudley Wood Practice	13th March 2020
Sandwell and West Birmingham CCG	Dr Nisha Pathak - Primary Care Centre	2nd March 2020
	Clifton Lane Medical Practice	12th March 2020
	Stonecross Medical Centre	2nd March 2020
	Swanpool Medical Centre	12th March 2020
Walsall CCG	Moxley Medical Centre	8th January 2020 (see narrative below)
Wolverhampton CCG	No inadequate rated practices	

Moxley Medical Centre has been re-registered as a partnership.

Support continues to be provided to practices to enable them to respond to the CQC requirements and implement sustainable improvements in order to receive an improved rating upon re-inspection. Individual CCG reports reflect the support provided to the practices and highlights positive outcomes for practices whose rating has improved from 'Requires Improvement' to 'Good' following re-inspection.

3. Health Protection

3.1 Personal Protective Equipment (PPE)

All primary care teams have worked in partnership with the distribution centre provision at Jubilee House to ensure sufficient supplies and replenishment of stock is prioritised. The service has been in place since early April and continues to provide stability to the provision of PPE in line with national guidance for general practice. It is clear that this provision has helped enormously with regular and much needed PPE supplies to Primary care.

3.2 Infection Prevention and Control

The planned 2020/21 work programme for infection prevention and control is currently on hold due to the Covid-19 pandemic. However advice and support has been ongoing in respect of IPC during Covid-19 and provided together with advice for managing differing cohorts of patients, including those requiring face to face consultations, this includes PPE advice, decontamination and waste management advices.

3.2 Immunisation

Routine immunisation and vaccination activity is in place. Each CCG currently has a workstream in place to plan for the forthcoming flu season, however it is clear that due consideration needs to be given to the impact of flu post Covid-19, particularly with our most vulnerable patients and a system wide Flu workstream incorporating Primary care is currently being planned. Work continues at a local place to promote and increase uptake of immunisations and flu vaccinations. Considerations in regards to the social distancing measures have been implemented to enable clinics to continue within primary care.

4. Patient Experience

4.1 Friends and Family Test

National guidance has placed this contractual quality metric on hold during the pandemic.

4.2 Complaints and Patient Concerns

Complaints relating to General Practice are managed via NHSE. From Monday 31 March 2020, NHS England and NHS Improvement supported all NHS providers to 'pause' new and ongoing complaints investigations, to allow providers to concentrate on front-line duties and responsiveness to coronavirus (COVID-19). The initial 'pause' period will be for three months from 31 March 2020.

There have some concerns raised whereby patients have complained about practices not accepting new patient registrations during the pandemic period – these have been picked up via Primary Care and appropriate resolution enacted.

4.3 Serious Incidents

The table below highlights the number of serious incidents reported within a primary care setting since April 2020:

CCG	Reported Sis (April 2020-date)	Learning
Dudley CCG	1 SI reported and under investigation (Pertaining to multiple providers, not just Primary care).	The Q&S team are currently collating a chronology of events to identify learning.
Sandwell and West Birmingham CCG	0 reported SIs	N/A
Walsall CCG	0 reported Sis	N/A
Wolverhampton CCG	0 reported Sis	N/A

END

Appendix 1

NHS
Dudley
Clinical Commissioning Group

Primary Care Analysis Tool

Primary Care Analysis Report
PCCC in Common, 23/06/2020

Produced : 04/06/2020

Rob Franklin – Performance Manager
Becky Willetts – Quality Assurance Co-ordinator

Primary Care Analysis Report – **Summary**

NHS Dudley Clinical Commissioning Group

Care Quality Commission (CQC)

- CQC routine inspections and Annual Regulatory Reviews (ARRs) are on hold due to the Covid-19 pandemic
- To ensure oversight of providers during the pandemic and to understand the impact of Covid-19 on patients, staff and services, CQC have developed the **Emergency Support Framework (ESF).** CQC inspectors will use a variety of sources of information to risk assess providers and make a decision on those who require an ESF call. The outcomes of the ESF will not be rated or published online. The framework went live Nationally for primary care on the 18/05/2020
- On the 15/04/2020 CQC published a statement regarding the steps they are taking to support adult social care during the Covid-19 pandemic. This includes administrative support for arranging coronavirus testing and increasing awareness of the impact of Covid-19 on adult social care through the inclusion of deaths reported by care homes in the ONS data. CQC continues to support the sector and respond to issues that have been raised
- 36 ARRs were completed prior to these being placed on hold due to Covid-19
- Three practices are currently in the process of completing a new registration application

- There have been four CQC reports published since the last committee report
- The CQC report for **Bean Road** was published on the 27/02/2020. The practice has been rated as Good overall with Requires Improvement (RI) in the Effective domain. The practice has been rated as RI in the following population groups: working age people and families, children and young people
- The CQC report for **Dudley Wood** was published on the 13/03/2020. The practice has been rated as Inadequate overall, with Inadequate in the Safe, Effective and Well-led domain. The practice has been rated as Inadequate in all of the population groups. This practice has been placed in Special Measures by CQC. Members of the primary care team and Q&S team met with the practice on the 03/03/2020 to discuss the actions the practice are taking and offer support where appropriate
- The CQC report for the follow-up visit to **The Greens** was published on the 27/03/2020. The practice has been rated as Good overall and in all domains (previously rated as Requires Improvement overall). The practice has been rated as Good for all population groups with the exception of the working age group which has been rated as Requires Improvement
- The CQC report for the follow-up visit to **Chapel Street** was published on the 30/04/2020. The practice has been rated as Requires Improvement overall, with Requires Improvement in the Safe, Effective and Well-led domain (previously rated as Good overall). The practice has been rated as Requires Improvement in the population groups of families, children and young people and working age people

Primary Care Analysis Report – **Summary continued**

NHS Dudley Clinical Commissioning Group

Infection Prevention & Control (IPC)

Immunisations

- Improving immunisation uptake remains a focus of the Q&S team during the Covid-19 pandemic. A work plan has been developed that encompasses actions that the team propose to take to improve uptake across the system.
- The immunisation dashboard is now being shared with practices on a monthly basis. It is intended that the dashboard will allow PCN's to look at their immunisation rates, including childhood immunisations, and for individual practices to look further into their own data.
- Following the success of the GP flu questionnaire in 19/20, this has recently been launched to primary care for the 20/21 flu season. The questionnaire will support practices to plan for the upcoming flu season. To date, seven questionnaires have been returned.
- The next Dudley Flu planning and Immunisation meeting is scheduled for the 24/06/2020.

Audits

- Infection control audits for 2020/21 are currently on hold due to Covid-19. These will be reviewed and resume at an appropriate time

Serious Incidents (SIs)

- A multi-provider SI has been reported to by the CCG (delayed diagnosis). The patient received care from a number of services in Dudley including primary care. The Q&S team are currently collating a chronology of events to identify learning.

Service Developments

Datix

- There has recently been an increase in the number of practices using the Datix system. There are 12 practices currently using Datix for internal incident reporting; a total of 25 practices are using the system for internal incident reporting and/or reporting patient safety concerns; a further nine practices have registered to use the system but have yet to report anything on Datix.

Covid-19 related concerns and incidents

- The Q&S team have implemented a system to enable Covid-19 incidents and patient safety concerns to be recorded on Datix and then appropriately escalated to the Black Country and West Birmingham CCGs incident centre, clinical leads within the CCG and colleagues within the safeguarding and commissioning team as required. We will be monitoring these concerns and identifying themes.

Other

Special Allocation Scheme (SAS)

- There are currently 18 patients on the SAS

Care Quality Commission Ratings (CQC Rating)

This section shows the results for the latest CQC inspections, the scores are calculated as follows; 1. Inadequate, 2. Requires Improvement. 3. Good, 4. Outstanding.

GP Practice	Practice Code	la test Report Date	Overall Rating	Caring	Effective	Responsive	Safe	Well-led
CHAPEL STREET SURGERY	M87628	30/04/ 202000:00:00	Requires Improvement	3	2	3	2	2
THE GREENS HEALTH CENTRE	M87012	27/03/2020 00:00:00	Good	3	3	3	3	3
DUDLEY WOOD SURGERY	Y02212	13/03/ 202000:00:00	Inadequate	3	1	3	1	1
BEAN MEDICAL PRACTICE	M87036	27/02/2020 00:00:00	Good	3	2	3	3	3
CENTRAL CLINIC	M87605	17/02/202000:00:00	Requires Improvement	2	2	3	2	3
COSELEY MEDICAL CENTRE	M87021	11/ 12/2019 00:00:00	Good	3	3	3	3	3
LINKS MEDICAL PRACTICE	M87617	12/08/ 2019 00:00:00	Good	3	3	3	3	4
QUARRY BANK MEDICAL CENTRE	M87027	15/07/2019 00:00:00	Good	3	3	3	3	3
STEPPINGSTONES MEDICAL PRACTICE	M87017	12/04/ 2019 00:00:00	Good	3	3	3	3	2
AW SURGERIES	M87009	06/03/2019 00:00:00	Good	3	3	2	3	3
BATH STREET MEDICAL CENTRE	M8 7621	21/01/2019 00:00:00	Good	3	3	3	3	3
KEELINGE HOUSE	M87601	21/ 01/2019 00:00:00	Good	3	3	3	3	3
THE WATERFRONT SURGERY	M8 7010	24/12/201800:00:00	Good	3	3	3	3	3
STOURSIDE MEDICAL PRACTICE	Y01756	06/12/2018 00:00:00	Good	3	3	3	3	3
THORNS ROAD	M87638	16/08/ 201800:00:00	Outstanding	3	4	3	3	4
LION HEALTH	M87011	09/08/2018 00:00:00	Good	3	3	3	3	3
PEDMORE M EDICAL PRACTICE	M87030	08/03/ 2018 00:00:00	Requires Improvement	3	3	3	2	2
CASTLE MEADOWS SURGERY	M87620	07/03/2018 00:00:00	Good	3	3	3	3	3
THREE VILLAGES M EDICAL PRACTICE	M87005	13/ 12/2017 00:00:00	Good	3	3	3	3	3
QUINCY RISE SURGERY	M87618	01/ 11/2017 00:00:00	Good	3	3	3	3	3
ST JAMES M EDICAL PRACTICE2	M87026	14/07/ 2017 00:00:00	Good	3	3	3	3	3
CLEMENT ROAD MEDICAL PRACTICE	M87034	22/05/2017 00:00:00	Good	3	3	3	3	3
NORTHWAY MEDICAL CENTRE	M87037	11/05/ 2017 00:00:00	Good	3	3	3	3	3
FELOON LANE PRACTICE	M87020	21/04/2017 00:00:00						

Quality and Safety	
Report Title: Primary Care Quality Report	**Report author and Title:** Simon Somers Primary Care Quality Lead
Date of Quality and Safety Committee: June 2020	**Contact Details:** simon.somers1@nhs.net Tel: 07834 172072
Agenda No: **Enclosure no:**	

Sign off from Chief Officers:

Chief Finance Officer:

Chief Officer for Quality:

Chief Officer for Strategic Commissioning & Redesign:

Chief Officer for Transformation:

Supporting Documents/further Reading:
(Highlight any documents or further reading for members which supports this report)
Inadequate CQC Rated practices

Pathak Primary Care Centre.pdf
Clifton Lane Medical Practice.pdf
Stone Cross Medical Centre.pdf
Swanpool Medical Centre.pdf

Previous Decision *(Inform the Governing Body/Committee if the paper has been reviewed or monitored by another committee and their recommendation or decision)*

Summary of purpose and scope of the report:
(Highlight key points you wish to bring to the attention of members)

This report provides oversight of the latest CQC ratings for SWB CCG member practices. The report gives the latest update on CCG support within primary care.

Recommendations:

Note content of the report and actions taken.

The Quality and Safety Committee are requested to:	
Action	
Approve	
Assurance	**x**
Decision	
Conflicts of Interests: **The recommended action by the author of the report is:**	
No conflict identified	
Conflict noted, conflicted party can participate in clinical discussion but not decision	
Conflict noted, conflicted party can remain in committee but not participate	

in discussion		
Conflicted party is excluded from discussion ***(this would be rare circumstances only)***		
Please state rationale for above decision:		
Strategic Priorities related to the report:		
Quality & Safety		x
Finance & Performance		
Partnership		
Strategic Commissioning and Redesign		
Organisational Development		
Primary Care Co-Commissioning		x
Collaborative Commissioning		
Implications:		
Financial		
Assurance Framework		
Risks and Legal Obligations	x	
Equality and Diversity		
Statutory and External Influences		
Further implications not stated		
Consultation:		
Patients		
Staff		x
Committees		
Public		
Partners		
Sponsored By: (Chief Officer)	Michelle Carolan	
Date Report received for Quality and Safety.		

1. Executive Summary

1.1 This report will focus on Care Quality Commission (CQC) ratings at practice level for those few inspected practices at this time. The Care Quality Commission has suspended its routine inspections of primary care due to the coronavirus outbreak; the suspension began on 16th March 2020 and remains in place.

The decision to suspend inspections where there are no immediate safety concerns is understood to have been taken by the CQC's executive team. This report will therefore focus on those practices recently inspected where immediate safety concerns were identified. CCG Quality assurance visits under the primary care quality group have also been suspended as staff are redeployed to support the covid-19 response. This direct response to covid-19 has also resulted in the temporary suspension and rollout of the primary care quality framework. However, oversight and engagement with practices identified as a concern is ongoing throughout these challenging times.

1.2. In quarter 4, quality assurance support has been provided to four practices where concerns identified by CQC inspections has been ongoing.

1.3. Following an inadequate inspection in September 2019, Dr Mohan S Saini, Soho Road received a follow up inspection from CQC in December 2019. After support from the primary care quality working group, the practice has met all the conditions placed upon it by the CQC and was rated good on 20th April 2020. The practice worked to turn around the inadequate rating in under six months and made significant improvements to patient care in that time period.

2.0 SWBCCG Practice Latest Published Ratings January 10th, 2020 to 11th May 2020

Practice	CQC Overall Rating	KLOE Safe	KLOE Effective	KLOE Caring	KLOE Responsive	KLOE Well-led
Dr Mohan Saini, Soho Road	Good	Good	Good	Good	Good	Good
Tower Hill	Requires Improvement	Inadequate	RI	Good	RI	RI
Primary Care Centre, West Bromwich	Inadequate	Inadequate	Inadequate	RI	Inadequate	Inadequate
Clifton Lane Medical Centre	Inadequate	Inadequate	Inadequate	RI	Inadequate	Inadequate
Swanpool Medical Centre	Inadequate	Inadequate	Inadequate	RI	Inadequate	Inadequate
Stone Cross Medical Centre	Inadequate	Inadequate	Inadequate	RI	Inadequate	Inadequate

3. Quality Assurance Support

3.1 In quarter 4, quality assurance support has been provided to practices rated requires improvement and inadequate by CQC above.

4. CQC Enforcement

4.1. Tower Hill Partnership was rated requiring improvement on 24th April 2020 and is receiving support in a number of areas. Work is progressing and the practice is engaging with the CQC and CCG to make the required improvements.

4.2 In December the Care Quality Commission advised of a number of issues with SWBCCG GP practices. The information provided required a timely response and CQC carried out un-announced inspections in December 2019 and January 2020. Significant concerns were identified by CQC at these inspections at the following sites:

- Primary Care Centre, West Bromwich
- Clifton Lane Medical Centre
- Swanpool Medical Centre

- Stone Cross Medical Centre

4.3 Across all sites significant concerns were identified across a broad area of general practice which are summarised below:

- Recruitment
- Infection Control
- Environmental Risk Assessment, including fire.
- Clinical Supervision
- Incident Reporting
- Complaint Handing
- Safeguarding Registers
- Patient Safety Alerts
- Staff Training
- Patient Group Directives
- Business Continuity Plans
- Quality Improvement Audits
- Safe Medicines Management
- Management of Hospital Correspondence
- Safeguarding
- Patient safety alerts
- Test results
- Patient engagement

5. CQC Immediate Conditions

5.1 Under section 31 of the Health and Social Care Act 2008, CQC has placed immediate conditions on the practices inspected. Practices are now engaging with CQC to meet the condition requirements as set out within the attached CQC reports.

5.2 The practices are working on immediate measures that will require detailed information to be provided on a range of processes and procedures. Immediate actions will also be required across a range of clinical and administrative concerns identified. Action plans with detailed and timed submissions of evidence has been developed. These have been developed with CCG officers working with the providers to provide the assurance required to mitigate any risk to patient safety.

6. Risk Summit & Investigations

6.1 The CCG has held several risk summits with Care Quality Commission, NHS England and CCG officers during January to discuss the initial findings, identify the main risk to patient safety, and to agree next steps and actions moving forward. The CCG Primary Care Quality Group is providing support to the practices. Ongoing summits are taking place when appropriate and required to manage the intervention required.

7. RCGP Support and Action Plans

7.1 The CCG has supported the development of immediate action plans for each site and has commissioned external support from the Royal College of General Practitioners (RCGP) to undertake in practice investigations and diagnostic reviews. This action is required to ensure an objective and proportionate response is taken by the CCG, and so the CCG can fully understand the risk and mitigation required. RCGP support commenced in early March and is ongoing.

7.2 The CCG is working closely with regulators including NHS England and performance referrals have been made where appropriate. The CCG is working closely with regulators and NHS England will also undertake investigations across all five sites to identify performance concerns. The CCG has requested on-going access to all sites, to gain further assurance regarding practice, governance, and patient safety. This will be reviewed as assurance builds, and patient risk is mitigated.

8. Contractual Levers

12.1 The CCG has issued contractual notices where appropriate and is working with the providers to resolve concerns identified.

9. Next Steps

9.1 Further updates on this enforcement action will be provided to committee to inform of progress and mitigation required.

Appendix 3

Walsall Clinical Commissioning Group

Walsall Clinical Commissioning Group
Primary Care Operational Group

TITLE OF REPORT	Primary Care Quality and Safety Report
PURPOSE OF REPORT	To provide an update on Quality and Safety within Primary Care.
Date	7th May 2020
KEY POINTS	• **Forrester St** – An inspection took place on 4th February following being placed in **'Special Measures'.** Good improvements have been noted after initially failing to comply with Regulations 12 and 17 under Section 29 of the Health and Social Care Act. The CQC published their report on 13th April 2020, where the practice was overall rated as "**Requires Improvement**". • **Moxley Medical Practice** - A CQC inspection took place on 7th November 2019 following a previous inspection in November 2018 where the practice was rated as "**Requires improvement**". • **Primary Care Improvement Plan**- the Datix pilot implementation, the Primary Care database and the Assurance visits have all been paused due to COVID 19.
RECOMMENDATION	Committee are invited to: • **Note** the contents of the report and the actions taken to address issues. • **Advise** of any Quality and Safety concerns to be escalated to the Place Based Commissioning Committee. • **Note routine and non-critical business functions may be affected by the coronavirus.**
COMMITTEE ACTION REQUIRED	Assurance
REPORT WRITTEN BY	Ruth Barnard, Quality & Safety Officer, Walsall CCG Sara Bailey, Deputy Chief Nurse Walsall CCG
REPORT SIGNED OFF BY	Sara Bailey - Deputy Chief Nurse, Walsall CCG
REPORT PRESENTED BY	Sara Bailey - Deputy Chief Nurse, Walsall CCG

Tick	Corporate Objective Summary	Cmt
	Developing the **Walsall Together** programme into a fully integrated care partnership supported by a new contractual arrangement from April 2019	CC
	Further development of **GP involvement in the Walsall Together** programme	PCCC
	To establish new **commissioning arrangement for MH & LD** in collaboration with the BC STP	CC/JCC
	To establish **new commissioning arrangements for Acute services** in collaboration with the BC STP	CC/JCC

	To **maintain financial sustainability** and ensure **delivery of the QIPP** programme (For 18/19 and plan for 19/20)	F&P
×	To deliver the CCG **quality and safety** responsibilities to improve the incident reporting, assurance and ensure that robust Quality Assurance processes are in place for all commissioned services.	Q&S
	To ensure **effective performance** across the system to deliver the locally agreed targets –especially ones in the lower quartile	F&P
	To improve the **communication and engagemen**t with system partners, providers and GPs	GB
	Continuing organisational development of **system and CCG leadership and capability** to ensure ongoing resilience and effectiveness	A&G/GB
	Supporting the evolution of the Black Country STP towards a **Black Country Integrated Care System**	JCC/GB

All papers are subject to the Freedom of Information Act. All papers marked as 'in confidence, not for publication or dissemination' are sent securely to named individuals and they cannot be distributed further without the written permission of the Chair. Exemption 41, Information provided in confidence, applies.

1. Care Quality Commission (CQC) Independent Inspections

1.1 Forrester Street Medical Centre

A CQC follow-up visit took place on 29 October 2019 following being placed in **'Special Measures'.**

The Practice were issued with two notices under Section 29 of the Health and Social Care Act 2008 failing to comply with:

- **Regulation 12 Safe care and treatment, of the Health and Social Care Act 2008**
- **Regulation 17 Good Governance, of the Health and Social Care Act 2008**.

During the visit, the CQC undertook a review of the action plan formulated by the practice and
were pleased with the progress made against it. In addition, the CCG's Quality & Safety Manager undertook a formal visit to the Practice on the 22nd January 2020 and was equally assured that significant progress had been made and could evidence that the Practice were incorporating wider work with the staff.

Forrester Street were inspected on the 4th February 2020 and CQQ published their report on 13th April 2002 and where rated overall as "**Requires Improvement".** The areas where the provider **must** make improvements are:

- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

The CQC will be inspecting all Modality GP Practices.

1.2 Moxley Medical Centre

A CQC inspection took place on 7th November 2019 following a previous inspection in November 2018 where the practice was rated as "**Requires Improvement**". The CQC identified several serious clinical concerns relating to staff competency, lack of clinical oversight and inadequate documentation.

1.3 Croft Surgery

A CQC inspection took place on the 21st January 2020 with the practice receiving an overall rating of **"Good".** The full report was published on the 25th February 2020. There was no previous report or rating on the CQC website for comparison.

Whilst no breaches of regulations were found, the CQC recommended the following **should:**

- Improve the investigative process when reviewing significant events.
- Improve document control.
- Record and respond to environmental and health and safety alerts.
- Consider reviewing the emergency protocol for receptionists.
- Include and raise staff awareness of practice vision and values.
- Consider a forward audit plan.

1.4 **Collingwood Surgery**

A CQC inspection took place on the 28th January 2020 with the practice receiving an overall rating of **"Good".** The full report was published on the 2nd March 2020. There was no previous report or rating on the CQC website for comparison.

Whilst no breaches of regulations were found, the CQC recommended the following **should:**

- Record completion of required actions on risk assessments
- Provide additional fire exit signs around the building.
- Collate all information relating to medicine and safety alerts within one document.
- Display information regarding the complaint procedure within the practice.
- Record the response to complaints, including detailing of how to escalate the complaint if required.

In light of the recent "G**ood**" rating and with no concerns identified, the practice will be subject to the usual schedule for monitoring and performance as part of the rolling programme of Integrated Assurance visits.

1.5 **CQC Inspections during COVID 19**

The CCG continues to liaise with CQC to support the inspection process. There have been zero inspections for Walsall during COVID19.

1.6 **CQC Ratings**

- **Inadequate** rated GP Practice = 1
- **Requires Improvement** rated GP Practice = 3

2.0 **GP Performance Concerns**

There have been no recent cases referred to the Performer Practice Information Gathering Group (PPIGG).

3.0 **COVID-19 (Coronavirus)**

The CCG have received correspondence from the NHSE Integrated Urgent and Emergency Care Lead advising that GP practices are inappropriately advising their patients' to call NHS111 even though they do not fulfil the pathway criteria for referral. GP practices are being asked to note:

- Current case definition for COVID-19 can be found at the following website: www.england.nhs.uk/coronavirus/primary-care/

- People who **do not** meet the latest case definition for COVID-19 should not be referred to NHS 111, but directed to general information and advice at www.nhs.uk/conditions/coronavirus-covid-19/

- Patients who **do not** present as COVID-19, who would otherwise be treated in the GP, pharmacy, or community settings, should continue to be offered these services and not unnecessarily referred to NHS 111. Practices are also asked to consider how to offer these services remotely via phone or video.

There have been some minor concerns raised regarding the service provision of some individual GP Practices during this pandemic period which may affect the expectations of their patients. These separate issues have been escalated as appropriate.

Appendix 4

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

Primary Care Commissioning Committee (General)
23rd June 2020

TITLE OF REPORT:	WCCG Monthly Primary Care Report
AUTHOR(s) OF REPORT:	M Boyce, Quality Assurance Co-ordinator
MANAGEMENT LEAD:	Sally Roberts, Chief Nurse.
PURPOSE OF REPORT:	To provide information around activity in primary care and highlighting actions taken around management and mitigation of risks. The data contained is for the reporting period of May 2020.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This report is confidential due to the sensitivity of data and level of detail and should not be shared outside of the committee.
RECOMMENDATION:	To note the content of all complaint related matters as requested by the Quality and Safety Committee.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	1. Improving the quality and safety of the services we commission, continually check, monitor and encourage providers to improve the quality and safety of patient services ensuring that patients are always at the centre of all our commissioning decisions. 2. Reducing Health Inequalities in Wolverhampton. 3. System effectiveness delivered within our financial envelope

PRIMARY CARE QUALITY DASHBOARD

RAG Ratings: 1a Business as usual; 1b Monitoring; 2 Recovery Action Plan in place; 3 RAP and escalation

Issue	Comments	Highlights from April 2020	Mitigation for May 2020	Date of expected achievement of performance	RAG
Serious Incidents	All RCAs are reviewed at SISG and escalated to PPIGG if appropriate.	0 SI's open within the CCG. No new SI's reported.	There have been no new serious incidents for primary care in May.	Ongoing.	1b
Quality Matters	All issues being addressed by appropriate teams at the CCG and trust that has raised the issue. For review at PPIGG as relevant	- There are 5 open QM's for primary care. - Proposed closure QM's have been sent to the provider raising the matter - 1 new QM was raised against a Wolverhampton surgery in April 2020	• Quality Matters has been quieter in May 2020 due to COVID19. • There are currently 13 open Quality Matters (QM) • 7 are overdue • 0 new QMs were reported in May.	Ongoing	1b
Escalation to NHSE	There have been no recent incidents escalated to NHSE. Should any require PPIGG escalation this will be made once investigation is completed by the GP practices.	No concerns have been discussed at PPIGG in April 2020 to date (correct at time of reporting).	No concerns have been discussed at PPIGG in May 2020 to date.	On going.	1b

Infection Prevention	IP audit cycle has re-commenced for 2019/20	• Average rating in February remains at 95% overall • IP scheduled visits have been highlighted in the *IP Section below.*	• There have been no visits in May 2020 due to covid19 related matters.	On going	1a
Flu Programme	Flu planning meetings have recommenced for 2019/20 flu season	Current uptake for week 04 (2019/2020) Over 65s – 67.1% Under 65s at risk – 40.1% All 2 year olds – 35.0% All 3 year olds – 40.1% Pregnant women – 38.7%	• The most recent data from Imm-form is only for February 2020. • There is no new data for May.	31st March 2020	2
Vaccination Programme	Vaccination programmes continue to be monitored	Work continues as previously	Work continues as previously	On-going	1a
ECOLI	Planning continues around training for practices in reduction of gram negative infection – collaboration with IP team, prescribing and continence teams. Some practices have still not identified a sepsis lead and this is being chased.	No further update.	There is no further information available at the time of reporting.	On-going	1a
MHRA	No issues at present.	No issues at the present moment.	MHRA alerts have been higher than usual due to COVID19 related releases on the CAS system.	None at present	1a
Complaints	No issues at present – quarterly report due, however not received from NHSE since Q1 2019/20	No new complaints noted.	New complaint data is now available for 2019/20 and is embedded in the main report.	On going	1b

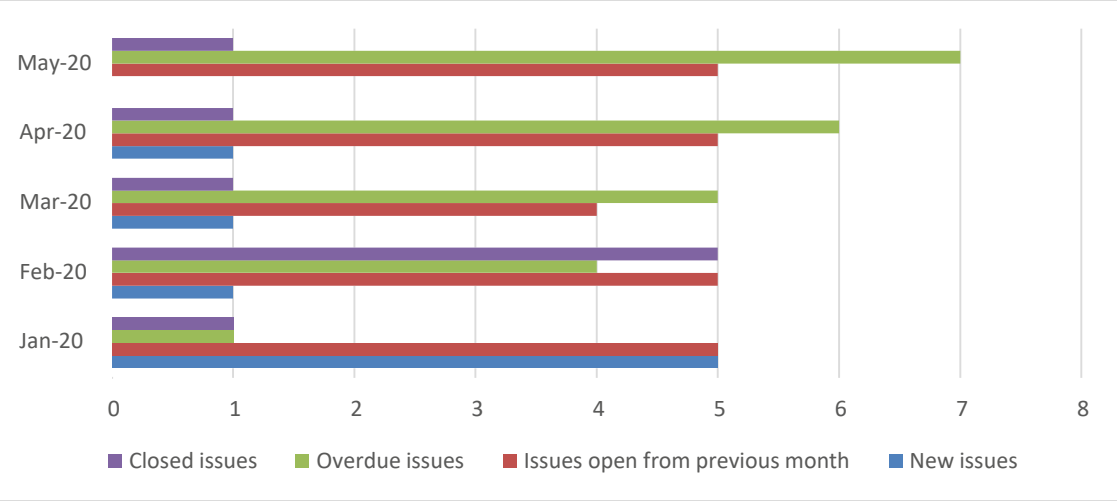
FFT	For highest and lowest uptake the locality managers have been contacted. Issues were discussed in PCCC meeting with no further action required.	• Practice responses in the West Midlands lowered from 66% in November 2019 to 64.3% in December 2019.	No new data has been made available due to COVID19 pressures.	On-going	1a
NICE Assurance	No actions at present	CCG NICE assurance group not currently being held due to local CCG changes. Practices are requested to view guidance on the NICE website in line with contractual requirements.		On going	1a
Collaborative contracting visits	All practices now complete the new cycle (which commenced in November 2019)	All visits have been cancelled due to COVID-19 activity.	Visits are due to re-commence virtually from July 2020.	On going	1a
CQC	Monitoring of practices and support continues.	There have been no new visits to any Wolverhampton GP practices in April 2020.	There have been no visits in May due to covid19 related matters.	On going	1b

BACKGROUND AND CURRENT SITUATION

This report provides an overview of primary care activity in Wolverhampton and related narrative. This aims to provide an assurance of monitoring of key areas of activity and mitigation where risks are identified.

1. PATIENT SAFETY

Measure	Trend	Assurance/Analysis
Serious Incidents	N/A – Unfortunately there is not enough data to display a graph/trend analysis. There has been no serious incident so far in 2020, and in 2019 there was only 1 unexpected death that was subsequently investigated by NHSE and closed. WCCG are still awaiting the West Midlands Screening and Immunisation Team feedback following a vaccination fridge incident identified in 2019 which this did not meet the threshold for being a reportable serious incident. This is still being managed by the West Midlands Screening and Immunisation Team.	**Incidents:** • All incidents are reviewed by the WCCG serious incident scrutiny group. • Incidents are also reviewed by NHSE PPIGG group where applicable.

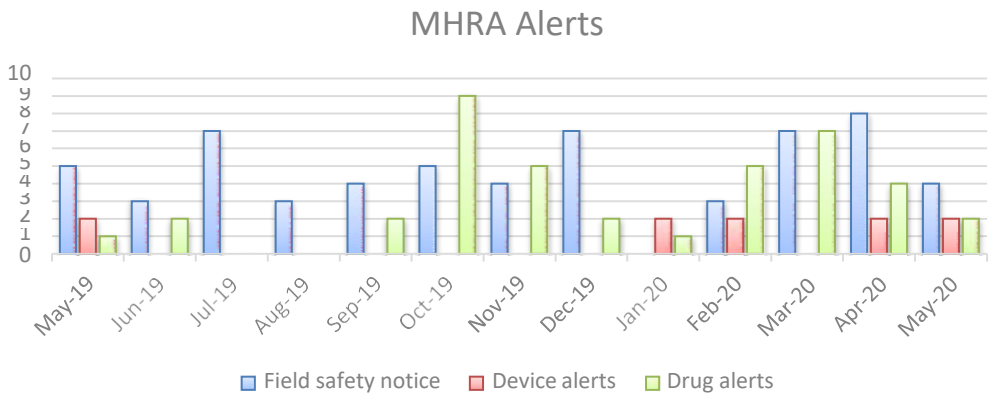
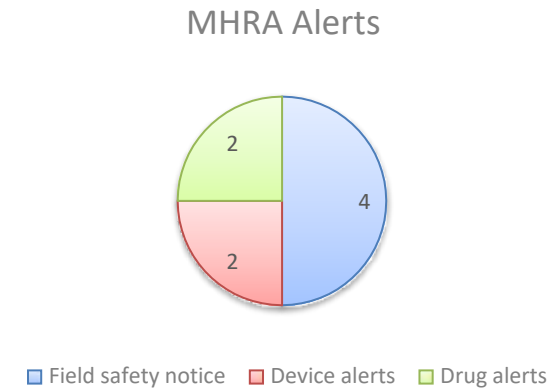
Quality Matters	 ^ Data accurate 01/06/20.	• Quality Matters has been quieter in May 2020 due to COVID19. • There are currently 13 open Quality Matters (QM) • 7 are overdue • 0 new QMs were reported in May. Recent themes from new QM's vary and are mainly compliance related issues regarding pathways, medication and community care.
Escalation to NHS England	There has been no formal escalation of any concerns or incidents within May 2020.	Not Applicable.

2. INFECTION PREVENTION

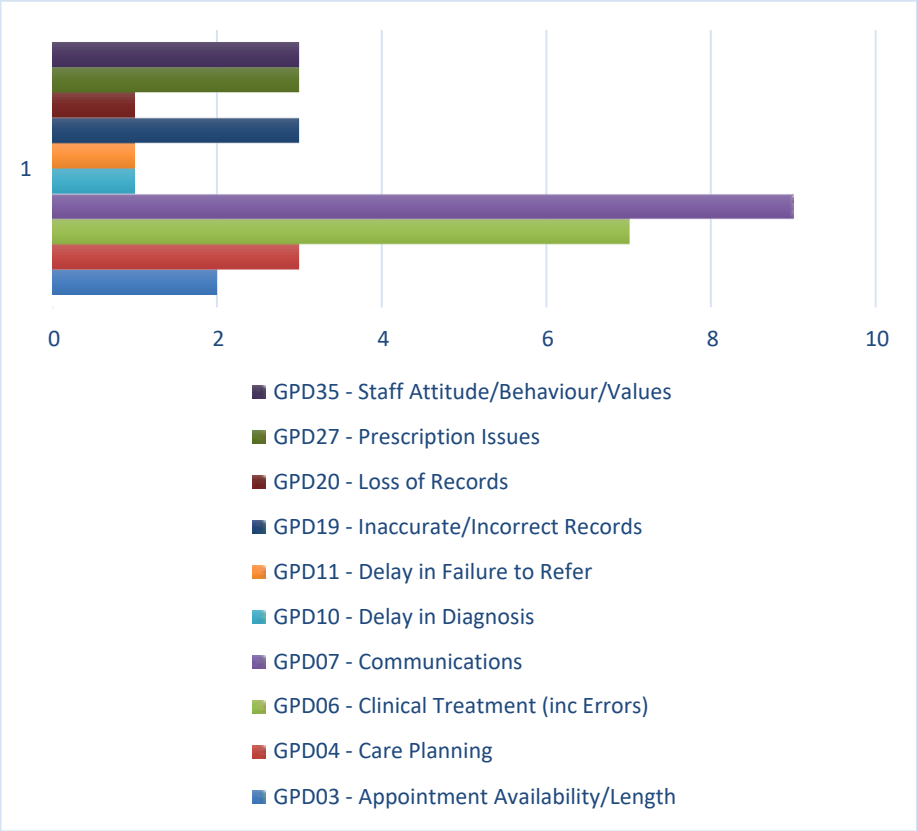
Measure	Trends	Assurance/Analysis
IP Audits	Main issues from 19/20 visits related to: • Refurbishments; - Sinks need replacing - Blinds need replacing - Toilet Refurbishments - Replacement of skirting boarding - Carpet removals - Other general equipment and furniture • PPE • Mandatory training • Cleaning audits • General de-cluttering	• **IP Audit Ratings:** Gold 97-100% Silver 91-96% Bronze 85-90%; No rating ≤84%. • Work will continue with RWT IP team around assurances. • Plans to support practices to make improvements around IP are being scoped by CCG • There have been no visits in May 2020 due to covid19 related matters.

Influenza vaccination programme	The delay in QIV (under 65) flu vaccine is not as marked as previously thought but risk identified and recorded on register Delays in ordering of nasal live vaccine for children identified nationally and is now on risk register – ordering has reopened now. Local plans around marketing, delivery and monitoring of vaccinations in collaboration with Public Health and GP/pharmacy partners now underway. Website available and Flu Fighters marketing materials The latest data available is for week 04 (2019/2020) Over 65s – 67.1% (Increased from 66.7% previously reported) Under 65s at risk – 40.1% (Increased from 38.6% previously reported) All 2 year olds – 35.0% (Increased from 33.6% previously reported) All 3 year olds – 40.1% (Increased from 37.7% previously reported) Pregnant women – 38.7% (increased from 37.7% previously reported).	• The most recent data from Imm-form is only for February 2020. • Monthly uptake dashboard has been provided to practices and an overview to CCGs/PH by NHSE, first data set available being monitored by Flu Group and Public Health • Work remains ongoing to promote uptake across the system. • Compared to last year, performance is better in the over 65s • This year there has been a delay on receiving the flu vaccination in the under 65s.
Vaccination programme	MMR uptake continues to be monitored Uptake 2018/19 – remains at 61.7% receiving 2 doses (Ages 12-18) and 62.9% (Ages 2-18). Reporting uptake was 95% across all Wolverhampton GP practices.	• There is no data available since 2018/19, therefore May 2020 remains in this current data position. • To continue to work with PH around uptake. • To feedback and receive data from regional screening and immunisation board. • MMR uptake added to collaborative contracting template • NHSE have put a specification in place to aid practices identification and vaccination of at risk groups and DNAs
MRSA Bacteraemia	Wolverhampton CCG have 2 cases reported in 2019 (June and November) however there is no indication of origin within the national data period e.g. GP surgery.	This will be continually monitored and any new instances will be reported via this report. There have been 0 new cases in May 2020

3. MHRA ALERTS

Measure	Overall Trend	Assurance/Analysis
MHRA Alerts		There are no concerns to report at present, monthly CAS alerts received during the month of May 2020 were; 

4. PATIENT EXPERIENCE

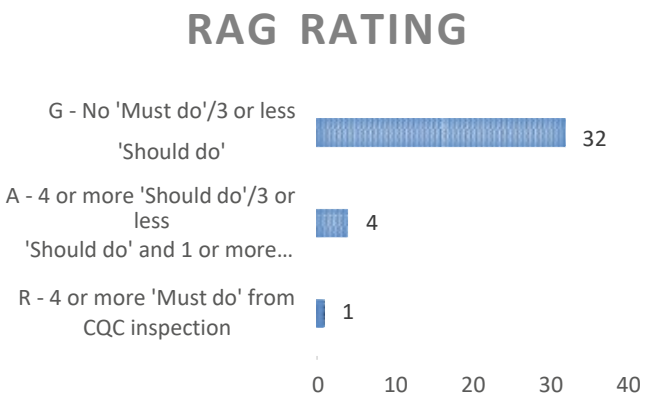
Measure	Trend	Assurance/Analysis
Complaints	Data has recently been received showing the following information for GP complaints made to NHSE during 2019/20. Categories for complaints in 19/20 were as follows;  	During May 2020 the CCG were not advised of any new complaint related matters or requested to dial into PPIGG or PAG. The overview for complaints in 2019/20 was; NHSE Complaints Period / Upheld / Not Upheld / Partly Upheld Q1 (April - June) – 15 new complaints: 4 / 11 / 0 Q2 (Jul - Sept) – 4 new complaints: 0 / 3 / 1 Q3 (Oct - Dec) – 16 new complaints: 6 / 10 / 0 Q4 (Jan - Mar) – 5 new complaints: 2 / 3 / 0

Friends and Family Test (FFT)	There have been no new submissions for FFT since February 2020 due to Covid19 related matters. This information will be provided when information is available to the CCG.

5. CLINICAL EFFECTIVENESS – NICE.

Updates which were previously provided via the CCG NICE Assurance group will no longer be provided in this report as the meeting has been stood down during a period of change for the CCG's in the Black Country.GP practices are recommended to ensure they are aware of relevant guidance being released by NICE with immediate effect.

6. REGULATORY ACTIVITY

Measure	Trend	Assurance/Analysis
Collaborative Contracting visits	Visits are ongoing on a monthly basis and a schedule of visits until mid 2020 has been set by the CCG. There are no specific trends related to primary care and actions are monitored on an individual practice visit basis.	Due to Covid19 related matters there have been no visits held in May 2020. There is a planned visit due to be held to a GP surgery (virtually) in July 2020 and a further update will be provided at that time.
CQC ratings	 **Inspections by year:** 2014 – 2 2015 – 2 2016 – 13 2017 – 13 2018 – 9 2019 – 5 2020 – 0	The CQC continue to liaise with CCG to support the inspection process. Outstanding actions are managed by inspectors via 3 monthly virtual or face to face review. Annual reviews and inspections continue several full inspections are due because of previous RI rating or contract changes. Several practices are due an inspection due to changes in provider and next inspections have been shared with CCG for discussion. Telephone follow ups currently being undertaken by the local CQC inspector. There have been 0 inspections for Wolverhampton in May 2020.

CQC Ratings by Domain	Overall	Safe	Effective	Caring	Responsive	Well-led	People with long term conditions	Families, children and young people	Older people	Working age people (including those recently retired and students)	People experiencing poor mental health (including people with dementia)	People whose circumstances may make them vulnerable
Outstanding	0	0	0	0	0	0	0	0	0	0	0	0
Good	39	34	41	42	42	39	40	40	40	40	40	40
Requires Improvement	3	8	1	0	0	2	2	2	2	2	2	2
Inadequate	0	0	0	0	0	1	0	0	0	0	0	0
	42	42	42	42	42	42	42	42	42	42	42	42

7. WORKFORCE DEVELOPMENT

7.1. WORKFORCE ACTIVITY

Measure	Assurance/Analysis
Recruitment and retention	GPNs: · GPN Champion programme continues with a virtual meeting held on 21st May 2020. Champions continue to support colleagues with the Covid-19 response, main focus being on patient and staff safety and smarter ways of working. · GPN Mentor programme continues · GPN-ST programme continues with 9 candidates currently in post and undertaking the Fundamentals programme at BCU, scoping is currently underway to further develop the programme going forward and ensure a pipeline of GPNs · GPN portfolio careers have been approved.

7.2 WORKFORCE NUMBERS

Measure	Trend	Assurance/Analysis
Workforce Numbers	All Fully Qualified GPs FTE – increase from September to December 2019 of 5.2 to 676.4 and a headcount increase of 23 to 945 All Nurses – increase in FTE of 0.1 to 411.7 and headcount of 2 from September to December 2019 to 561 All other Direct Patient Care – increase in FTE of 12. 8 to 305.2 and headcount of 22 to 447 Admin and Clerical saw an increase of 30 FTE to 1,764.2 and a headcount of 42 to 2,444	All increasing slightly. Target for 20/21 is to increase the GP workforce by an additional 13 GPs FTE to 689 Plan is to increase GPN FTE to 420 during the year – an additional 9 FTE nurses These will increase significantly due to the Additional Role Reimbursement Scheme – across the STP we are expecting around 147 additional FTE e.g. Physician Associates, Clinical Pharmacists, First Contact Practitioners, Social Prescribing Link workers etc The forecast for this group is to maintain the current numbers.

7.3 TRAINING AND DEVELOPMENT

Measure	Assurance/Analysis
Nurse/HCA/Nursing Associate	Virtual training forums are being provided for all nurses by Walsall, Wolverhampton and Sandwell Training Hub and Futureproof Dudley, the following topics are being covered to ensure all staff have access to support: • Women's health • Sexual health and contraception • CPR and anaphylaxis • Immunisation • Asthma • COPD

	• Diabetes Dedicated HCA training is being developed by the Training Hub and a venepuncture update is planned imminently to support with Covid antibody testing. HEE sponsored programme numbers have now been confirmed with: · Fundamentals of General Practice Nursing – 8 · Specialist Practice – 5 · Advanced Clinical Practice – 2 full MSc and 2 top up CPD funding is available to all Registered Nurses as part of the national CPD funding programme (£333 per nurse per year for 3 years) Additional free virtual training covering Clinical Supervision and new nurse supervision standards has also been made available by HEE.

8 RECOMMENDATIONS.

The committee are requested to note the content contained within this report as requested at the March Committee.

The Committee is requested to:

Receive and **note** the information provided in this report.
Discuss any aspects of concern and **agree** on action to be taken

Details –	**02.06.20**
Clinical View	**S Parvez**
Public/ Patient View	**M Boyce**
Finance Implications discussed with Finance Team	**N/A**
Quality Implications discussed with Quality and Risk Team	**S Parvez**
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	**M Boyce**

Working together for healthier futures

Black Country and West Birmingham Sustainability and Transformation Partnership (STP) Training Hub

Assurance and Update Report to Primary Care Commissioning Committee in Common 23rd June 2020

Author: Paul Aldridge, General Practice Forward View (GPFV Programme Manager for the Black Country and West Birmingham STP

Authorised by: Sarah Southall, Head of Primary Care (Wolverhampton CCG) and GPFV Programme Director for the Black Country and West Birmingham STP

NHS Dudley Clinical Commissioning Group
NHS Sandwell and West Birmingham Clinical Commissioning Group
NHS Walsall Clinical Commissioning Group
NHS Wolverhampton Clinical Commissioning Group

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1 Purpose

To update the Committees on the work of the new single STP Training Hub since April 1st 2020 and also to seek approval to mobilise a number of new schemes Context.

2 Key Points

2.1 Following a significant increase in the expectations from Health Education England and the NHS Long Term Plan of the functions to be delivered by Training Hubs, the STP has undergone a significant piece of organisational development and transition to ensure that it has a Training Hub in place to deliver these expectations. As such, there is now a single Training Hub in place serving the 4 CCGs and 5 places across the STP, with a proposed governance structure in place to ensure accountability and decision making points are defined. This team brings together the GPFV Workforce Retention Team, Sandwell and West Birmingham Training Hub, with Futureproof Health becoming a delivery partner. The proposed governance structure is included at Appendix A.

2.2 The Hub has made a considerable effort to support the Primary Care response to the Covid-19 pandemic over the last 10 to 12 weeks, whilst also continuing to support the development of the workforce where possible utilising digital technology and remote working. A full update on the work of the Training Hub and key next steps is included at Appendix B.

2.3 An outline plan has also been developed for 20/21 that builds upon the work from 19/20, with some informed assumptions made about funding allocations that the STP is awaiting from NHSE/I and Health Education England (HEE) that are due imminently. These schemes are designed to achieve the key outcomes that are included in the STP Primary Care Strategy and meet NHSE/I expectations around the recruitment and retention of GPs, Nurses and the new roles coming into Primary Care as part of the Primary Care Network Directly Enhanced Service (PCN DES). The full Programme and latest financial monitoring statement is included at Appendix C.

2.4 In order to underpin this key and significant programme of work it has been established that the Training Hub needs a single Learner Management System that has the capability to:-

- Capture and report quickly and efficiently on Key Performance Indicators and Outcomes
- Track learners and identify when mandatory training is expiring
- Enable the Hub to strategically manage delivery including quickly identifying those individuals that could be candidates for a new programme of work

As such, an options appraisal exercise has been undertaken and a preferred supplier chosen by all CCG Primary Care Leads across the STP and further detail can be found in Appendix H.

3 Recommendations

3.1 To note and approve the proposed governance arrangements for the Training Hub as outlined in Appendix A

3.2 To note and recognise the work of the Training Hub in supporting the Covid-19 response and to approve the mobilisation of the new schemes that were approved in principle by the Primary and Community Care Workforce Implementation Group on 2nd June 2020 and included in the Appendices to this report, specifically:-

Scheme Name	Financial Implication	Key Outcomes	Appendix
Primary Care Network Portfolio Careers	£156k – externally allocated from assumed NHSE/I 20/21 funding for General Practice Retention	Workforce retention and care closer to home	Appendix D
GP Fellowships	£162k – externally funded from NHSE/I GPFV Fellowships Allocation 19/20 rising to a total of £239k once 20/21 Fellowships Allocations are received	GP Recruitment and Retention	Appendix E
Continual Professional Development (CPD) for Nurses, Midwives and Allied Health Professionals	£189k – externally allocated from Health Education England	Workforce Retention and Capability/Skills Development	Appendix F
General Practice Nurse Specialty Training Programme 2020-21	£139k – externally funded from 20/21 NHSE/I Fellowships Allocations once received	General Practice Nurse Recruitment and Retention	Appendix G

3.2 For Wolverhampton CCG's Primary Care Committee (as host CCG) to approve the implementation of the Learner Management System at a cost of £22k in the first instance, with the acknowledgment that should the number of licenses required increase, there will be a pro-

rata increase in cost for the remainder the year up to a maximum level of 28k. The Year 1 costs will be met entirely from HEE externally funded Additional Training Hub Allocations received in 19/20. The ongoing revenue costs post year one are £12k per year and will be funded externally from HEE Training Hub Allocations. In addition:-

- To delegate the management of both the procurement and implementation of the Learner Management System to the Primary and Community Care Workforce Implementation Group, with matters for escalation coming to this meeting.
- To note that Information Governance have been fully involved in this process and have approved the Data Privacy Impact Awareness document to enable the work to proceed. They will also form part of the task and finish group during implementation to ensure that matters of data security and information governance are fully compliant and protected across the partners involved in the use of the system.

4 Financial Implications

4.1 The Training Hub and all programmes of work that are delivered within their remit are funded from sources external to the CCG, namely HEE and NHSE/I. A full breakdown of the funding and spend to date is included at Appendix B.

4.2 It must be noted that all 20/21 allocations included in this Appendix are assumed based on a Memorandum of Understanding received in April 2019 which outlined planned funding for 20/21. These values may increase, reduce or amend in name, however no expenditure on the schemes proposed in this paper will be made until funding is confirmed by NHSE/I but the plans to mobilise need to be made so that schemes are ready as funding is typically time limited and it is vital that the Training Hub is proactive and ready to respond.

4.2 For accounting and financial governance purposes, Wolverhampton CCG is the host of the Hub and the recording of income and expenditure will be through its accounts as well as the adherence to the CCG's financial and procurement processes.

5 Risks and Legal Obligations

5.1 The key risks that Committee are asked to note that are associated with this report are concerned with the impact of the Covid-19 pandemic on staff resources to manage the full programme and clinician time to allocate to their own development, along with the current uncertainty over the value, timing and exact conditions of workforce related funding that will be coming down to STPs for 20/21.

5.2 In mitigation of the above, NHSE/I have assured the STP that significant funding is imminent and the Hub has sufficient funds from 19/20 to continue to deliver aspects of the programme until funding is confirmed. The Hub will not commit expenditure on any schemes planned to be funded from 20/21 allocations until confirmation is received.

5.3 There are no legal obligations or implications to consider from this report.

6 Equality and Diversity

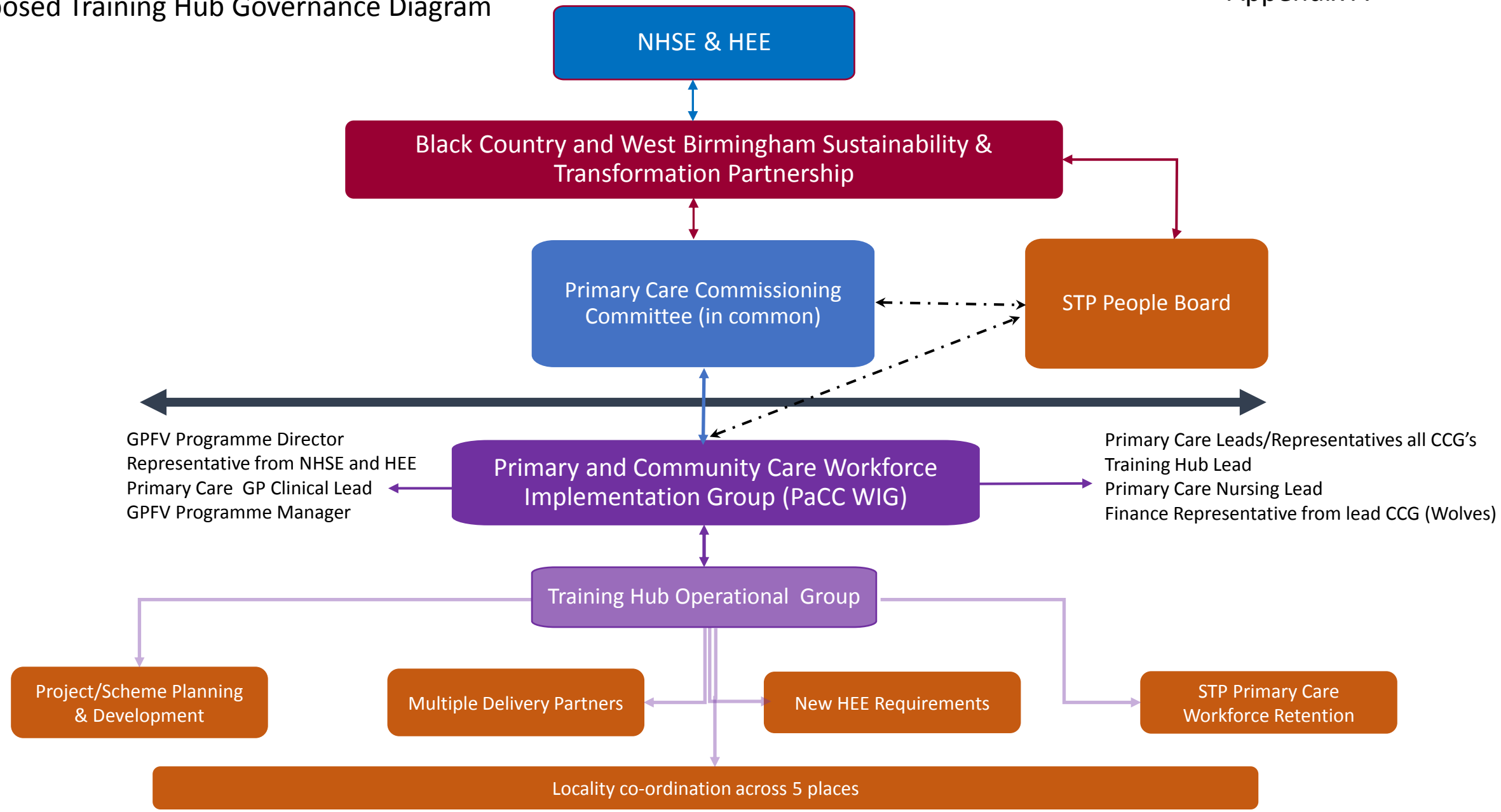
6.1 There are no implications associated with this report.

7 Table of Appendices

Appendix Reference	Name
Appendix A	*Proposed Training Hub Governance Structure*
Appendix B	*Training Hub Update Report – April to June 2020*
Appendix C	*Financial Monitoring Statement*
Appendix D	*Primary Care Network Portfolio Careers Scheme Proposal*
Appendix E	*GP Fellowships Scheme Proposal*
Appendix F	*Continual Professional Development (CPD) for Nurses, Midwives and Allied Health Professionals Scheme Proposal*
Appendix G	*General Practice Nurse Specialty Training Programme 2020-21 Scheme Proposal*
Appendix H	*Learner Management System Options Appraisal*
Appendix I	*Scheme Dashboards April to May 2020*

Appendix A

Proposed Training Hub Governance Diagram



Working together for healthier futures

Appendix B Black Country and West Birmingham STP Training Hub

Update Report for the Period April to June 2020 to Primary Care Commissioning Committee in Common 23rd June 2020

NHS Dudley Clinical Commissioning Group
NHS Sandwell and West Birmingham Clinical Commissioning Group
NHS Walsall Clinical Commissioning Group
NHS Wolverhampton Clinical Commissioning Group

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1 Purpose

The purpose of this report is to highlight the key pieces of work and achievements of the Training hub over the past two months and to give a brief overview of the key work to be delivered over the next month.

2 Context

The Black Country and West Birmingham Training Hub was officially established on 1st April 2020 and consists of a combination of the former STP GPFV Primary Care Workforce Retention Team, the former Sandwell and West Birmingham Training Hub Team and Futureproof acting as a key delivery partner.

Due to the context of the Covid-19 crisis the opportunity for the team to undergo the planned organisational development and have a formal structure have been delayed so the team is very much working in shadow form with the programme of work in the early stages of being transitioned into one plan.

This report aims to bring together as much of this work as possible

3 Programme Highlights and Key Next Steps

3.1 Covid-19 response

The Training Hub team members have spent the majority of their time and resource supporting the Primary Care response to the Covid-19 crisis. The team have supported the Primary Care Leads and Incident room in designing and subsequently presenting and reporting on key information for decision making and risk management.

Specific work includes the development of complex spreadsheets to capture, analyse and report on levels of staff sickness/absence across each Practice within the 4 CCGs. This work involved a design from scratch and always to the incredibly tight deadlines and need for accuracy required by the incident room on a daily basis. This work continues to be supported and delivered every working day as part of the Primary Care situation report (Sitrep).

In addition, the team have supported with the capture and analysis of data from each Primary Care Red Site, again supporting the design of a data capture template and developing reports that are provided on a daily basis to the incident room and analysts across the STP to provide key insight on the capacity levels required to support the crisis on an ongoing basis.

The Team have also led on the co-ordination of Primary Care staff Covid-19 testing since this was first made available. This work involves providing and collating information from each CCG and ensuring submissions to the incident room are prepared and submitted to tight (and often changing) deadlines as we moved through the crisis. We have supported the testing

now of nearly 500 colleagues or their families and continue to do so every day of the week including weekends and bank holidays.

The team also produce a Sitrep slide pack for the Primary Care Leads and Managing Directors of each CCG that captures and presents graphical data of practice Red Amber Green (RAG) ratings, sickness, trends, testing data and red site information. Heatmaps are also produced on a daily basis for each practice to highlight those practices that may be at risk due to workforce absence and all these are analysed and reported at Primary Care Network (PCN) and CCG summary also.

Some members of the team have also been working on the front line supporting the clinical delivery of testing/swabbing as well as supporting the setting up of one of the red sites.

The team have needed to be incredibly resilient, responsive to change and effectively learn a new job in a very short amount of time – whilst ensuring deadlines are met, accuracy is maintained and also to continue to support the workforce on some of the ongoing parts of their day job. This effort stretches way beyond the individuals of the Training Hub team – but the team have been the central design, co-ordination, analysis and reporting point for all of the above.

The next steps over the coming weeks will be to continue the support above as well as any other support that the team are asked to provide to support the restoration and recovery.

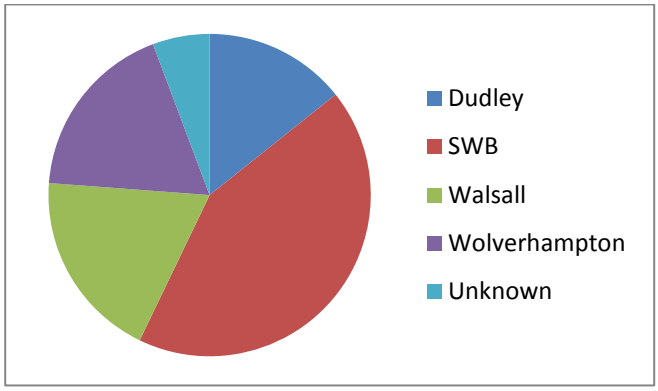
3.2 Remote Consultation Training

Given the need for clinicians to carry out remote consultations during the Covid-19 pandemic, online training has been provided to update clinical staff and ensure patients receive a quality service. By offering this training we are able to support staff to continue to deliver care to patients despite the difficult circumstances.

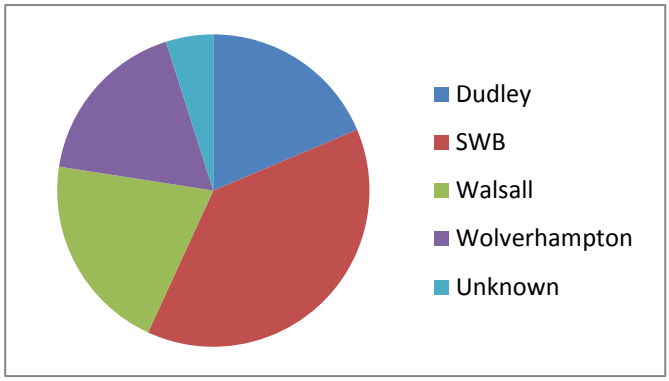
There have been 12 webinars provided in May 2020, with half for GPs and other clinicians and half for nursing staff. The first two GP dates were ring-fenced for First 5 (GPs within their first 5 years post qualification) and trainee GPs initially before being offered out more widely as it was felt that this cohort may not have had the opportunity to attend this training previously. All other places were provided on a first come, first served basis.

The breakdown of bookings by CCG is as follows for the first eight sessions. The proportion of bookings for each CCG was almost identical across both groups and roughly proportionate to the number of staff in each CCG. The GP bookings included salaried, partner, trainee and locum GPs, physician associates and practice pharmacists. The nurse bookings included General Practice Nurses, Advances Nurse Practitioners, Health Care Assistants and a variety of nurse specialists.

GPs and others (105 bookings)



Nursing staff (102 bookings)



A further four sessions have also been planned due to the high demand and excellent feedback.

Feedback from delegates has been incredibly positive with the following comments collected by the training provider:

- *Excellent webinar. Very relevant to the current situation and also useful for the future.*
- *Interesting and insightful, thank you. It reinforces a lot of the good practices we do already.*
- *Very thorough presentation. Leaves me feeling better informed on doing telephone triaging effectively in primary care.*
- *Really well set up/run and really useful resources. Thank you very much!*
- *Thank you, it has been very helpful even for an experienced GP. A bit more about reception triage/questions would have been useful. I will have a look at the website too. Dr Faarrup is a proper jobbing GP which helps!*

- *Excellent session especially useful to help me structure my remote consultations. I will apply this in my session later this evening!*
- *A very useful summary on consulting during Covid. Very clear and concise presentation which was delivered at perfect pace and level. Great to have pack sent out beforehand too. Thanks!*
- *Found this webinar very useful in current situation.*

3.3 Virtual GPN Nurse Forums

In order to continue with the support for nurses the Training Hub sourced and facilitated some virtual training for nurses which has proven popular and has resulted in a proposal being prepared and approved by the Primary and Community Workforce Implementation Group (PaCC WIG) on 2nd June 2020 to hold more of these sessions until it's possible that nurses can once again meet in forums together.

Virtual training which began in May with Diabetes and received 78 Delegates booked on with excellent feedback and a further session on Contraception which received over 68 Delegates (Delegates advised that there was more than one person on some devices – hence the number would have been higher than listed)

One Practice Manager commented *"I would just like to thank the team for providing the virtual training – staff were very impressed with the content and delivery and this should be the way forward staff felt it very beneficial"*

The next steps are to organise the next set of training/updates.

3.4 General Practice Nurse (GPN) Specialty Training

In December 2019, the STP Primary Care Workforce team successfully bid for funding from HEE and NHSE/I to recruit and train 10 GPN Specialty Trainees. Interest in this opportunity was high, with applications from more than 40 nurses (with a requirement that they be newly-qualified) and 15 practices.

Following an application process, 10 GPN Trainees were recruited by practices and commenced their posts and training in March 2020. Their posts are fully funded for 9 months, along with Fundamentals of General Practice Nursing (FGPN) course fees. Following completion of their training, the nurses will be supported to gain permanent employment in either their host practices or in another practice within the STP.

The trainees were inducted into the programme on 23rd March 2020, the day the nationwide lockdown due to Covid-19 was announced. As a result, Birmingham City University (BCU) moved their teaching online to enable the course to continue, and the trainees were encouraged to network with each other via WhatsApp.

Unfortunately, one trainee withdrew from the programme to support the Covid-19 response in secondary care however the remaining nine trainees continue to engage well with the course. The course lead at BCU has suggested that the university will retain some online delivery post-Covid-19 as it has been an effective method of teaching the material. There are some elements, such as cytology training, which must be delivered face to face and these modules have been postponed to late 2020. While the nurses are not having the general practice experience they anticipated due to the pandemic, they are well supported in practice and have been offered additional peer mentorship and regular contact from the GPN Professional Lead.

Next steps - due to the postponement of face to face teaching elements it will be necessary to extend the training period by two months to the end of January 2021. It is proposed that salaries for the additional period are supported with New to Practice funding.

Given the interest in the opportunity from qualified nurses, it is proposed that the scheme is extended in 2020-21 subject to the Fellowships funding allocation being received. A separate proposal for which has been developed in support of this and was fully supported by the PaCC WIG on 2nd June 2020 and will be recommended to be approved at the Primary Care Commissioning Committees in Common meeting on 23rd June 2020.

3.5 GP Fellowships and First 5 (GPs within their first 5 years post qualification)

Significant progress has been made in designing a GP Fellowship and new First 5 offer across the STP. A draft proposal was developed following on from the first co-design event with HEE, Training Programme Directors (TPDs), Newly Qualified GPs and the team in March and shared for discussion at a further virtual co-design event in May 2020. This event was really positive and the feedback and amendments from this have been made with a second draft proposal to be made to the WIG on 2nd June 2020. Delivery will hopefully commence very early June with the Fellows in post by September 2020. The number of places available is subject to funding, but the STP is aiming to support at least 2 per place before the end of the financial year. This programme is also being designed to encourage and support more practices to become training practices and to target those practices most in need of GP resilience.

The STP GP Clinical Lead for workforce has also established a Frist 5 GP Whats App group to continue to offer support as a single point of contact which already has reached over 50 participants.

The next steps in this scheme assuming approval to mobilise is received are to recruit to the training facilitator roles and develop a process for advertising interest to practices and potential Fellows. An insight piece of work is also being undertaken to identify practices that may be in most need of a Fellow. In addition, content for the GP leavers' conference is to be finalised and speakers booked – this will allow for communication and marketing activity to commence culminating in the first event before the end of June 2020.

3.6 Portfolio Careers

Throughout April and May the team have continued to support the GP Portfolio careers project to ensure the existing two cohorts progress continues to be tracked. In addition, the team have carried out an appreciative inquiry and a new project proposal has been developed which has been designed to strengthen the governance processes, improve the application process but also to widen participation to other healthcare professionals across Primary Care Networks (PCNs). The new design also clarifies the roles and responsibilities of the PCN, Clinical Director, CCG and Training Hub to ensure collective ownership for the project and alignment with PCN population health needs and CCG priorities.

3.7 Continual Professional Development (CPD) for Nurses and other AHPs

Health Education England are providing funding of £1,000 per nurse, midwife and allied health professional (including dietitians, occupational therapists, paramedics and physiotherapists) over three years, with payments of £333 pounds per person, per year, regardless of hours worked. Guidance was received in May 2020 which outlined the following requirements:

- The funding is to be utilised to support CPD requirements of staff linked to personal professional requirements as well as system and population health priorities.
- Funding cannot be used for backfill, travel, subsistence or IT equipment.
- Investment plans must be requested from Primary Care Networks outlining how they will manage their share of the funding.
- The STP Training Hub will monitor uptake and spend and report this back to the national team. The national team requires confirmation of completion of learning but not portfolio evidence.

The Training Hub has produced a proposal for how this will be approached across the STP along with a draft process for approval.

3.8 Training Hub Website Design

Significant progress has been made over the past few weeks with the design of the new website with a view to going live very early June. The look and feel of the website have been improved, content has been provided and now the user flow/experience around the website needs some fine tuning. Plans are also in place to train members of the team so that the content can be amended and loaded locally.

3.9 Programme Planning, Governance and Financial Monitoring

Over the past 2 months key programme governance activities have taken place to ensure that:-

- The financial position for the GPFV Funding Allocations for 19/20 was recorded and accruals made to enable continuation of schemes into 20/21 that had to be paused due to the crisis
- An outline plan and draft funding position for 20/21 developed in order to assist with scheme prioritisation (Programme Tracker and Financial Monitoring Statement)
- A revised governance structure developed in line with HEE Training Hub SOP guidance and STP governance processes along with a draft Terms of Reference for the newly established Primary and Community Care Workforce Implementation Group (PaCC WIG) and for a new Training Hub Operational Group.
- Reporting lines developed into the first Primary Care Commissioning Committee in Common to be held on 23/6/2020 for all the CCGs within the STP.

3.10 Video Group Consultations

The Training Hub is working closely with the National Team who are leading on the roll out of training and support to enable practices to develop Video Group Consultations. The offer has been communicated out to all practices via the GP Newsletter and the Workforce App and 5 practices have currently expressed their interest to the Hub who will support and track their progress over the coming weeks and months

The next steps are to continue to support the practices with their expressions of interest and track their progress and outcomes through the scheme. There will be opportunities in the future to link this work with the Medical Education and Portfolio Careers schemes

3.11 GPs with additional capacity

The team have been communicating out to practices and co-ordinating the responses to the opportunity to utilise those GPs that have expressed an interest in working additional hours to support the Covid-19 effort in primary care across the STP. To date the Hub have received several expressions of interest which are being followed up

3.12 New Role Development

The team are following up on the successful Physician Associate recruitment event that took place almost immediately prior to the lockdown. This work includes following up with the PCNs and individuals that attended the event and finding out the latest status from all with a view to supporting the next stages. The outcome from this work will be available in June.

In addition, the team will be collating all PCN information regarding the new roles that they wish to recruit to as part of the Additional Roles Reimbursement Scheme with a view to offering support for STP wide recruitment.

3.13 Medical Education Programme

Prior to the pandemic, four key areas were selected for Medical Education and providers approved. As face to face training is not possible currently, we have been working with providers to deliver virtual education and training where possible.

- End of Life (Birmingham St Mary's Hospice) – four webinars in Advance Care Planning for GPs and nurses have been arranged and advertised to staff via STP communications channels. They will be held in June and July and further sessions will be arranged if demand is high. EoL leads from across the STP have been consulted on the content and delivery.
- Asthma (STP Respiratory Group) – the group is working on developing the asthma pathway resources which were due to be launched at four place-based events; they are looking into the possibility of online delivery.
- Paediatrics (BCU) – new born and infant physical examination (NIPE) training was due to be held. This must be delivered as a face to face workshop therefore it has been postponed until this is possible.
- Frailty workshops (arranged by Wolverhampton CCG Quality Team. Funding provided for venues and printing) – postponed

Webinars in remote consultations have also been provided for GPs, nurses and Physician Associates (see separate update for details).

3.14 Other scheme brief updates

The Mentoring and GPN Mentoring schemes are still open and being accessed by a number of staff. The Mentoring scheme has been adjusted over the last 2 months to cover more clinical groups including Clinical Pharmacists and Physician Associates.

Next steps are to hold the quarterly mentoring meeting at the end of June and continue to publicise and monitor the uptake and outcomes from the scheme

Some of the wider programme of work has been delayed due to crisis including the Phoenix GP Programme but will be ran as soon as possible.

3.15 Training Hub Transition Plan

The training hub transitional plan underpins the work to develop a single training hub across the STP. Achievements to date include:-

- High level target operating model agreed for new single STP hub.
- Migration to the single Black Country and West Birmingham Training Hub from 1st April 2020.
- Interim contract awarded by HEE for transition period, ending 30th September 2020.
- Q1 Memorandum of Understanding signed with Future Proof Health to secure support to Dudley during transition, and maintain status quo following Covid-19 outbreak.
- Initial discussions with Wolverhampton University regarding Higher Education Institutes (HEI) assessment of training practice suitability and developing a hub and spoke placement model dedicated to primary care.
- Training Needs Analysis Request for Quotations (RFQ) issued – initial approach yielded unsuitable responses therefore an RFQ issued under the NHS Shared Services Consult 18 framework. Nine responses received, one rejected as a result of late submission.
- Requirements for Learner Management System (LMS) scoped and RFQ's issued.
- Options appraisal for LMS developed, preferred supplier identified and agreed by leads. Data Privacy Impact Assessment (DPIA) developed and approved.
- RFQ for organisational development support beyond that funded by HEE written, quotations assessed, and preferred suppliers identified. Currently awaiting approval to commit spend with work commencing summer/autumn 2020.
- Discussions started with CSU communications team concerning moving perception to a single hub identity and associated contact points.
- Contributed to extended student placements, bringing back returning staff and Covid-19 sickness reporting during Covid-19 crisis

Key activity for the next month will be focussed upon:-

- Develop plan for Q3 and beyond, including infrastructure needs for HEE.
- Create task and finish group for LMS system, aim to be live by end September 2020.
- Enter design phase for LMS system, design user group strategies according to need and information security, develop reporting matrix and identify staff training needs.
- Update action and transition plan according to requirements identified above.
- Agree training priorities with CCG colleagues to ensure delivery plan encompasses locality needs and priorities.
- Identify support needs in Dudley as part of infrastructure development, including interim arrangement for Q2 with Future Proof Health.
- Hold penultimate Organisational Development session that was postponed from 17th March.

Appendix C

Black Country and West Birmingham STP Training Hub

Financial Monitoring 2020-2021

Black Country and West Birmingham Primary Care Workforce
Your career in Primary Care

Scheme/Activity	Status	Funding Carried Forward from 2019/2020	NHSE/I GPFV *Estimated* GP Retention Funding 2020/2021	NHSE/I GPFV *Estimated* GPN Retention Funding 2020/2021	NHSE/I GPFV *Estimated* Reception and Clerical 2020/21	HEE Training Hub 2020/21	HEE CPD for Nurses, Midwives and Allied Health Professionals 2020/21	Total Funding Available	Total Committed Expenditure to Date	Estimated Funding Remaining	Total Forecast Expenditure	Purpose
GP Primary Care Network Portfolio Careers	Mobilised	184,807		0	0			**184,807**	184,807	**0**	184,807	To fund Cohort 2 and the remaining balance from cohort 1 GP Portfolio Careers
Primary Care Network Portfolio Careers	Design	0	156,280	0	0			**156,280**	0	**156,280**	156,280	To fund a new PCN based portfolio careers scheme for all clinical staff centred around the population health needs of each PCN.
GP Fellowships and First 5 Programme	Design	181,000	0	0	0			**181,000**	19,440	**161,560**	181,000	To fund a redesign of the GP First 5 offer to extend to supporting practices who wish to take on a newly qualified GP (Fellowships Offer)
Mentoring (GPs, Pas and Clinical Pharmacists)	Mobilised	6,540	65,000	0	0			**71,540**	6,473	**65,067**	71,540	Structured mentoring support offer delivered by the GP Mentors to GPs, PAs and Clinical Phamacists across the STP
GP Clinical Lead for Retention/Single Point of Access	Mobilised	3,575	30,000	0	0			**33,575**	2,579	**30,996**	33,575	Clinical leadership and support for the Training Hub
GP Welcome Back and Legacy Scheme	Carried Forward from 19/20	26,918	0	0	0			**26,918**	0	**26,918**	26,918	Scheme carried forward from 19/20 to incentivise practices to support GPs who would otherwise choose to retire/leve the profession to remain in practice longer whilst legacy planning can be undertaken. In addition funding available to incentivise practices to ease GPs back into work who wish to return following extended leave of absence e.g. maternity, sickness, career break etc
GP Mid-Career Scheme (Phoenix GP Programme)	Carried Forward from 19/20	22,625	0	0	0			**22,625**	2,933	**19,693**	22,625	To fund Phoenix GP Programme - carried forward from previous year due to covid-19
GP Locum Champion	Carried Forward from 19/20	18,360	0	0	0			**18,360**	0	**18,360**	18,360	To fund Locum Champion roles to help develop a locum offer for the STP
General Practice Nurse - PCN Nurse Champions	Carried Forward from 19/20	9,002	0	46,463	0			**55,465**	450	**55,015**	55,465	Scheme to facilitate getting the GPN voice heard and involved in the leadership of PCNs and to develop a structured two way communication process between PCN leads and GPNs on the ground. Needs review and consideration around funding into current years and beyond
General Practice Nurse - Network and Recognition Event/Awards	Carried Forward from 19/20	0	0	10,000	0			**10,000**	4,000	**6,000**	10,000	Structured Peer network support and develpoment opportunties for GPNs. Virtual network proposal completed for first few months of 20/21.
General Practice Nurse - Peer Mentoring and Preceptorship Support	Carried Forward from 19/20	46,000	0	0				**46,000**	5,279	**40,721**	46,000	GPNs and HCAs have aceess to a structrued peer mentoring scheme, with nurses new in practice having preceptorship support to help transition them into practice following academic studies
General Practice Nurse - Pipeline Development (includes GPN Specialty Project)	Carried Forward from 19/20	148,959	0	0	0			**148,959**	125,214	**23,745**	148,959	Includes Fundamantals + commissioned from the HEI at £45,314. Awaiting confirmation of Fellowships Funding for 20/21. Consideration to developing and funding our local Speciality Nurse Programme to further develop the pipeline. Follow up and outcomes of the speciality training programme currently live to be reported
General Practice Nurse - GPN Professional Lead/Single Point of Contact	Carried Forward from 19/20	22,863	0	50,137	0			**73,000**	8,885	**64,115**	73,000	Clinical leadership and support for the Training Hub and delivery of the STP GPN Strategy
CPD for Nurses, Midwives and Allied Health Professionals 2020/21 to	Design						189,000	**189,000**	0	**189,000**	189,000	Funding from HEE to support skills and capability buidling across the wider primary care workforce
Pharmacy Network	Carried Forward from 19/20	5,000	5,000	0	0			**10,000**	3,200	**6,800**	10,000	Peer network support and development opportunities for Pharmacists across system and sectors
Physican Associates Network	Design	0						**0**	0	**0**	0	To develop a network of support for PA s across the STP in conjunction with Ambassador
Reception and Clerical Skills and Capability Development	Design	58,309	0	0	245,346			**303,655**	8,470	**295,185**	303,655	Ensure reception and clerical staff have access to schemes to enable continual professinal development, key updates and pathways to develop into other workforce roles if they wish e.g. HCA, Care Navigators etc
Four Pillars - Medical Education Academy	Carried Forward from 19/20	61,497	63,520	0	0			**125,017**	60,196	**64,821**	125,017	Funding has been utilised to develop a medical education programme that Clinical leads have identified as priorities for general practice staff. The areas which are being progressed in 2019/20 are: • End of Life: Sage & Thyme foundation level communication training for all staff groups and Advance Care Planning training for GPs and ANPs • Paediatrics: Newborn and infant physical examination (NIPE) training for GPs • Respiratory: asthma treatment resources and launch events for GPs, nurses and clinical pharmacists • Frailty: workshops for all clinical staff Other areas to be developed in 2020/21 include diabetes, CVD, mental health, pharmacy and personalisation for all staff groups.
Training Hub Operational Costs	Mobilised					130,736		**130,736**	32,684	**98,052**	130,736	Core funding from HEE to cover infrastructure costs for Training Hubs e.g. staffing and overheads
Training Hub Development and Transtion Plan Delivery	Carried Forward from 19/20	129,610	0					**129,610**	114,492	**15,118**	129,610	Includes Project Management, Learner Management System, Organisational Development and Training Needs Analysis
Communications and Publicity	Carried Forward from 19/20	57,375	0	0	0			**57,375**	57,375	**0**	57,375	To provide specialist support to produce marketing and branding information to ensure all the workforce have access to the Hub and its offer. Commissioned support from the CSU.
Total		**982,440**	**319,800**	**106,600**	**245,346**	**130,736**	**189,000**	**1,973,922**	**636,476**	**1,337,446**	**1,973,922**	

Black Country and West Birmingham Sustainability and Transformation Partnership (STP)

Appendix D - PCN Portfolio Careers Proposal

June 2020

1. Scheme Outline

1.1 The Black Country and West Birmingham STP were identified as an area struggling to retain GPs and its wider Primary Care Workforce. In 2018 The Black Country and West Birmingham were placed into the National GP Retention Intensive Support Site (GPRISS) pilot.

1.2 The pilot was established to support struggling areas to develop local schemes and initiatives to encourage local GPs to stay within the area, with the aim to retain and develop the GP workforce.

1.3 The Black Country and West Birmingham STP, Primary Care Workforce developed a scheme called GP Portfolio Careers. The scheme incentivises GPs into developing a portfolio career, aiming to provide flexibility into their career through choosing to increase their clinical skills and knowledge within an area of interest.

1.4 The GP Portfolio Career has now been running for two years, with great success across all areas within the Black Country and West Birmingham. At the end of the second year an appreciative inquiry took place on the 28th April 2020 to identify what was working well, why it was working well and how this could be strengthened and refreshed for 2020/2021.

1.5 The full appreciative inquiry report can be found in appendix 1, the main successes of the GP Portfolio Career over the last two years highlighted within the inquiry were:

- Cohort 1 - approved 32 portfolio careers applications, with 18/34 PCNs accessing the scheme.
- Cohort 2 - approved 31 portfolio careers applications, with 18/34 PCNs accessing the scheme.
- The GPs had the freedom to explore and fulfil their passion.
- Robust governance processes in place including strict authorisation process.
- Panel meetings that review all applications and score them based on a scoring matrix and comments from PCN Clinical Director and CCG.
- Good promotion of the scheme via the workforce app, workforce website and events, it's easy to promote as its clear what's available and what is expected.
- The GP portfolio career was replicated in 2019/20 for GPNs.

1.6 The GP portfolio career scheme adaptability and popularity has demonstrated there is a possibility to strengthen and expand the scheme for the wider primary care clinical workforce.

1.7 The appreciative inquiry concluded in order to explore and offer a portfolio scheme for the wider clinical workforce such as GPS, Nurses, Clinical Pharmacists or Physician Associates. The scheme would need to be improved and redesigned, the areas that needed strengthening were as follows:

- Scoring Matrix – to allow more scrutiny of applications in terms of the benefits to the CCG, PCN, individual and patient population.
- Application and Process – robust guidance notes need to be developed, including timescales and detailing roles and responsibilities of each stakeholder which can be found in appendix 2. An online application process to make it easier to complete and return avoiding duplication.
- Panel Meetings – to reduce the panel meetings to quarterly, only providing 4 opportunities for applicants to apply. The aim is to receive more robust

applications, which will have an impact on the PCN, patient population and clinical priorities as well as improving the overall time management of the applications.

- Finance Process – an online learner system to be developed which would track each applicant to effectively allow for accurate monitoring and reporting. An online learner system is currently being sourced and would be an asset to support the finance tracking and overall budget monitoring of the scheme. Also to review how payments can be made faster such as developing payment agreements with PCNs to receive the funds of the portfolio career(s).
- Follow Ups – An online system would support the monitoring and progress of each applicant to ensure upon completion the benefits realisation could be carried out in a timely manner.
- Portfolio Package – the design work of the portfolio scheme needs to be carried out in conjunction with the PCNs and Primary Care Team in the CCGs to ensure there is a shared vision and purpose. This needs to be carried out through co-design events.

1.8 It is proposed therefore for 2020/2021 a new portfolio scheme for the wider clinical workforce will be designed by all three stakeholders to ensure there is ownership and accountability. The three stakeholders, PCN, CCG and Training Hubs will have key roles and responsibilities set out in the draft guidance that has been developed in appendix 2.

1.9 The design of the new portfolio scheme will be undertaken through a number of co-design events with all three stakeholders to understand how portfolio careers can be aimed around PCNs clinical priorities, PCN development and patient population. The vision is that PCNs could potentially develop a PCN portfolio package aimed at the wider clinical workforce and clinical need.

1.10 As well as ownership from the PCNs there needs to be ownership from CCGs to ensure that future portfolio career applications meet the PCN needs and are prioritised based on local intelligence. The Training Hubs also need to ensure this is all coordinated, tracked and monitored in line with the CCG Primary Care Teams and PCNs.

1.11 To support the development of the portfolio scheme an online support package needs to be developed, this will benefit the coordination and management of each application as it will be automated providing an effective way to manage continued increase demand of portfolio careers going forward. This will provide a more positive experience for the applicant, CCG and PCN. It will also improve the overall time management and address current process issues.

1.12 It is envisaged that the proposal of having shared responsibility and a joint approach from all stakeholders, PCN, CCG and Training Hubs, there will be collective response on all applications. This will result in more relevant applications that are beneficial for the PCN patient population as well as linking with CCG local intelligence and commissioner intentions.

2. Strategy Alignment

2.1 The Black Country and West Birmingham STP Primary Care Strategy aim is not only to provide a primary care workforce fit for the future, but to have an STP where people want to work and feel valued, recognised and supported to grow and develop within their roles. This is evident within the STP Primary Care Strategy under section 5.3.

2.2 The Black Country and West Birmingham STP Primary Care Strategy recognises clinical staff play a fundamental role in delivering Primary Care and there is commitment to invest to this part of the workforce. The Strategy has made a commitment to actively promote career opportunities and identify development for GPs and the clinical workforce through the portfolio careers based on PCN clinical needs.

2.3 The STP Primary Care Strategy outlines the need for continued support to strengthen GP workforce and will fund and facilitate a number of schemes across the next five years which includes portfolio careers.

3. Funding and Resources

3.1 The portfolio careers is funded through the GP retention funds, for cohort 3 portfolio careers allocation at the time of writing this funding stands at £156,280. This will allow each PCN to access funds up to £4596 to allow them to develop a portfolio package for their PCN.

3.2 The funding allocations may change based on future fund allocations, which are yet to be confirmed.

3.3 There is a need to review the process for making payments to ensure better time management of payments, to design an agreement form so that PCN can receive the funding direct but this will be subject to terms and conditions.

3.4 It is intended it will be a three way approach from all stakeholders who will support the development of this scheme.

4. Outcome, Benefits, Measures

4.1 The outcome of delivering the portfolio careers ensures the commitment and accountability of all the stakeholders to ensure its delivery and continued success. It supports the investment of the Primary Care Clinical Workforce and increases workforce satisfaction and retention in the Black Country and West Birmingham.

4.2 The benefits of providing the portfolio career package at PCN level will not only support the wider primary care clinical workforce development but supports clinical priorities through improving services of their patient population.

4.3 The scheme will be measured through the developed on a one line system that will track each applicant through the portfolio journey. It will provide online application, alerts and generate automated e-mails to each of the stakeholders. The tracking of a portfolio career from application to completion will provide a more reliable, streamline and central and coordinated approach.

4.4 The scheme will be monitored through the online management system and feed into the monthly dashboard and budget reporting systems through the agreed governance processes.

5. Timescales

5.1 The duration to deliver this scheme will be from September 2020 to March 2021. The success of the scheme will be realised upon the completion of the training and monitoring of the portfolio scheme.

6. Key Deliverables and Milestones

6.1 The key deliverables and milestones to deliver this scheme are as follows:

- Project Proposal to be submitted to the Workforce Implementation Group - June 2020.
- Co-design events to be developed and communication with Stakeholders to be undertaken - July 2020.
- Co-design events to be delivered - August 2020 – September 2020.
- Plan the panel meetings around new timescales – August 2020
- Promote the portfolio scheme - September 2020 – March 2021
- Monitoring uptake – September 2020 – March 2021
- Review financial budgets and report - September 2020 – March 2021

7. Key Risks

- Lack of uptake to the programme, the scheme will not be delivered to its full potential across the STP. In order to mitigate this risk the Project Manager will ensure close liaison with stakeholders to track and identify potential portfolio career schemes and actively promote the scheme.

- The delay in undertaking the co-design events due to COVID-19 and social distancing. This will be mitigated by ensuring active communication with the stakeholders via e-mail or teams meetings to make sure everyone is clear of the expectations of the new portfolio scheme.

- Not all primary care clinical workforce are aware they can access the portfolio scheme. This will be mitigated through the communication and engagement across the PCNs to make sure they are aware of this opportunity; this can be done through the newsletter, website and app.

8. Key Assumptions

8.1 The key assumptions are as follows:

- That the wider primary care clinical workforce want to expand upon their development through a portfolio career.
- The PCN, CCG and Training Hubs commit to the scheme and fulfil their roles and responsibilities.
- All of the stakeholders are committed in engagement and promotion of the scheme, to ensure a portfolio careers benefit the PCN clinical priorities and the patient population.

9. Key Interdependencies

9.1 The key independencies are as follows:

- Links into New to Practice Programme
- Links into the Medical Education Programme
- PCN clinical priorities
- CCG commissioning intentions

10. Authorisation

Position	Name	Date
Project Manager	Laura Sharpe	20.05.20
GPFV Programme Manager	Paul Aldridge	02.06.20
GPFV Programme Director	Sarah Southall	02.06.20
GP Clinical Lead	Dr Raj Kalia	2/6/2020
Primary and Community Care Workforce Implementation Group		2/6/2020

11. Appendices

11.1 Appendix 1 – GP Portfolio Careers Appreciative Inquiry Report
Appendix 2 – Portfolio Careers Guidance

Appendix 1

Healthier Futures
Black Country and West Birmingham

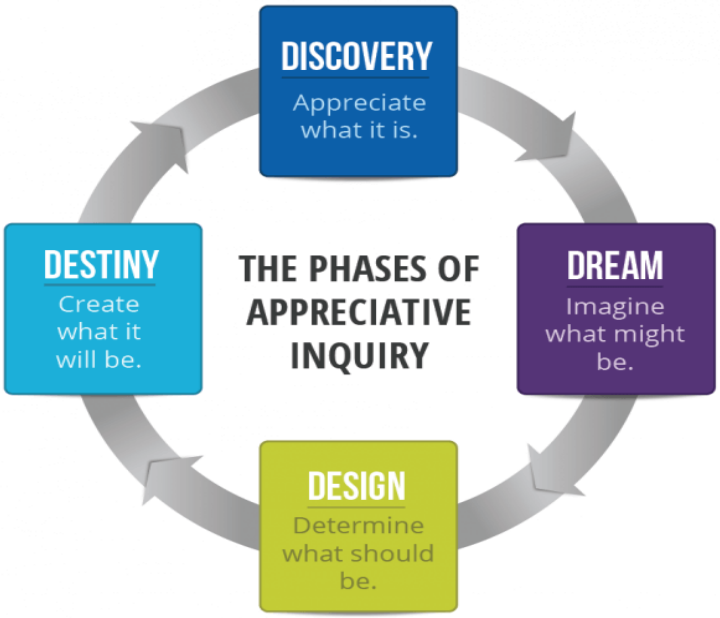
Black Country and West Birmingham
Primary Care Workforce
Your career in Primary Care

GP Portfolio Careers: Appreciative Inquiry
28th April 2020 Virtual Meeting through Microsoft Teams

Attendees: Sarah Southall; Dr Rajiv Kalia; Laura Sharpe

The core aim of the workshop was to utilise the Appreciative Inquiry (Figure 1) approach to focus on identifying what is working well, analysing why it is working well, and then to build on these strengths to refresh, reenergise and relaunch the GP Portfolio Careers.

Figure 1: The Phases of Appreciative Inquiry



Discovery – What is

The Black Country and West Birmingham STP were identified as an area that was struggling to retain GPs and its wider Primary Care Workforce. The Black Country and West Birmingham were placed into the National GP Retention Intensive Support Site (GPRISS) pilot in July 2018. The pilot was established to invest into those areas struggling to enable them to establish local schemes and initiatives to encourage local GPs to stay within the areas. This was achieved through promoting new ways of working and offering support with the aim to retain and develop the GP workforce.

The Black Country and West Birmingham STP, Primary Care Workforce Team undertook a series of co-design events with the GPs from which four local initiatives were developed, one of these was the GP Portfolio Careers. The GP Portfolio Scheme incentivises GPs into developing a portfolio career aiming to provide flexibility into their career through choosing to increase their clinical skills and knowledge within an area of interest. The scheme also encourages GPs and PCN Clinical Directors to work together to not only determine an area of interest but also to encompass this with the local priority needs for the patient population.

The Black Country and West Birmingham STP Primary Care Workforce Team work achieved during the GPRISS pilot in 2018/2019 has since been recognised Nationally as best practice. The below are some case studies of GPs who have accessed the GP Portfolio scheme through the GRPISS programme in 2018/2019.

The GP Portfolio Career has now been running for two years with great success across all areas of the Black Country and West Birmingham. The breakdown per year is as follows:

Cohort 1 - 2018/2019			**Cohort 2 – 2019/2020**		
Area	**Number of Applications**	**Number of PCNs Accessed Scheme**	**Area**	**Number of Applications**	**Number of PCNs Accessed Scheme**
Dudley	12	5/6	Dudley	3	2/6
Sandwell and West Birmingham	8	6/15	Sandwell and West Birmingham	10	7/15
Walsall	2	2/7	Walsall	9	5/7
Wolverhampton	10	5/6	Wolverhampton	9	4/6
Total	**32**	**18/34**	**Total**	**31**	**18/34**

PCNs not accessed funds in Cohort 1 and Cohort 2	
Dudley	All PCNs have accessed funding.
Sandwell and West Birmingham	Caritas, Oldbury and Langley, Pioneers Sandwell North, United Healthcare Network, Vision Health Partnership, Central Health Partnership
Walsall	North PCN, East 1 PCN and South 2 PCN
Wolverhampton	Unity East and Unity West

The GP Portfolio schemes have proven to be successful over the last two years as it allows GPs within the Black Country and West Birmingham the freedom to explore and fulfil their passion. The scheme has been designed with robust governance processes as each application is subject to endorsements from the PCN Clinical Director and local CCG before it is reviewed and scored at a monthly panel meeting. This is supported with the good marketing and promotion via the workforce app, workforce website and events, as the scheme is easy to promote to GPs because it's clear what's available and what is expected when undertaking a portfolio career. The GP portfolio career scheme has been replicated in 20219/2020 for GPNs, the schemes adaptability and popularity can be easily expanded and strengthened giving the potential to develop this at a much wider scale for all primary care clinical staff.

Dream – Imagine what it might be

It was highlighted in order to strengthen the current process the areas which could be built upon and improved through redesign are as follows:

- **Scoring Matrix**
  The scoring needs to be revisited to provide more variation to provide more scrutiny of applications. The scoring matrix to be redesign which includes expanding the scoring levels and splitting the benefit to CCG, PCN, Practice and individual to allow the panel to review and score the applications in more detail.

- **Application Form and Process**
  The application to be reviewed to make it easier to understand and complete, this will be supported by robust guidance notes outlining the level of detail expected. The aim of this is to reduce the number off incomplete or insufficient applications received. This process would be ideally supported by an online application process, which will require the applicant to have to complete each section before it has been submitted. The online system could also provide useful tips and support through the completion of the application. It would automatically set up to send the application to the PCN Clinical Director and CCG for review, comment and approval again promoting the Clinical Director and CCG to state how and why this application will benefit the PCN.

- **Panel Meetings**
  The panel meetings to be reduced to allow for comprehensive applications to be considered by the Panel. To reduce the panel meetings to every 3 months will support better time management of applications from when they are received and allow more time to support to the GP. Through having stricter timescales by only having 4 opportunities throughout the year to apply for funding the applications received will be more robust and result in potentially having more impact on the PCN and patient population.

- **Finance Process**
  A more streamlined finance system which allows payment to providers and individuals to be made in a timelier manner. The tracker of the finance reporting and for each applicant could be ideally supported through an online learner system set up for each applicant to effectively allow for accurate monitoring and reporting. An online learner system is currently being sourced and would be a tremendous asset to support the finance tracking for each individual and overall budget monitoring of the scheme. To support faster payments and reduce the time management of the current process, payment agreements could be put in place with the PCN to receive the funds for the portfolio career.

- **Follow Ups**
  As the scheme has been running for two years and continues with pace there is need to focus on those who are due to completing their courses/training. This is vital to ensure the outcomes of the applications have been met and both GP and Clinical Directors are supported by the Training Hub and CCG Primary Care Teams, to ensure these skills and knowledge are fully utilised and the patient population and PCN are feeling the benefits. This would be greatly supported through an online system which provides alerts to when applicants need to be contacted and followed up and keeps regular engagement with applicants.

- **Portfolio Package**
  Ideally going forward into the third year of portfolio careers, design work needs to be carried out in conjunction with PCNS and CCG Primary Care Teams to construct a shared vision and purpose. There is a need to hold co-design events with the CCG and PCNs to construct how they want to use the funding effectively going forward into 2020/2021. It will also provide an opportunity to determine a clear guide on the clinical needs based on their patient population and how this funding can be utilised to support these priorities.

  There is scope as part of the co-design to review how portfolio careers is offered and the opportunity to expand and strengthen the scheme due to its adaptability, as portfolio careers could support the wider clinical workforce. Ideally this is to be explored through the co-design event and the idea of providing and offering portfolio packages which PCNS can apply. This approach however needs a more coordinated approach in conjunction with the following:
  - PCN/place based level – supports the clinical priorities for patient population and place based agenda
  - CCG Primary Care Teams – supporting the supervising and review based on commissioner and local intelligence
  - Training Hub – to support the coordination, promotion, tracking and monitoring.

  In order for the funding to be used more effectively to benefit not only the individual, PCN and patient population it will be a good opportunity to review the new ways of working throughout COVID-19 and enhance these relationships and maintain them going forward.

Design – Determine what it should be

The design of what the portfolio scheme could be for 2020/2021 would need the following design work to be undertaken:

- **Online Support Package**
  To have an learner management system which will support a central and coordinated approach for the portfolio careers scheme which:
  - Records and tracks all portfolio career learners across the Black Country and West Birmingham.
  - Provides management and finance reporting.
  - Tracks applications throughout the whole process and provide advice/tips on application process.
  - Allow partners discreet access to provide approvals and review applications.
  - Monitoring and follow up system though providing alerts to notify when applicants need to be reviewed contacted and followed up.

- **Guidance**
  The development of having clear guidance will outline the roles and responsibilities of all stakeholders and confirm the process for the scheme as well as providing helpful tips on how to complete applications.

- **Portfolio Package**
  The design of future portfolio careers would need to take a three way approach from all stakeholders, this ensures that there is ownership and accountability. The three stakeholders, PCN, CCG Primary Care Teams and Training Hubs will have key roles and responsibilities which will be set out within new guidance that will be developed. The approach of having all stakeholders responsible for the scheme will strengthen the applications that are received and will provide more benefit and relevance for the PCN patient population as well as linking with CCG local intelligence and commissioner intentions. This will also ensures the scheme is valued by all stakeholders and which will inherit into the ICP work programme.

  The portfolio scheme is a golden tread supporting workforce satisfaction and retention within the Black Country and West Birmingham. The success has contributed to the investment into the primary care workforce, through upskilling staff and in turn making them feel valued. The benefits of investing into the portfolio scheme and redesigning this to become more accessible to the wider clinical workforce will not only strengthen the workforce but the services that are offered to patients across the Black Country and West Birmingham. It will also reinforce the wider working at a PCN level and build upon existing relationships that have been formed and new ways of working especially within the current circumstances.

- **Funding Confirmation**
  The portfolio careers is funded through the GP retention funds, for cohort 3 portfolio careers allocation at the time of writing this funding stands at £156,280. This will allow each PCN to access funds up to £4596 to allow them to develop a portfolio package for their PCN. This may change based on future fund allocations which are yet to be confirmed. There is a need to review the process for making payments to ensure better time management of payments, to design an agreement form so that PCN can receive the funding direct but this will be subject to terms and conditions.

Destiny – Create what will be

In order to create what the scheme will be, there will be a need to undertake the following:

- **Co-design Events**
  Co-design events with the PCNs need to be planned to understand how portfolio careers can be aimed at what they need based on clinical priorities and benefits to the PCN development and patient population. It is important to understand what the PCN needs and how this could potentially developed in to offering a PCN package which could see and benefit the wider clinical workforce. The co-design event will help to set out clear guidance of how funds can be spent and the roles and responsibilities of stakeholders going forward, to ensure there is more ownership and accountability for this scheme and the ongoing developments of approved applications.

  The co-design event will also need to include the CCG Primary Care Teams and Training Hub in order to ensure there is a joined up vision and approach to the new portfolio scheme. There needs to be ownership from CCGs to ensure that future portfolio career applications meet the PCN needs and are prioritised based on local intelligence. The Training Hubs also need to ensure this is all coordinated, tracked and monitored in line with the CCG Primary Care Teams and PCNs.
  By holding these co-design events it will achieve a coordinated and collective response from all stakeholders and provide a shared vision and clear direction for the portfolio scheme. It will also aim to ensure that the portfolio careers are:

  - Prioritised by population health needs
  - Support the delivery of local framework
  - Support commissioning intentions.

- **Guidance**
  The guidance notes will need to be developed and shared as part of the redesign work with the PCNs, CCG Primary Care Teams and Training Hubs. This is vital to provide clear direction to all stakeholders on their roles and responsibilities and ensure sign up to the approach for this scheme. The guidance notes will also provide clear instruction on the process and application form, with the aim that applications will be completed to higher

standard and the process becomes more streamlined.

- **Online Support Package**
  At the moment a lot of time is spent coordinating each application manually, which involves a lot of time between the GP and Project Manager to ensure applications are ready and fully completed in readiness for monthly panel meetings. To support this process and reduce the time in chasing, manually reporting and monitoring each application and portfolio career, an on line support package would address some of these current process issues and improve the overall time management, monitoring, reporting and tracking for each portfolio career. Through having a system which tracks each portfolio career and can provide key functions such as creating alerts and generate automated e-mails the tracking of a portfolio career from application to completion will provide a more reliable, streamline and central and coordinated approach.

  The benefits of having an online system will provide a more positive experience for the applicant as they will be able to check on progress through logging into the site. It will also provide step by step instructions on how to complete the application and what level of detail is required. This will support and reduce the need of returning applications for further work and in return provide more robust applications. The applications will also be shared electronically with PCN Clinical Directors and CCGs for review, comment and approval, again this will tighten up the process and ensure they have considered the benefits and considered how this portfolio career will come into fruition.

  The implementation of an online management system will provide an automated and effective way of managing the continued increase demand of portfolio careers going forward. This will in turn provide improved time management, timescales, reporting and monitoring as well as providing an overall better experience for our applicants and stakeholders.

  Recommendations
  1. There will be more PCN and CCG ownership which will be wrapped around prioritised health population needs at place/PCN level.
  2. To hold the panel meetings less frequent on a quarterly basis to allow for more robust applications and support time management.
  3. To reinforce the portfolio careers with dedicated timescales to ensure a smoother process of applications.
  4. The development of a new electronic application form supported if possible by an electronic learner database.
  5. The scheme will be open to all clinical health professions based on population health needs.

Healthier Futures
Black Country and West Birmingham

Black Country and West Birmingham
Primary Care Workforce
Your career in Primary Care

The Black Country and West Birmingham STP
Portfolio Guidance

The Portfolio Scheme is open to each Primary Care Network (PCNs) within the Black Country and West Birmingham footprint and provides a financial incentive to PCNs, which is available until March 2021. Each PCN can access funds to upskill their clinical workforce to work differently or expand their current services within the PCN.

The PCN are encouraged to consider health population needs affecting their area and where opportunities could exist for their clinical workforce, whether this is through GPS, Nurses, Clinical Pharmacists or Physician Associates. This is an opportunity for PCNs to develop a portfolio package that can enhance skills and knowledge as well as investing in their workforce. The concept of portfolio careers is to develop flexible career opportunities whilst retaining clinical staff, as this strengthens and develops areas of specialities for both the individual(s) and PCN.

The staff benefit from funded support and career development, whilst the Primary Care Network benefits by increased clinical workforce with specialisms and most importantly the patient population benefit from more specialised care closer to home.

This guidance has been developed to provide clear direction and support on the portfolio careers process and outline the key roles and responsibilities for each stakeholder. The roles and responsibilities are as follows:

Stakeholder Roles and Responsibilities

Applicants Role and Responsibilities

- To liaise and seek advice from the PCN Clinical Director to discuss potential portfolio career interest.
- To liaise with the PCN and CCG to plan and built upon portfolio career to understand how this will benefit the PCN, individual, patient and population health need priorities.
- Work with the PCN and CCG to set out a clear plan how on how these new skills and knowledge will be utilised following completion.
- To research the educational and training needs to understand estimated costs and details.
- To complete and return the application in full adhering to guideline timescales.
- Keep in contact with the PCN and Training Hub on progress throughout the portfolio career.
- To attend education/training until fruition within in agreed timescales.

Primary Care Network Role

- To agree on the PCN clinical priorities in which portfolio applications can be considered.
- To agree on how funds can be spent and how best to allocate funds based on clinical priorities and patient population needed for your area.
- To provide support to applicants with their portfolio career application(s) and provide guidance on the future design and ambition of the portfolio career.
- Provide advice on the portfolio career from start to finish from application to fruition.
- To develop ideas and plan collectively as a PCN a portfolio career package that will benefit the PCN, patient population and applicant(s) across the wider clinical workforce.
- To liaise with the CCG on potential portfolio careers if there are potential changes to how services may be delivered following completion.

Primary Care Network Responsibilities

- Ensure applications meet the PCN and patient population need before applications are submitted.
- To ensure discussions have taken place with the applicant(s) and the wider PCN to ensure the portfolio career can be facilitated and becomes business as usual following completion.
- Review the applications and ensure they are completed in full, including the PCN Clinical Director section. The Clinical Director section needs to be written by the PCN Clinical Director and have clear aims and objectives of what the PCN and applicant(s) are trying to achieve though outlining the benefits and evidence if available to support the application(s).
- Support the applicant(s) once the portfolio careers are completed to review in conjunction with the applicants, CCG and Training hub to plan how the new skills and knowledge can now be used as per applications aims and objectives.
- To inform the CCG of any implications or changes to current commissioned services.

CCG Primary Care Team Role

- To have oversight of the applications being developed by PCNs to ensure they are achievable and have the best possible outcomes for the local populations.
- Work in conjunction with the PCNs to develop ideas, plan and produce portfolio applications based on clinical priorities and population needs.
- Ensure they understand the applicants and the potential impact on current commissioned services.

CCG Primary Care Team Responsibilities

- To liaise with PCNs on applications and work together on proposals if there are changes to how services will be delivered and managed following completion.
- Need to be sighted on any implications to current services and how this will be managed.
- Review each application before submission to the training hub and complete the relevant section for CCG approval.
- CGG approval needs to ensure they fully understand how the portfolio career will benefit the PCN and patient population. They need to understand the plan of how this portfolio career will be achieved and managed going forward.
- To have oversight and work with the PCN on the longer term impacts on commissioning.

Training Hub Role

- To work with the PCNs and CCG Primary Care Teams to plan, design and agree how the portfolio funding can be best utilised.
- To develop the portfolio careers programme plan for approval within the established and agreed governance processes.
- Set up learning database which records, tracks and monitors each portfolio career application.
- Hold panel meetings including an independent reviewer periodically to assess and review applications.
- To be the key stakeholder that coordinates the planning and support needed by the CCG primary Care and PCN.
- To be the budget holder of the portfolio careers funding.
- To market and promote the portfolio scheme.

Training Hub Responsibilities

- Ensures the coordination of all applications to make sure applications are comprehensive in readiness for the panel meetings.
- To liaise with applicants, PCNs and CCG Primary Care Teams regarding applications to ensure applications are progressing to minimise delays.
- Hold panel meetings and undertake scoring based on scoring matrix and comments from PCN and CCG.
- Confirms the outcomes of panel to the PCN and CCG.
- Monitoring and reporting on finances to appropriate meetings.
- To ensure finances are processed, paid and tracked in a timely manner.
- Monitor all applications via a learner management system.
- Ensure and coordinate follow up with each applicant, PCN and CCG following completion.
- To fed into governance reporting and tracking to ensure the current position feds into the agreed governance processes.

Process Timescales

Initial Enquiry	Response to be made within 2-3 working days
Application Process	Application to be submitted at least 6 weeks before panel meeting.
Approval Process	Final application with section A, B and C fully completed to be submitted 4 week before panel meeting.
Panel Process	Panel meeting to take place quarterly, system and notes to be completed 1 week after the panel meeting.
Panel Outcome	Outcome of panel shared with application within 1 week of the panel meeting. Applicant to return signed learning agreement within 1 week of receipt.
Finance	All funds for training and backfill need to be paid/reimbursed by end of financial year. Dashboard and budget monitoring to take place monthly.
Monitoring	All approved applications to be reviewed on a quarterly basis. Monthly reporting to appropriate meetings following governance processes.
Benefit Realisation	To review each applicant upon completion of their portfolio career. To undertake discussions with PCN, CCG and applicant at least month before completion to review how skills will be utilised.

Guidance on how to complete the Portfolio Application

Portfolio Career Application - Financial Incentive Form	
SECTION A: TO BE COMPLETED BY THE APPLICANT	
Full Name:	
Role:	GP ☐ General Practice Nurse ☐ Clinical Pharmacist ☐ Physician Associate ☐ If you are GP please state the following: Salaried ☐ Partner ☐ Locum ☐
Career Stage:	Final Year Trainee ☐ New to Practice (within last 12 months) ☐ First 5 Years ☐ Mid-Career/Late Career ☐
CCG Name:	
PCN:	
Name of PCN Clinical Director:	
Main Practice Base Address:	
Email Address:	
Contact Number:	
Area(s) of Interest:	Please state what area you wish to pursue your portfolio career
Have you applied previously for Portfolio Career funding (Yes/No). If yes, what was the outcome?	Please state yes or no. If yes please state what you applied for and the outcome of this portfolio career.
Supporting Statement Type & Description of support required	Please provide a statement on the type of support needed out lining the following: • Description of area(s) of interest i.e. primary/secondary care/educational/leadership. • Training and supervisory support needs that are required to undertaken this portfolio career. • The number of training/supervisory sessions being considered and where/who with.

Anticipated Total Cost of education/training:	Please state the total of the anticipated cost	
Training Provider: **(Include contact details)**	Please state the training provider of where you will be undertaking the course/training. If you are having supervisory sessions please state if known the provider of where this will be undertaken. Please provide contact details of training provider.	
Training Start and End Dates:	Please state start and end dates of training.	
Impact on Current Clinical Sessions: ▪ Please tick each relevant box	How many sessions do you currently work	Please state how many sessions you're contracted to work currently?
	Reduction in number of sessions in practice	Yes/No. If Yes, how many:
	Reduction in current sessions & potential for specialist clinic in Practice Group	Yes/No
	Portfolio career will be additional to existing sessions in Primary Care	Yes/No
	Are there any educational needs you require support with?	Yes/No
Additional information regarding impact on current clinical sessions:	Please state what the impact on current clinical sessions will be and how this may be resolved. This will need to be discussed with Practice, PCN and CCG.	
Portfolio Partner Organisation:	Please provide details of who your portfolio partner is/could be and if you have made contact already.	
Financial Support:	Education/Training, including books (£)	Please provide a breakdown of costs confirming how the funding will be used.
	Backfill (£)	Please state the number of backfill sessions required maximum of 12 clinical sessions.
	Total Cost	Please state the overall total cost of education/training and backfill
Supporting information:	Please state the reason of why you are applying for the portfolio career what to you want to achieve once completion. Please state what are the aims and objectives and benefits to you, PCN and the patient population. Also consider the plan and how these skills and knowledge will be fully	

(max. 500 words)	utilised following completion.			
SECTION B: TO BE COMPLETED BY THE APPLICANTS PCN CLINICAL DIRECTOR				
Clinical Director Comments/supporting statement	Please review and comment on how this will benefit the PCN and patient population and highlight the aims and objectives of this portfolio career. Provide insight onto the discussions and plans that have been developed between the PCN, applicant and CCG Primary Care Teams. Also ensure that you specify if there could be any impact to current commissioned services and if these have been discussed with the CCG.			
PCN Clinical Director	**Signature:**		Date:	
SECTION C: TO BE COMPLETED BY THE APPLICANTS CCG PRIMARY CARE LEAD				
CCG Primary Care Lead Comments/Supporting Statement	Please state if there is a population health need for this portfolio career, and how this meets the CCG priorities. Please also consider and state if there is an impact on CCG commissioning and how this is being managed with the PCN.			
CCG Primary Care Lead	**Signature:**		**Date:**	
SECTION D: OFFICE USE ONLY PLEASE DO NOT COMPLETE				
Approval to Proceed: YES: ☐ **NO:** ☐				
Funding Allocation		**Agreed Start Date:**		
Signed Clinical Lead		**Date:**		
Signed Programme Director		**Date:**		
LS/May2020/v2				

Initial Enquiry

- Enquiries received via the GPFV Primary Care Central Inbox
- Project Team to respond with scheme information and application form

Application Process

- Completed application received from applicant via the GPFV Primary Central Inbox
- Project Lead to review and liaise with applicant regarding application (in/out scope)
- Revised application received if further work is needed to strengthen the application
- Project Lead to advise applicant of next step(s) of the process

Approval Process

To be accepted and shared at the panel meeting for consideration, the following steps need to be fulfilled:

- Section A of the application is completed in full by the applicant.
- Section B of the application has been approved and completed in full by the PCN Clinical Director as per guidance criteria.
- Section C of the application has been approved and completed in full by the CCG Lead as per the guidance criteria.

Panel Process

- Applications are submitted to Panel.
- Panel meetings to be held on a quarterly basis
- Applications reviewed by Panel and scored based on scoring matrix and comments from PCN and CCG.
- Notes taken at panel, which outlines the final score comments from the panel and the final decision.
- The Portfolio Career Central Database is updated.

Panel Outcome

-Notification to applicant following panel consideration (unsuccessful/unable to proceed/queries)
- Broker discussion(s) with applicant and issue learning agreement based on Panel Approval
- Identify clinical attachment provider and broker discussions if needed
- Issue learning agreement to obtain signature from applicant which is their commitment undertake the training.
- Learning agreement from applicant to be returned within a week of receipt to secure funding.

Finance

- Liaise with applicant regarding process for payment of course fees and backfill
- Reconcile incoming invoices against individual learning agreements once received
- Liaise with Finance to ensure payments are processed
- Liaise with Finance to review the monthly leger to ensure payments made.
- Project Team to update Portfolio Career Central Database

Monitoring

- Monitor progress of each individual portfolio careers.
- Ensure the Portfolio Career Central Database is continuality update updated.
- Monitor finances ensures accurate to find into budget reporting
- Provide assurance through the dashboard report following agreed governance processes, which is updated from the Portfolio Career Central Database.

Benefits Realisation

Monitor the portfolio careers to determine the impact has been on the following:

- Service, Patients, PCN and Individual
- Promote the success through the newsletter, app and other promotion methods.

Black Country and West Birmingham Sustainability and Transformation Partnership (STP)

GPFV Programme 2020/2021

Appendix E - GP Fellowships

June 2020

1. Scheme Outline

1.1 Funding was made available in 2019/20 from NHS England for General Practice Fellowships, of which £180,000 is available, with further funding expected in 2020/21. The national guidance states that Fellowships will support newly qualified GPs and nurses to gain experience as a valued, employed member of the primary care team, within a supportive environment. The programme will also help practices, PCNs and ICSs/STPs to recruit and retain GPs and nurses by offering attractive roles that lead to long term employment within primary care. (*General Practice Fellowships: Making primary care a great place to work.*)

1.2 It is proposed that part of this funding is utilised to introduce a structured, supportive fellowship programme for GPs to introduce them to working in general practice, which benefits both the GP and their employing practice.

1.3 As per the national guidance, the Fellowship will be open to applications from newly qualified GPs (within 12 months post-CCT) who are entering salaried positions in general practice, but places will be limited. It will also include a structured support offer for GPs in the first five years of their career.

1.4 This document outlines a proposed Fellowship structure which has been co-designed with GP colleagues from across the STP.

1.5 **Fellowship Structure**

- Employment with a single GP practice, although Fellows may work across a Primary Care Network (PCN);
- Detailed induction, including:
    - local referral pathways and PCN structure;
    - spending time with all members of the practice team to build relationships;
    - spending time with local pharmacy colleagues, PCN Clinical Director and lead GPs from each practice within the PCN;
    - attending PCN board meeting/s;
    - spending time with CCG colleagues to learn more about population health management, commissioning, etc. (based upon personal interests and CCG staff capacity);
    - the employing practices will support their Fellows to develop place-based referral pathway guides which can be shared with other practices and updated on an annual basis.
- Regular supervision from a named, experienced GP supervisor for the first six months of employment (weekly in months 1-3, fortnightly in months 4-6), with progress captured via a template;
- Backfill for one session per week CPD for the first six months;
- Monthly, structured learning sets led by an experienced GP in small groups, to be held within the working week;
- Fellows will take on a leadership project or opportunity within their practice or wider PCN relating to specific areas of interest or an overall improvement agenda, e.g. leading QI projects, being the point of contact for all trainees from across the PCN, becoming the lead for the implementation of PCN DES specifications (e.g. lead for care homes), prescribing improvements, QOF;
- Access to the existing portfolio career scheme to develop skills in an area of interest (e.g. medical education, long term conditions, mental health) in line with PCN needs;
- Funded mentorship from an experienced GP via the existing peer mentor scheme;
- An annual celebration event to bring all Fellows and First 5s from across the STP together, to include CPD content, a poster display from the Fellows, networking and an awards ceremony for those Fellows and First 5s who have successfully developed portfolio careers, taken on leadership roles within PCNs, and made a demonstrable impact upon their practice and patients.

1.6 **Support for First 5 GPs**

The current First 5 Network for early career GPs, which involves monthly learning events, has seen poor attendance since autumn 2019, with numbers often in single figures despite efforts made to promote and market the offer. However, those GPs who do attend evaluate the quality of the events very highly. It is suggested that the most effective aspects of the First 5 Network, such as the quality of speakers and content, is retained but learning is delivered in a different format.

Through enabling current and future First 5 GPs to access the learning sets that form part of the Fellowship scheme, the support for GPs in the early stages of their career will be maintained. This will put the focus onto the content of the sessions and reduce the cost of venues and catering considerably. By providing weekday sessions with backfill, GPs are more likely to be able to attend whilst maintaining their work-life balance. First 5s can select the sessions they attend based on the agenda. Places will be limited and must be booked online. They will be backfilled for those who attend the full session; those who DNA will not be able to rebook for three months.

First 5s will also have access to mentoring, portfolio careers and will be actively encouraged to access leadership opportunities within their PCNs.

1.7 **Learning Sets**

Learning sets will be held on a monthly basis and will form part of the Fellowship agreement. By meeting with each other on a regular basis, along with other First 5 GPs, Fellows will benefit from a similar model of peer support to the VTS programme.

It is proposed that two facilitators are recruited from the current GP workforce, following the recruitment process used for GP peer mentors. Those GPs who are due to retire or are looking to reduce their hours will be encouraged to apply for the positions, as this will retain their skills and expertise within the workforce.

The content of the sessions will be co-designed with Fellows to ensure it reflects their needs and interests and allows them some ownership of the programme. Sessions may include practical topics, such as business skills, as well as clinical topics. The early sessions will cover national policy and context, e.g. the Long Term Plan, GP Forward View, Primary Care Networks.

While they will lead the sessions, facilitators and Fellows may invite guest speakers, for example:

- Local GPWERs and GPWSIs who can provide relevant support in areas of interest;
- CCG colleagues who may provide insight into commissioning, etc.;
- Local LMC representatives;
- Colleagues in 'new roles' in general practice, such as pharmacists and Physician Associates;
- Representatives from relevant organisations, such as the National Association of Link Workers.

The Primary Care Workforce team will work with the facilitators to support this programme.

Given the small group sizes, it is anticipated that the learning sets will be held at a practice within the facilitators' PCNs which have an adequate room available. However, where this is not possible, funding for venues will be provided.

1.8 **Application Process**

Newly-qualified GPs and employing practices will both need to apply to participate in the Fellowship scheme to ensure the right candidates and employers are given this opportunity.

Aspiring training practices will be encouraged to apply in order to support their progress towards achieving training practice status. Practices which have only one or two partner/salaried GPs will also be actively encouraged to apply to support their own resilience and succession planning.

Practices will be scored on how they will meet the requirements of the Fellowship, including:

- how they will provide support to their recruit;
- how they would deploy them in practice;
- the benefits to the practice/PCN of participating in the scheme.

Applications from prospective Fellows and practices will be reviewed and matched via an annual panel made up of the Clinical Lead, Programme Director and Project Manager to ensure GP portfolio interests satisfy local population health needs.

Formal interviews will take place with practice employers as panel members to enable them to have the final decision on which GPs they would like to employ; employment is expected to continue beyond the Fellowship year. This model of matching and interviewing was employed for the STP's GPN Specialty Training scheme and was very successful, with all practices recruiting candidates as a result of the process.

2. Strategy Alignment

2.1 The Black Country STP Primary Care Strategy focuses on how we support primary care and PCNs through ongoing training, development, education and leadership (within both the clinical and non-clinical workforce).

2.2 There is an expectation that the Black Country & West Birmingham STP will 'convert' 60% of GP trainees into substantive posts in 2020-21. This scheme will support this objective by making the Black Country & West Birmingham an attractive place to work for newly-qualified GPs and supporting a number of GPs with a structured offer of employment and valuable opportunities.

3. Funding and Resources

3.1 The majority of the funding will pay for backfill for the GP Fellows, First 5s and supervisors, as well as facilitator time.

- Backfill for Fellows for one session of CPD per week for six months, to include monthly learning sets - **£8840.64 per Fellowship**
- Backfill for GP supervisors to support Fellows over the first six months of the programme - **£6,630.48 per Fellowship**
- Two GP Facilitators (to provide a variety of experience and cover in the event of sickness/annual leave) - **£13,260.96 in total**
- Backfill for First 5 GPs for attendance at learning sets, to enable them to attend during the working week - **£4,420.32 per First 5 GP**
- Celebration event - **£5,000**

3.2 Option 1: Do nothing. No offer is made available to newly-qualified GPs or practices and they are not incentivised to seek roles in the Black Country & West Birmingham. No benefits realised.

Option 2: Fund 2 GP Facilitator roles, 5 GP Fellowships, backfill for 15 First 5s at monthly learning sets and celebration event. **Total cost £161,921.36**

Option 3: Fund 2 GP Facilitator roles, 10 GP Fellowships and places for 15 First 5s at monthly learning sets. **Total cost £239,276.96**

It is recommended that the WIG approves option 3 on the assumption that the STP will receive further General Practice Fellowships funding this year in line with the 2019/20 funding.

4. Outcome, Benefits and Measures

4.1 Feedback will be collected from all stakeholders throughout the length of the programme, with final evaluation to be undertaken after 12 months.

4.2 Quantitative data will include the number of Fellows, increase in training practices (if any), and number of Fellows working locally post-Fellowship. Qualitative data will be gathered via regular feedback from the following:

- Fellows on their experience, any further support they require, likelihood of staying in local general practice after the Fellowship;
- GP supervisors via templates completed during the first six months of the Fellowship;
- GP employers on their experience of hosting Fellows and the impact upon their practices;
- First 5s on learning sets and access to other opportunities;
- GP Facilitators on the delivery of learning sets.

5. Timescales

- June 2020 – Fellowship offer advertised and applications invited from prospective Fellows, host practices and GP Facilitators
- July 2020 – interviews held and successful applicants confirmed
- August 2020 – development of early learning sets and confirmation of portfolio/leadership opportunities
- September 2020 – Fellowships commence
- December 2020 / March 2021 / June 2021 – quarterly reviews
- September 2020 – final evaluation and launch of year two

6. Key Deliverables and Milestones

- Create marketing & comms materials to advertise Fellowships programme
- Advertise for Fellow, host practice and GP Facilitator roles
- Interview and appoint two GP Facilitators
- Panel to review and approve GP and practice applications
- Confirm host practices and arrange interviews for Fellowship applicants
- Confirm successful applicants
- Work with Facilitators to develop learning set content; advertise to First 5s
- Launch Fellowship programme
- Ongoing monitoring and evaluation

7. Key Risks

- If there are not enough applicants to fill the places, the funding will not be spent – to be mitigated through effective communications and marketing
- If there are not enough practices interested in taking a Fellow, the opportunity will not be available - to be mitigated through effective communications and marketing and 'selling' the long-term benefits of the scheme to practices and PCNs

8. Key Assumptions

- Additional Fellowships funding will be received from NHS England in line with 2019/20 funding.
- There will be enough interest to recruit 10 GPs onto the Fellowship programme.
- There will be enough interest from practices to support 10 Fellowships.

9. Key Interdependencies

- Portfolio Careers scheme
- Medical Education Programme

10. Authorisation

Position	Name	Date
Project Manager	Alyson Hall	29/05/2020
GPFV Programme Manager	Paul Aldridge	2/6/2020
GPFV Programme Director	Sarah Southall	2/6/2020
Clinical Lead	Dr Rajiv Kalia	2/6/2020
Primary and Community Care Workforce Implementation Group		2/6/2020

Black Country and West Birmingham Sustainability and Transformation Partnership (STP)

GPFV Programme 2020/21

Appendix F - CPD for Nurses, Midwives and Allied Health Professionals

May 2020

Overview

Health Education England is providing funding of £1000 per nurse, midwife and allied health professional (including dietitians, occupational therapists, paramedics and physiotherapists) over three years, with payments of £333 pounds per person, per year, regardless of hours worked.

Guidance was received in May 2020 which outlined the following requirements:

- The funding is to be utilised to support CPD requirements of staff linked to personal professional requirements as well as system and population health priorities.
- Funding cannot be used for backfill, travel, subsistence or IT equipment.
- Investment plans must be requested from Primary Care Networks outlining how they will manage their share of the funding.
- The STP Training Hub will monitor uptake and spend and report this back to the national team. The national team requires confirmation of completion of learning but not portfolio evidence.

Process

An investment plan template will be sent out to all PCNs from the Training Hub requesting information about the CPD requirements of staff. The information required in the investment plan will be accessed through current intelligence around population needs, skills shortages and appraisal processes.

Engagement with all staff will be necessary to ensure all nurses and AHPs are aware of the opportunity and communicate any additional CPD needs to their PCN Clinical Directors for inclusion in the investment plan.

Principles and criteria for utilisation of this funding will need to be provided by PCNs to ensure the best use of funding for both personal education needs and population health needs.

The Training Hub will collate the information submitted by all PCNs and summarise the key CPD themes (common requests for particular courses, workshops, webinars and other requests to support CPD) and bespoke specialist courses, to be managed on a case by case basis.

Plans will be reviewed by the Clinical Lead for Workforce and GPN Professional Lead and approved or returned if further detail is required. Following approval, funding will be confirmed with PCNs and released upon the receipt of a signed MOU.

CPD will be carried out remotely via online training and webinars until it is safe for face to face training to recommence. Evidence of completion of courses in the form of certificates or reflective statements will be required from staff who access this funding. It is proposed that the collection of this information is managed via the Training Hub learner management system which is currently in development.

Strategy Alignment

The Black Country STP Primary Care Strategy focuses on how we support primary care and emergent PCNs through ongoing training, development, education and leadership. This scheme supports training and education for nurses and AHPs to enable them to increase their skills and provide additional services for patients.

This scheme satisfies action 7 of the GPN 10 Point Plan ('Support access to educational programmes') and several elements of the GP Forward View:

- **Workforce:** One of the 10 High Impact Actions, 'develop the team', encourages practices to broaden the workforce, to reduce demand for GP time and connect the patient more directly

with the most appropriate professional.

- **Workload:** Practices are encouraged to change the way they work in order to release time for care, by utilising all members of the practice team more effectively and thereby reducing GP workload.

- **Care Redesign:** The GPFV supports practices to strengthen and redesign general practice, including finding new ways of working through training and development.

Funding and Resources

The funding for the Black Country & West Birmingham is £189,000 in 2020/21 which would provide individual CPD payments of £333 to 567 nurses, midwives and AHPs across the STP.

Timescales

- June 2020 – Training Hub engages with PCNs and wider workforce to promote the offer and request investment plans.
- August 2020 – PCNs return investment plans for review.
- September 2020 – Training Hub reviews investment plans and confirms allocations; funding is released to PCNs.
- October 2020-March 2021 – Training Hub monitors uptake and spend and reports to HEE.

Authorisation

Position	Name	Date
Project Manager	Alyson Hall	29/05/2020
GPFV Programme Manager	Paul Aldridge	2/6/2020
GPFV Programme Director	Sarah Southall	2/6/2020
GPN Professional Lead Nurse	Liz Corrigan	2/6/2020
Primary and Community Care Workforce Implementation Group		2/6/2020

Black Country and West Birmingham Sustainability and Transformation Partnership (STP)

GPFV Programme 2020/2021

Appendix G - General Practice Nurse Specialty Training Programme

June 2020

1. Scheme Outline

1.1 General practices in the Black Country and West Birmingham continue to face significant challenges in both recruiting and retaining nursing staff. Locally, approximately 60% of nursing staff are aged 50 and above, and there is a shortage of younger nurses joining the profession to replace them. General practice across the STP faces a cliff edge should the majority of these older nurses choose to retire within the next five years.

1.2 In December 2019, the STP successfully bid for funding from HEE and NHSE to recruit and train 10 GPN Specialty Trainees. Interest in this opportunity was high, with applications from more than 40 nurses (with a requirement that they be newly-qualified) and 15 practices. Posts are fully funded for 9 months, along with Fundamentals of General Practice Nursing (FGPN) course fees. In addition, the STP managed the application process on behalf of practices, shortlisted the candidates and coordinated a 'speed dating' style interview day to enable recruitment at scale. 10 GPN Trainees were recruited by practices and commenced their posts and training in March 2020. Following completion of their training, the nurses will be supported to gain permanent employment in either their host practices or in another practice within the STP.

1.3 A similar scheme was run by Sandwell & West Birmingham CCG from January 2019 which offered recruitment support and funding to bring 10 new nurses into general practice. This offer included match-funding the salaries of the new nurse recruits for 12 months, funding places on the FGPN course and hosting a 'marketplace' recruitment event. The SWB CCG scheme resulted in 13 nurses being recruited to 10 practices, which were expected to retain the nurses as part of their workforce at the end of the scheme.

1.4 Given the proven appetite of nurses to work in general practice, and the need to recruit new nurses into the workforce, it is proposed that the GPN Specialty Trainee programme is adapted and extended to make this opportunity available to more candidates in 2020/21.

1.5 The proposed programme will support the recruitment of a further five GPNs across the STP to practices which have current or anticipated vacancies. It will offer the following:

- Support for salary costs for the five nurses for 9 months at 37.5 hours per week;
- Fundamentals of General Practice Nursing (FGPN) course fees funded for all recruits;
- Management of the application and shortlisting process and coordination of an interview day to enable recruitment by the practices.

1.6 **Requirements from participating practices**: To ensure the nurses receive high quality support and training, interested practices must demonstrate their commitment to providing a supportive environment for the development of their newly recruited nurse. This will be via Expression of Interest and will include:

- Ensuring the recruited nurse is released to attend agreed training and development events, including but not limited to the FGPN course (released time will be from contracted hours);
- Identify a member of practice staff responsible to deliver mentorship and clinical supervision and ensure sufficient, regular time is agreed for this to take place, outlining how this will be delivered;
- The practice must have a current Good or Outstanding CQC rating;
- Participating practices must fully participate in project evaluation in conjunction with the STP, which will take place throughout the length of the scheme.

1.7 Successful practices will be required to sign up to a Memorandum of Understanding with the STP confirming that they meet the necessary criteria and commit to supporting the new nurse.

1.8 **Nurse recruitment:** Prospective nurse applicants will be engaged via the STP's well-established

relationships with our two local HEIs. To facilitate recruitment at scale, applications will be managed centrally by the STP team via NHS Jobs. Following this, PCNs which are successful through the EOI process and nurses applying for the posts will be invited to attend a 'speed dating' style event to enable the matching of practices with recruits.

1.9 Once the training period is completed, the nurses will be supported to apply for identified vacancies within the STP. This may be at their training practice, within the same PCN, or in a practice within another PCN, and will offer at least an equivalent salary.

1.10 **Fundamentals of General Practice Nursing (FGPN) course:** Places will be funded through this scheme at the University of Wolverhampton and Birmingham City University. As an STP we have the benefit of two local FGPN programmes, so we will be able to offer flexibility for the recruits to choose the university which best suits their needs.

1.11 Employing practices will be expected to release time for their nurse recruits who are employed through this scheme to be able to attend FGPN study days as part of their contracted hours.

1.12 **Other support available to the nurses**: As per the New to Practice Fellowships and other opportunities available across the STP, the new nurse recruits will have access to peer mentorship and GPN networks, in addition to the clinical mentorship they will be provided with by their practice as part of the FGPN course.

1.13 Once they have completed the FGPN course, eligible nurses will have access to further opportunities, such Specialist Practice, leadership development and portfolio career opportunities (subject to application, individual preference and PCN needs).

2. Strategy Alignment

2.1 The Black Country and West Birmingham STP Primary Care Strategy focuses on how we support primary care and PCNs through ongoing training, development, education and leadership (within both the clinical and non-clinical workforce).

2.2 Black Country and West Birmingham STP GPN Strategy aims to ensure that every nurse, regardless of which point they are at in their career, receives the support and recognition they need, and aims to make a career in local general practice an attractive option for newly qualified nurses.

2.3 Locally, approximately 60% of nursing staff are aged 50 and above, and there is a shortage of new nurses joining the profession to replace them. The STP has initiated a number of projects to limit the impact of this issue, which this programme will complement.

3. Funding and Resources

3.1 The scheme will offer support for salary costs for the five nurses for 9 months at 37.5 hours per week. Salary costs are equivalent to the bottom spine point of AfC Band 5 (£24,907) plus 28% on-costs. Other terms and conditions will be decided by individual practices; however this will be taken into consideration during the practice EOI process to encourage fair and equitable T&Cs.

3.2 General practice providers will be the employer. Following the training period, the employing practice will assume responsibility for full salary costs of at least an equivalent rate.

3.3 **Options Appraisal**

Option 1:
Do nothing. No new nurses will be recruited and trained in general practice.

Option 2:

- Provide 50% salary contribution plus 28% on-costs x9 months for 5 nurses - £11,955.36 per nurse
- Fund FGPN places x5 nurses - £3,400 per nurse
- Fund advertising and interview event costs at £2,500
- **Total cost - £79,276.80**

Option 3:

- Fully fund salaries plus 28% on-costs x9 months for 5 nurses - £23,910.72 per nurse
- Fund FGPN places x5 nurses - £3,400 per nurse
- Fund advertising and interview event costs - £2,500
- **Total cost - £139,053.60**

3.4 **It is recommended that the Board approves Option 2.** By requiring participating practices to fund 50% of the salary, we ensure 'buy-in' from the practices to support and develop their recruit(s) as they will potentially remain part of their workforce beyond the life of the scheme.

4. Outcome, Benefits and Measures

4.1 Feedback will be collected from all stakeholders throughout the length of the programme, with final evaluation to be undertaken after 12 months.

4.2 Quantitative data will include the number of Specialty Trainees which enter the programme and the number remaining in local practices at key points post-training. Qualitative data will be gathered via regular feedback from the following:

- Specialty Trainees on their experience, any further support they require, and likelihood of staying in local general practice after the programme;
- In-practice mentors on the progress of the trainees;
- GP employers on their experience of hosting trainees and the impact upon their practices;
- University partners on the delivery of the educational component and trainee engagement.

5. Timescales

- September 2020 – posts advertised and practice EOIs requested
- October 2020 – successful practices confirmed and interviews held with nurse applicants
- November 2020 – notice period; practices carry out pre-employment checks
- January 2021 – posts and course commences (TBC with universities)

6. Key Deliverables and Milestones

- Create marketing & comms materials to advertise GPN-ST programme
- Advertise for trainee posts and PCN/practice employers
- Panel to shortlist applicants and review practice EOI
- Confirm host practices and arrange interview day for GPN-ST applicants
- Confirm successful applicants
- Practices carry out pre-employment checks and arrange contracts
- Work with university partners to develop induction material
- Launch GPN-ST programme
- Ongoing monitoring and evaluation

7. Key Risks

- If there are not enough applicants to fill the places, the funding will not be spent – to be mitigated through effective communications and marketing.
- If there are not enough practices interested in taking a GPN Specialty Trainee, the opportunity will not be available - to be mitigated through effective communications and marketing and 'selling' the long-term benefits of the scheme to practices and PCNs.

8. Key Assumptions

- Additional GP Forward View funding will be received from NHS England in line with 2019/20 funding.
- There will be enough interest to recruit 5 nurses onto the programme.
- There will be enough interest from practices to support 5 places.
- Vacancies will be available for GPN-STs to move into following training.

9. Key Interdependencies

- Other GPN schemes, including peer mentoring, GPN networks and CPD offers.

10. Authorisation

Position	Name	Date
Project Manager	Alyson Hall	29/05/2020
GPFV Programme Manager	Paul Aldridge	2/6/2020
GPFV Programme Director	Sarah Southall	2/6/2020
GPN Professional Nurse Lead	Liz Corrigan	2/6/2020
Primary and Community Care Workforce Implementation Group		2/6/2020

Black Country & West Birmingham Sustainability and Transformation Partnership.

Training Hub Learner Management System
Options Appraisal

1. Service Requested

In order to achieve the plans for primary care across the STP, and ensure that we meet the requirements from HEE, work done to date has established that the Training Hub needs a single learning management system. One with the capability to run and monitor new roles and the programmes developed to support them; one that tracks learners and identifies when mandatory training is expiring; and one that enables the Hub to strategically manage delivery, quickly identifying those individuals that could be candidates for a new programme of work. A number of other areas were identified as being required, and for ease of analysis, a table is given below outlining these requirements and which systems accommodate them.

2. Contract Details Award

Suppliers were advised that it was expected that the supplier appointed will commence as soon as is practicable in the current climate. Where direct human intervention and consultancy is required, suppliers indicated that it should be possible to commence design during the isolation period. Some of the products are an "off the shelf" solution, and therefore this is not an issue, although having internal capability to design and customise the product may be.

The suppliers were advised that the quotations received would be awarded based upon internal assessment of both price and methodology to be used. Standard NHS terms and conditions will apply, and failure to deliver the required products according to the timetable above will result in the contract being declared null and void.

3. Recommendation

Due to the variation in approach, and the fact that some quotes are based on "estimated design consultancy" rather than actual quoted time, it is difficult to accurately compare the systems on cost. However, functionality is more easily determined using the table in section 4. Bids were assessed on a traditional cost:quality split of 40:60 weighting.

Although there are distinct similarities between some of the items, the recommended system is **Bid Reference B**. This system includes all of the functionality that the Training Hub requires, with the added security of the costs including installation, design and hosting.

It is recommended that the STP procure a 500 licence system, at the lower of the two quotes, in the first instance, with the acknowledgment that should the number of licenses required increase, there will be a pro-rata increase in cost for the remainder of that year. To procure immediately with 3,000 user licenses, the cost would still be ranked at E using the rankings below.

4. Systems reviewed

Criteria					
Supplier Bid Reference	A	B	C	D	E
Learner Tracking					
Design and deliver programme events			?	?	
Financial tracking for HEE/NHSE reporting	?				
Mandatory learning and expiry tracking					
Programme design					
Proven STP Level management information			?	?	
Online course prospectus and booking facility					
Import of previous data					
Customisable multi-user group functionality					
Ability to assign access to delivery partners					
Design and amend programmes and reporting without recourse to consultancy					
User level specific reporting, with internal amendment and design capability					
Proactive learner identification			?	?	
Discreet access for delivery partners					
Income tracking and management			?	?	
Programme/course cost tracking and fee calculation					

Note: ? indicates not clear in documentation received;
Shaded cell indicates that is demonstrated;
Blank cell means not available in this system.

For the purposes of the bid assessment and commercial confidentiality, each individual system below is referenced in letter form only, and prices ranked by A being the highest cost, to E being the lowest cost. The preferred supplier has been selected based upon a 60:40 split of meeting the objectives listed above and cost.

Bid Reference A: This is a specific, powerful system created for HR management within primary care, and is the only primary care specific system in this analysis. A large south-east STP are currently trialling the system across their STP footprint, but this was due to commence late February/early March 2020 and therefore it is, as yet, unproven at scale, if the trial commenced on time. The advantages to this system are that there is an incentive for practices to utilise it, as there are many powerful components that will be useful to practices.

Year One Cost:- A
Ongoing Costs:- A p.a.

Bid Reference B: This is an LMS aimed both at large employing organisations and universities. The provider counts many NHS organisations among their client base, although they have not specifically worked with a Training Hub in the past. The advantages to this system are that it is one of the most powerful LMS on the market. It is the most customisable system and allows the Training Hub full design and customisation of reports and courses. There is also the advantage that it can be purchased and set up with a small number of licences (500), which will enable delivery partners, practices and the GPFV team and Training Hub staff to access in year one, with a pro-rata ability to upgrade to the next licence band (3000 users) in year. Licences for staff that leave can be reassigned once historical information is archived and/or deleted.

Year One Cost: E
Ongoing Cost: E p.a.

Bid Reference C: This is widely regarding as the market leader, based upon the brand platform

reputation as a whole. The advantage here is that it will automatically link to any other systems using this platform internally. However the brand generally requires a great deal of consultation time and design input, and the costings provided online are system procurement costs only. This means that a separate project team would need to be employed to design and build this "off-the-shelf" system. These costs are estimated at £20,000 in the quotation received, which feels unrealistically low based upon the level of work needed.

Year One Cost: C
Ongoing Cost: C p.a.

Bid Reference D: This is a completely "off the shelf" solution, which again requires specialist internal knowledge to design and customise to the STP requirements.

Year One Cost: D
Ongoing Cost: D p.a.

Bid Reference E: This is by far the most traditional software offering, with the quote being based upon the STP being able to "host" the software on an internal network, hosting, which is the case in all of the other quotes, means that internal capacity for data storage is not required. The system appears to be very complex and cumbersome, indicated by the outline proposal sent and the difficulty in identifying the purpose of each module being quoted for. Conversations over a three-week period have given an indicative modular structure and costing, yet this is caveated that they believe modules have not been added that could be essential.

Year One Cost: B
Ongoing cost B p.a.

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Appendix H

Black Country and West Birmingham Training Hub

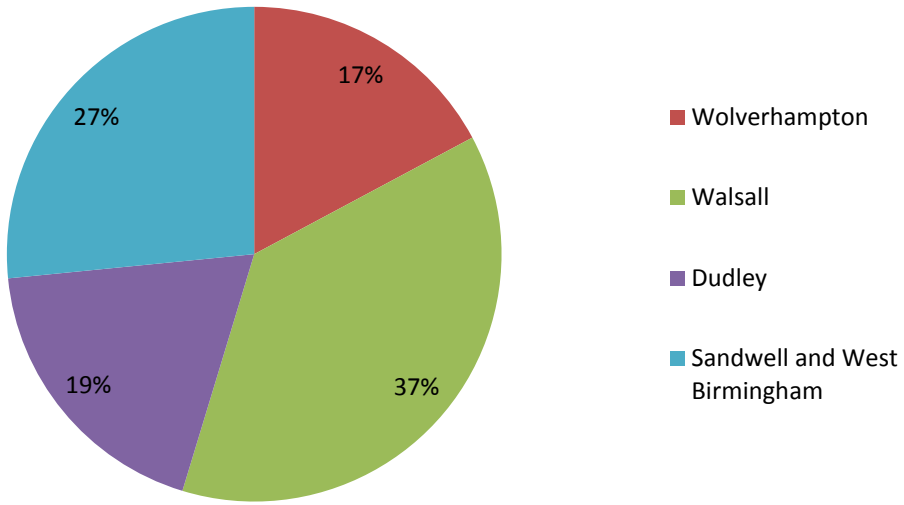
GP Scheme Dashboards 2020/2021 as at 26/05/2020

Building Healthier, Happier Communities

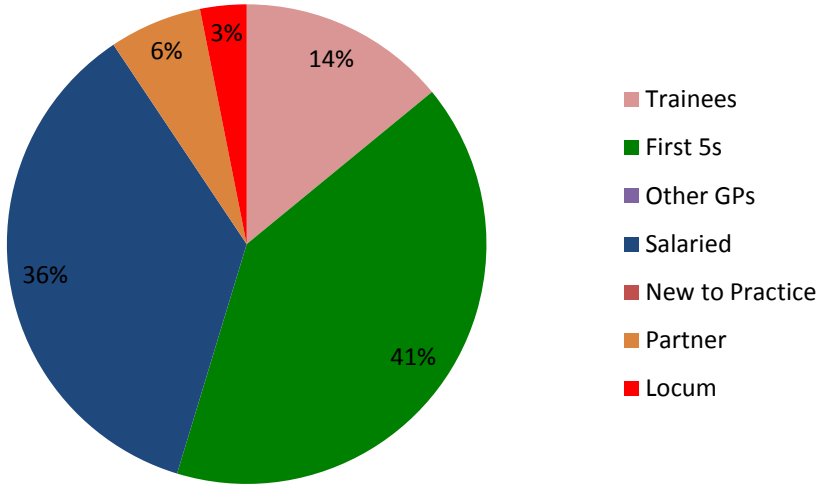
Peer Mentoring

1. There are currently 64 mentees accessing the scheme.
2. The CCG and Phase breakdown is shown below where this has been identified.

Peer Mentoring Numbers



Peer Mentoring - Phase



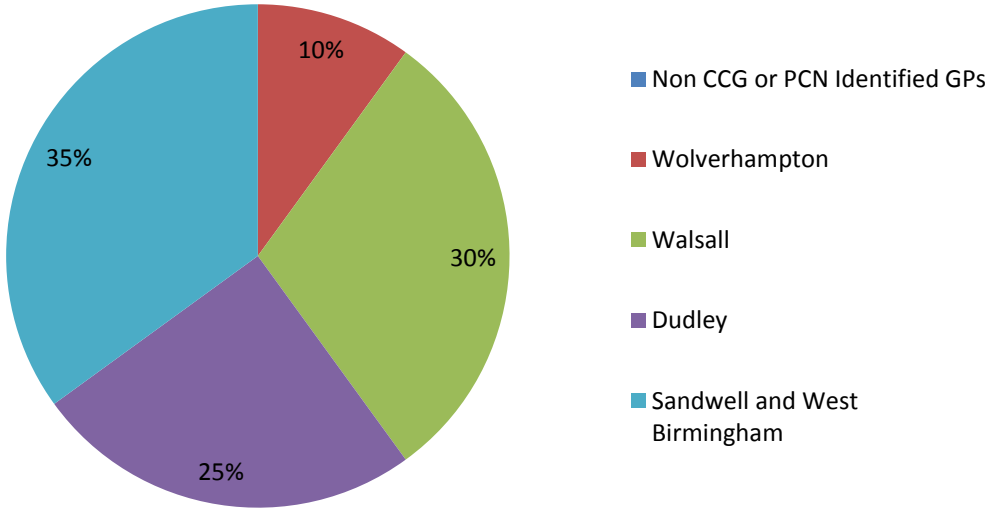
First Five

First 5 Networks

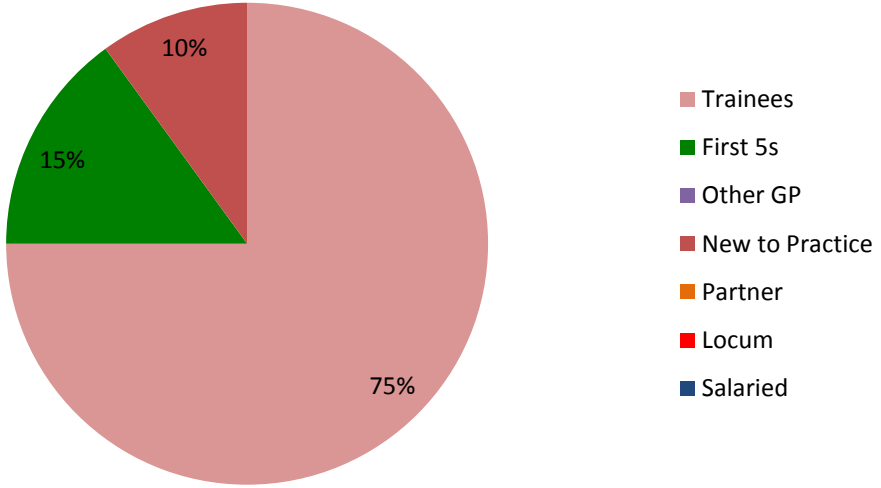
1. First 5 remote consultation webinars have taken place, the priority was given to First 5s/Trainees and 20 have participated in the first four sessions (of 105 people). There may have been others that participated but did not register as First 5/Trainees.

2. The CCG and Phase breakdown is shown below where this has been identified.

First 5 Numbers



First 5 Phase



Portfolio Careers

1. 31 applications were approved in 2029/2020.

2. An appreciative inquiry took place on the 28th April 2020, to review the scheme's success, which has led to a new proposal being developed for 2020/21. It is proposed new scheme will be open to the wider clinical workforce and aimed at PCN level and their clinical priorities. The draft proposal will be taken to the Workforce Implementation Group Meeting in June.

3. The GP Portfolio breakdown across a two year period is as follows:

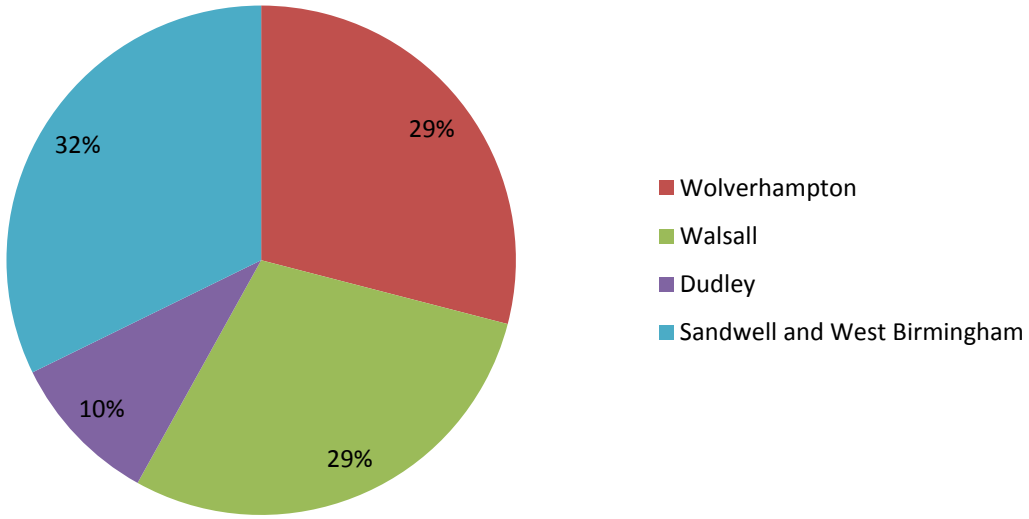
Cohort 1 - 2018/2019			**Cohort 2 – 2019/2020**		
Area	**Number of Applications**	**Number of PCNs Accessed Scheme**	**Area**	**Number of Applications**	**Number of PCNs Accessed Scheme**
Dudley	12	5/6	Dudley	3	2/6
Sandwell and West Birmingham	8	6/15	Sandwell and West Birmingham	10	7/15
Walsall	2	2/7	Walsall	9	5/7
Wolverhampton	10	5/6	Wolverhampton	9	4/6
Total	**32**	**18/34**	**Total**	**31**	**18/34**

Portfolio Careers

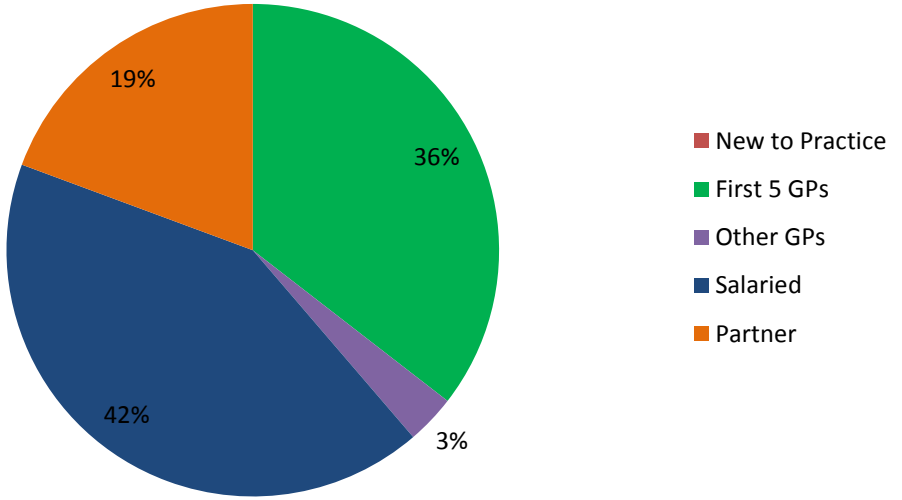
4 The CCG and Phase breakdown is shown below where this has been identified.

Portfolio Careers

Portfolio Careers Numbers



Phase - GP Careers



Portfolio Careers

Summary of Portfolio Specialties 2019/2020 Cohort 2

CCG	PCN	Portfolio Speciality
Dudley	Dudley and Netherton	Diabetes
Dudley	Dudley and Netherton	Pain Management
Dudley	Stourbridge, Wollescote & Lye	Neurolinguistic Programming and Coaching
Walsall	West One	Paediatrics and Child Health
Walsall	West One	Woman's Health
Walsall	West One	Palliative Care
Walsall	East Two	Sexual and Reproductive Health
Walsall	East Two	Mental Health
Walsall	East Two	Mental Health
Walsall	West Two	Minor Surgery
Walsall	South 1	Pain Management
Walsall	North	Women's Health

Portfolio Careers

Summary of Portfolio Specialties 2019/2020 Cohort 2

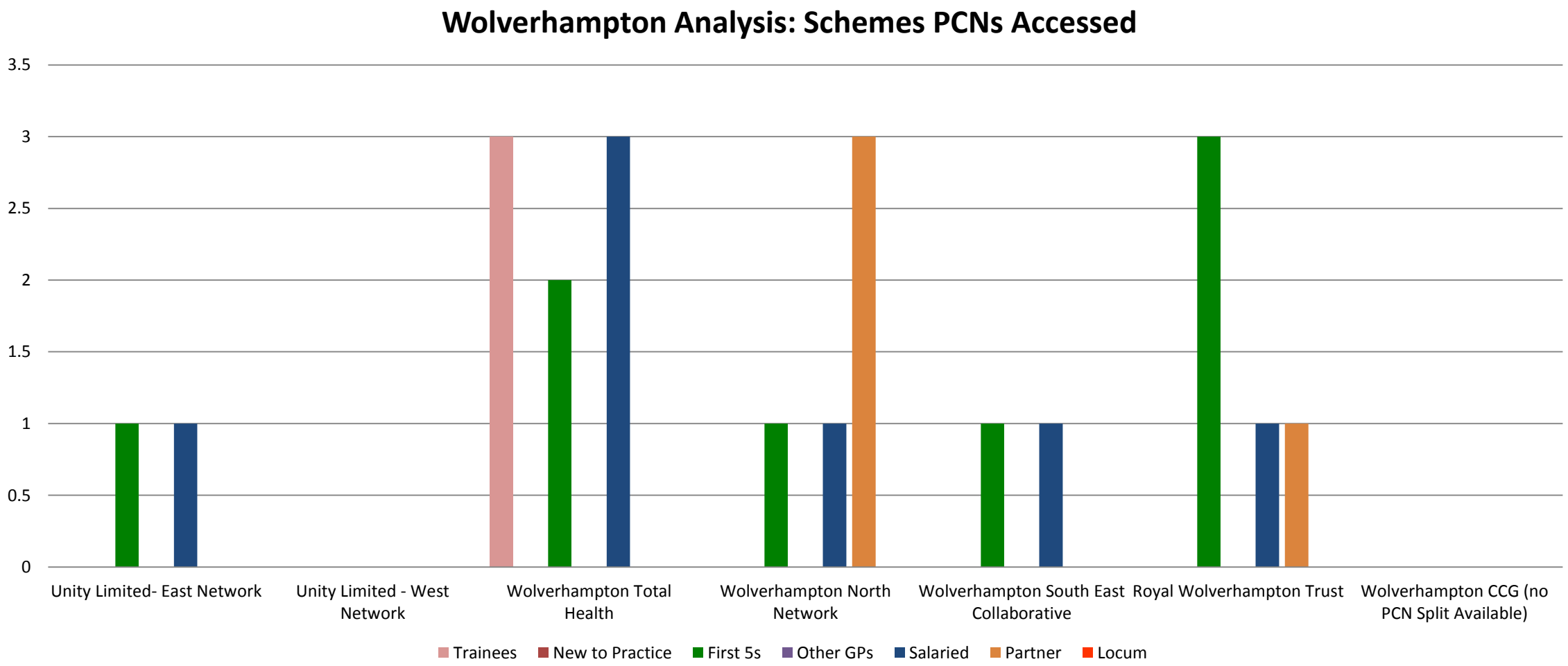
CCG	PCN	Portfolio Speciality
Sandwell and West Birmingham	Pioneers for Health South	Women's health
Sandwell and West Birmingham	Central Healthcare Partnership	Medical Education
Sandwell and West Birmingham	Newcomen and Health	Minor Surgery
Sandwell and West Birmingham	Urban Health	Gynaecology
Sandwell and West Birmingham	Urban Health	Medical Education
Sandwell and West Birmingham	Your Health Partnership	Life Style Medicine
Sandwell and West Birmingham	Your Health Partnership	Palliative Care
Sandwell and West Birmingham	Citrus Health	Urology
Sandwell and West Birmingham	Citrus Health	Medical Education
Sandwell and West Birmingham	I3	Cardiology

Portfolio Careers

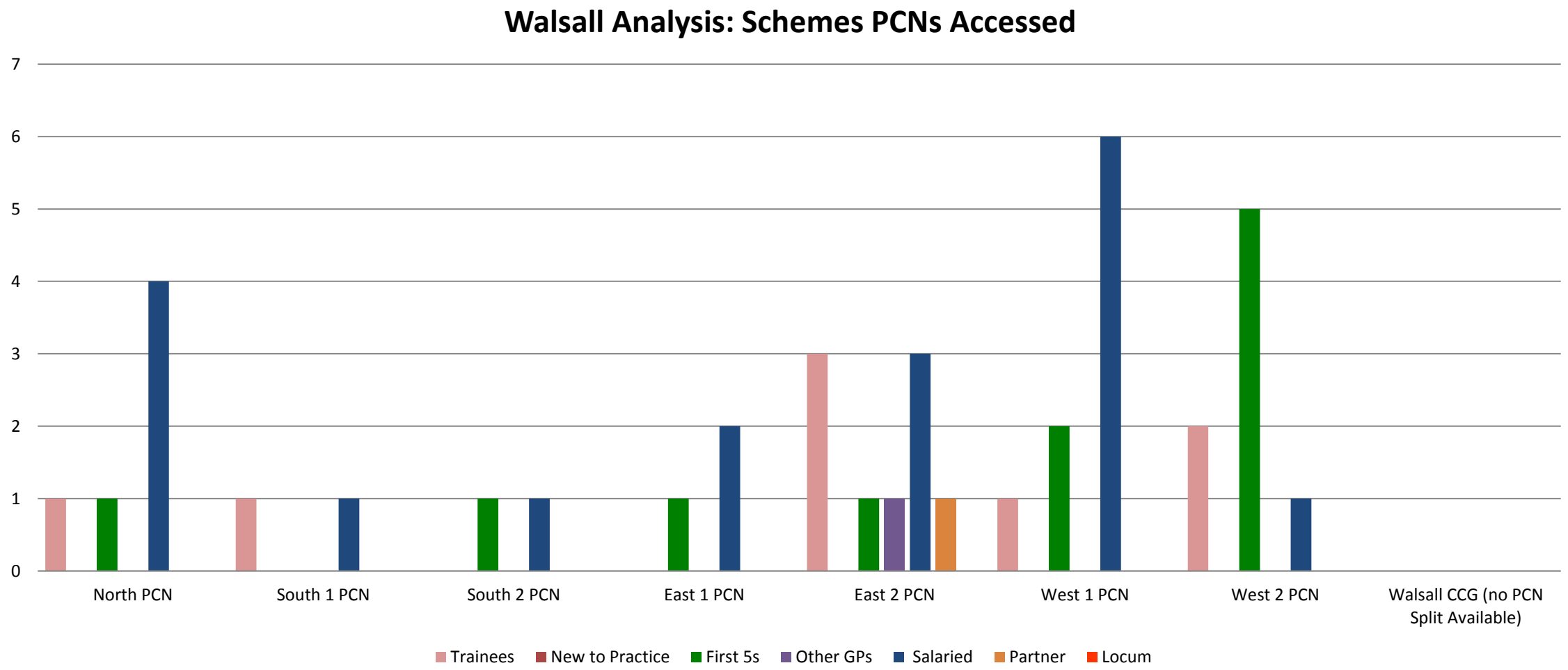
Summary of Portfolio Specialties 2019/2020 Cohort 2

CCG	PCN	Portfolio Speciality
Wolverhampton	Wolverhampton Total Health	O&G/Community Gynaecology and Menopause
Wolverhampton	Wolverhampton Total Health	Obstetrics and Gynaecology
Wolverhampton	Wolverhampton Total Health	Medical Education
Wolverhampton	Wolverhampton North	Woman's Health
Wolverhampton	Wolverhampton North	Minor Surgery
Wolverhampton	Wolverhampton North	MSK/Chronic Pain Management
Wolverhampton	Wolverhampton North	Diabetes
Wolverhampton	Wolverhampton South East	Urology
Wolverhampton	Royal Wolverhampton Trust	Paediatrics

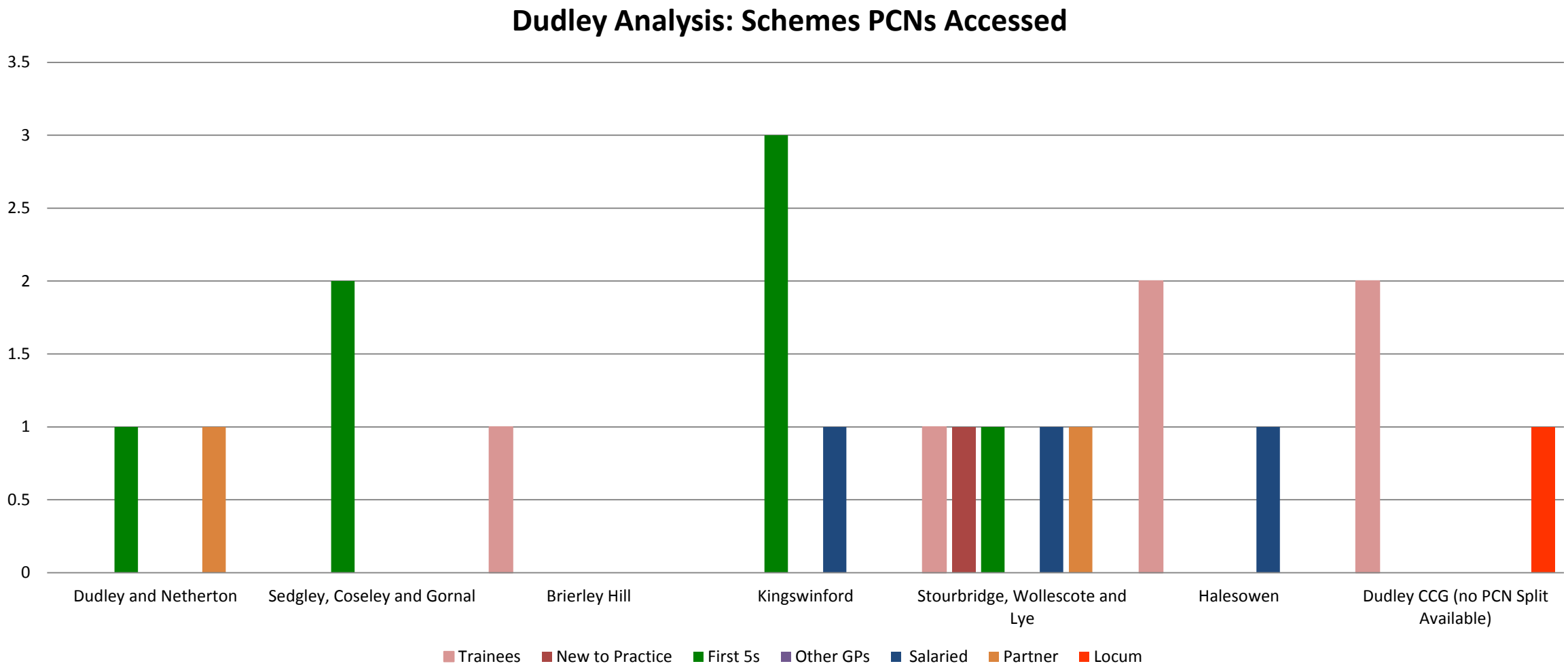
PCN Analysis - Wolverhampton



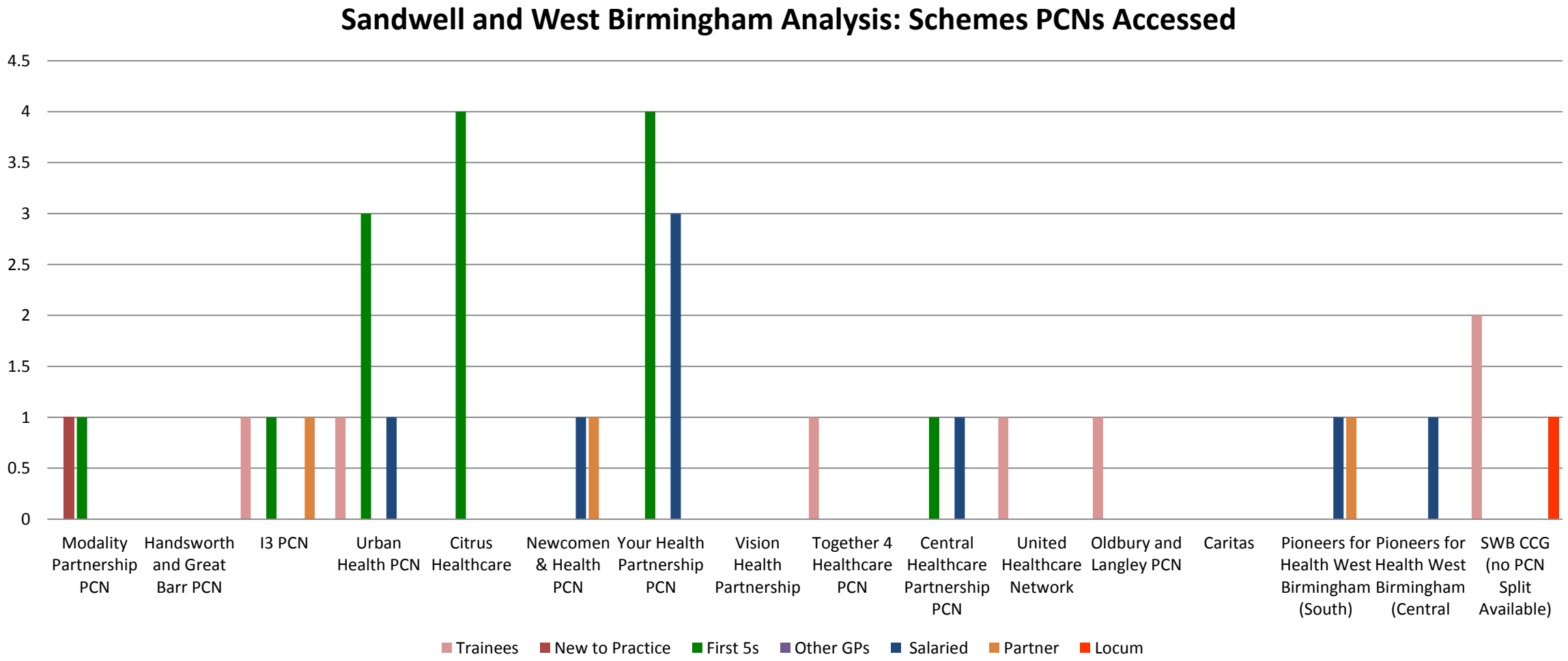
PCN Analysis - Walsall



PCN Analysis -Dudley



PCN Analysis – Sandwell and West Birmingham



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Black Country and West Birmingham Training Hub

GPN Scheme Dashboard 2020/2021 as at 26/05/2020

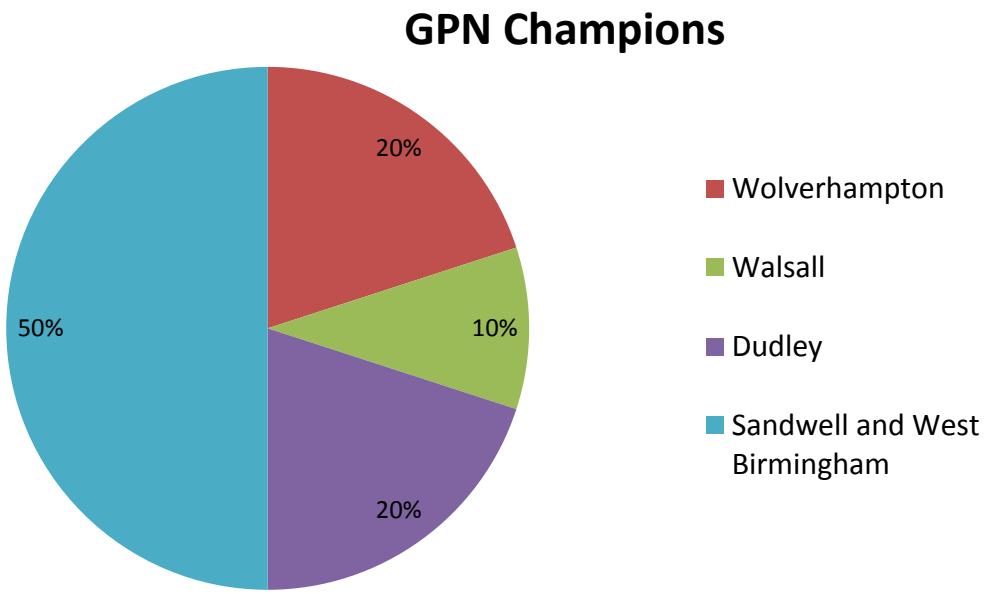
Building Healthier, Happier Communities

GPN Champions

1. 10 General Practice Nurse Champions have been appointed.

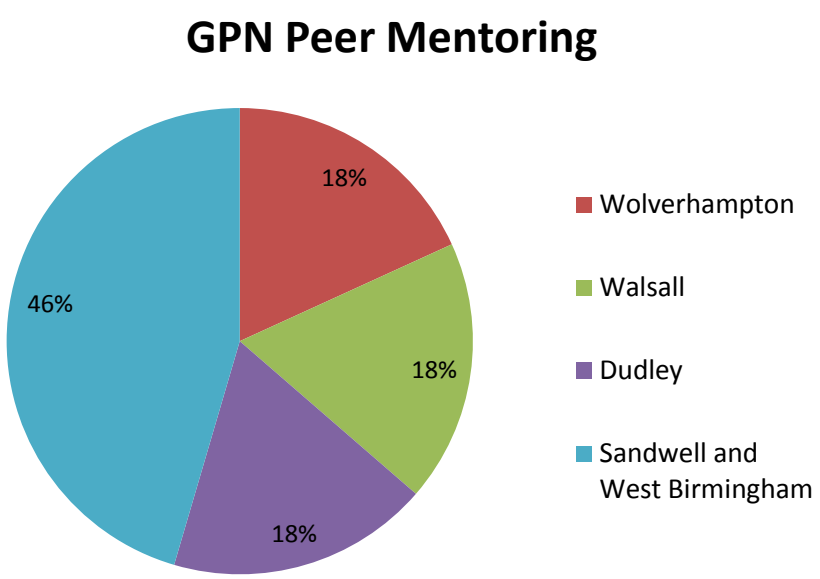
2. The Champions are being overseen by Liz Corrigan, GPN Professional Lead, who has met with each of them individually and will arrange regular group meetings throughout the year. A two day leadership development programme has been commissioned from the RCN to support the Champions in their role.

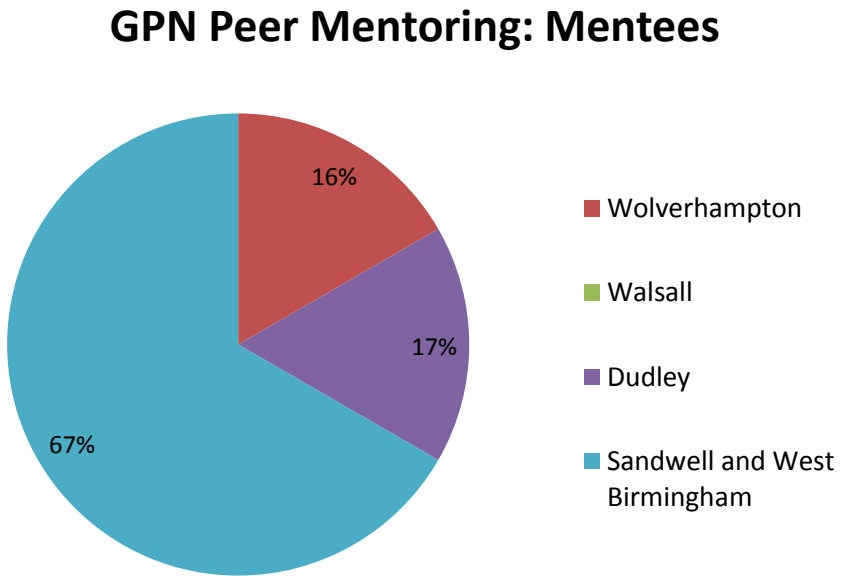
3. The split by CCG can be found below.



GPN Peer Mentoring

1. There are 11 GPN Peer Mentors that have been appointed, to date there have been 6 mentees that have accessed the scheme.
2. The split by CCG can be found below.

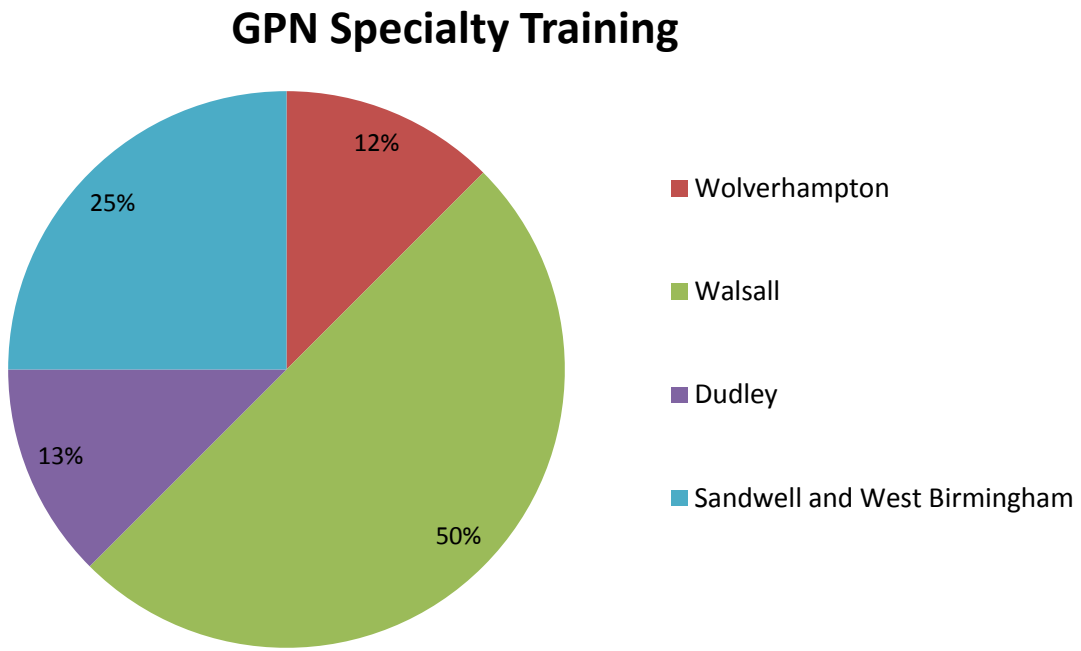




GPN Specialty Training

1. There are 9 GPNs who have accessed the GPN Specialty Training Programme

2. The split by CCG can be found below.



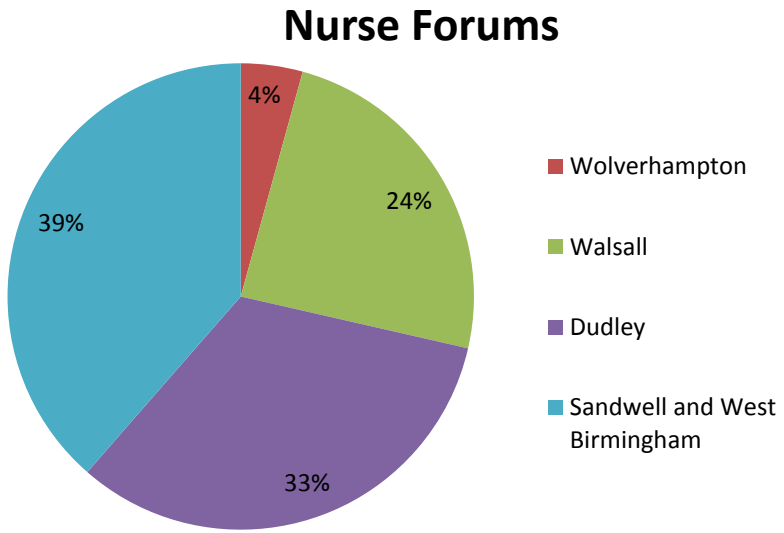
Nurse Forums

1. All April 2020 Nurse Forums were cancelled due to COVID- 19.

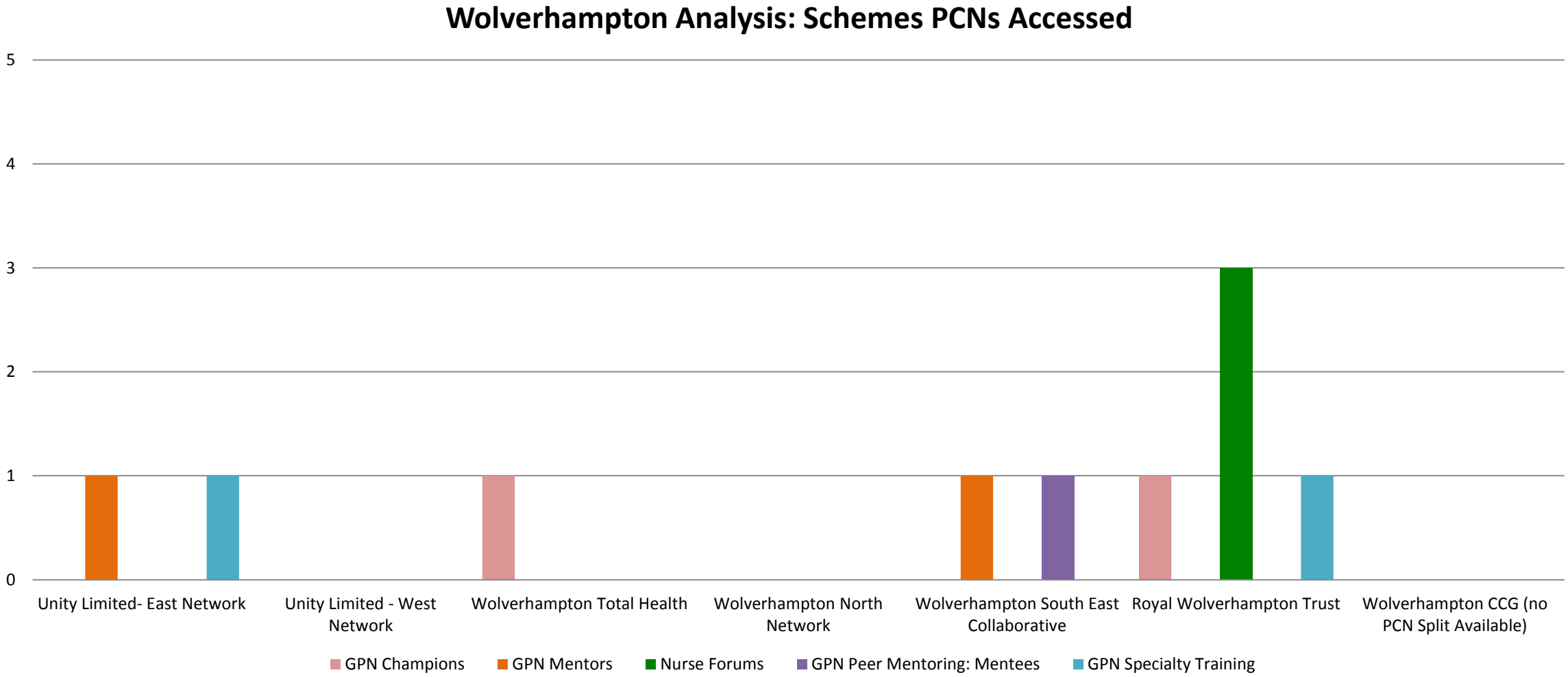
2. Since May 2020 the Nurse Forums will be delivered virtually and topics and speakers have been confirmed for the next three months.

3. 70 staff members accessed the May virtual nurse forum meetings. The breakdown by CCG is as follows:
   - Wolverhampton – 3
   - Walsall – 17
   - Dudley - 23
   - Sandwell and West Birmingham - 27

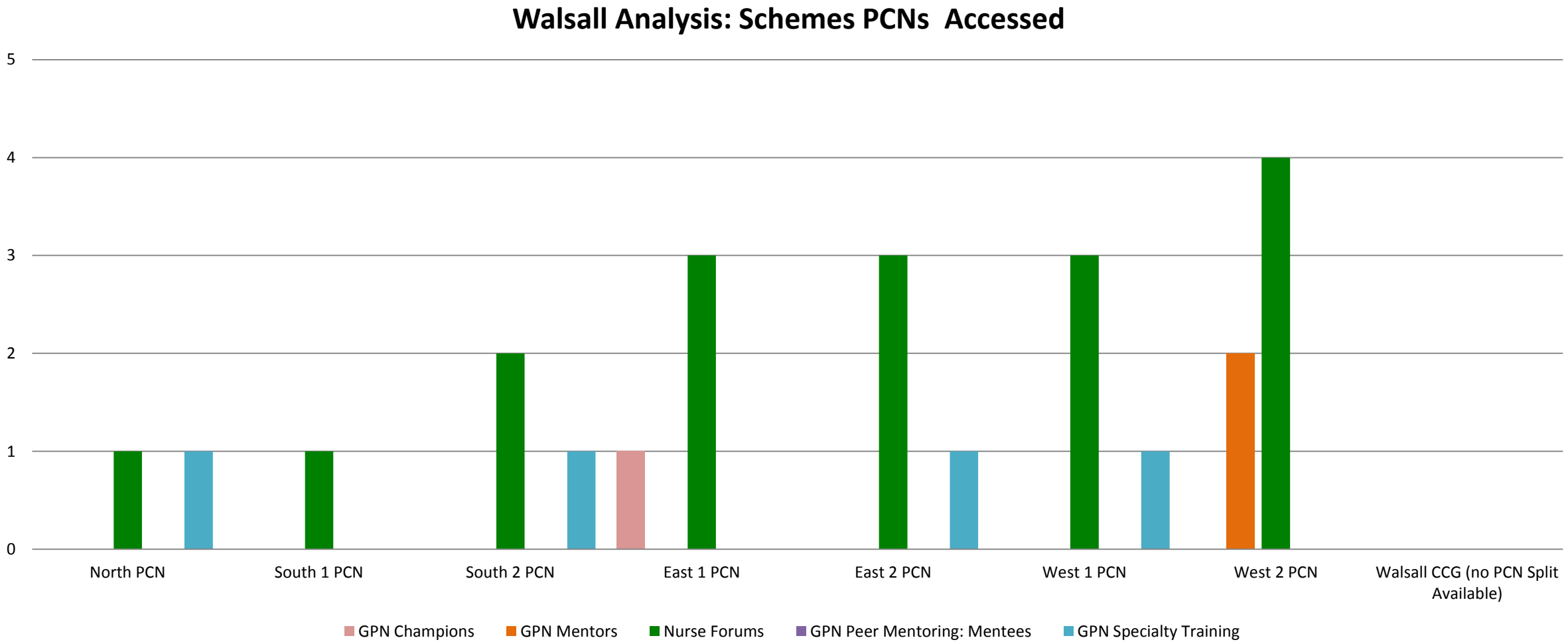
4. The split by CCG can be found below.



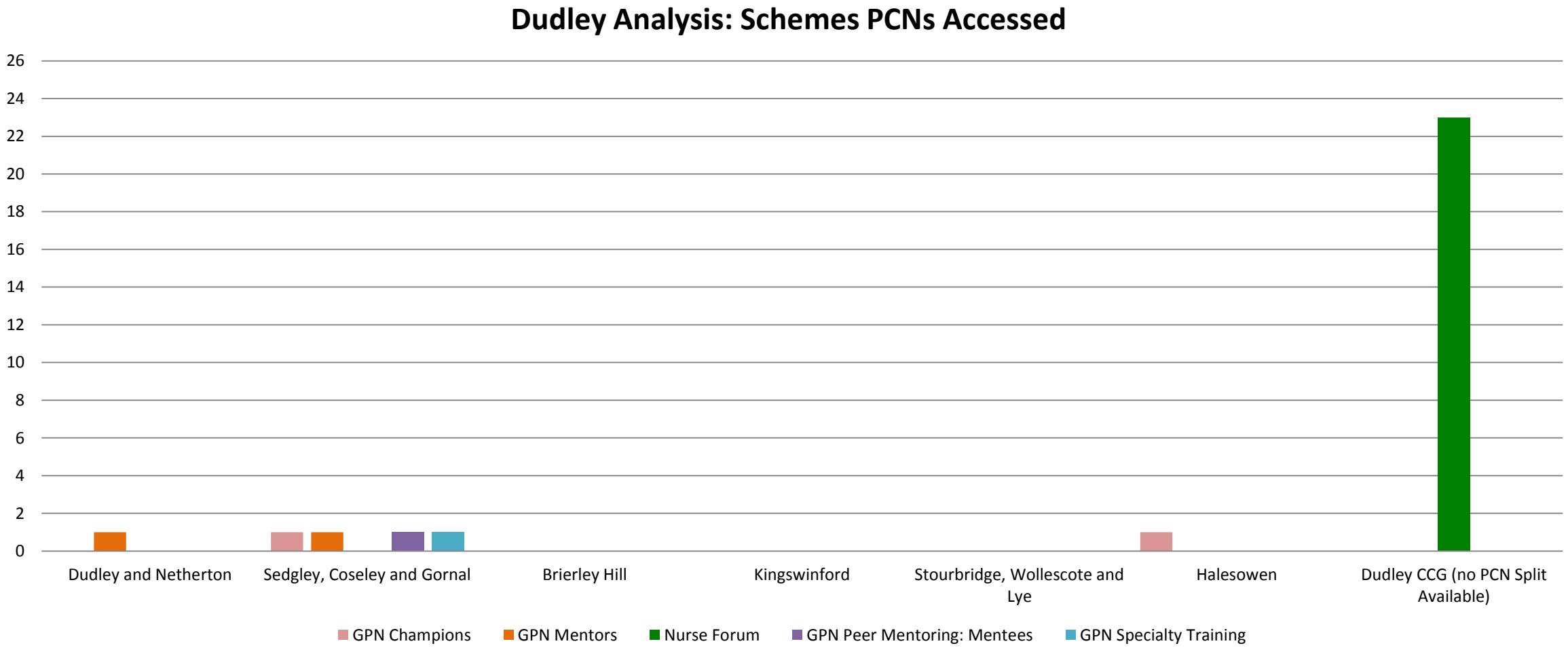
PCN Analysis - Wolverhampton



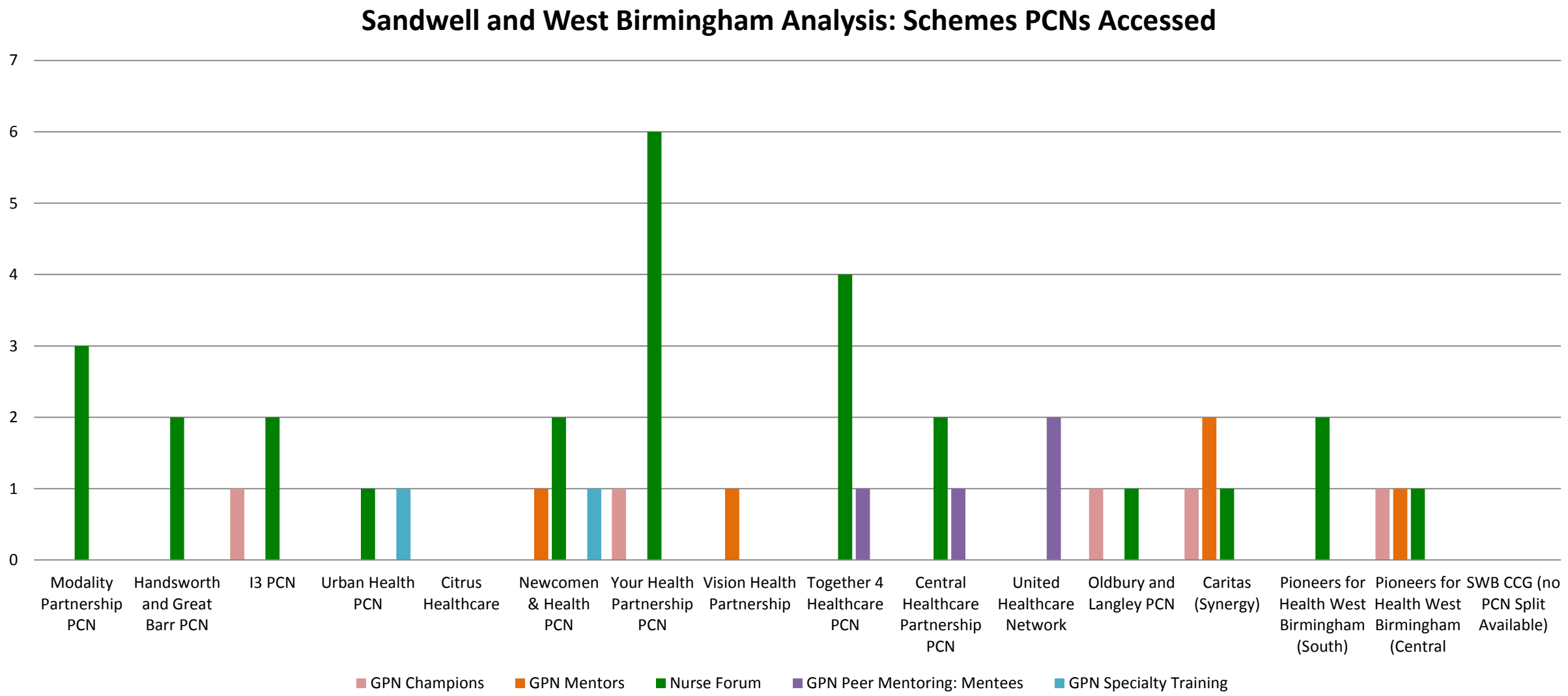
PCN Analysis - Walsall



PCN Analysis -Dudley



PCN Analysis – Sandwell and West Birmingham



Healthier Futures
Black Country and West Birmingham

Black Country and West Birmingham
Primary Care Workforce
Your career in Primary Care

Black Country and West Birmingham Training Hub

Other Schemes Dashboard 2020/2021 as at 26/05/2020

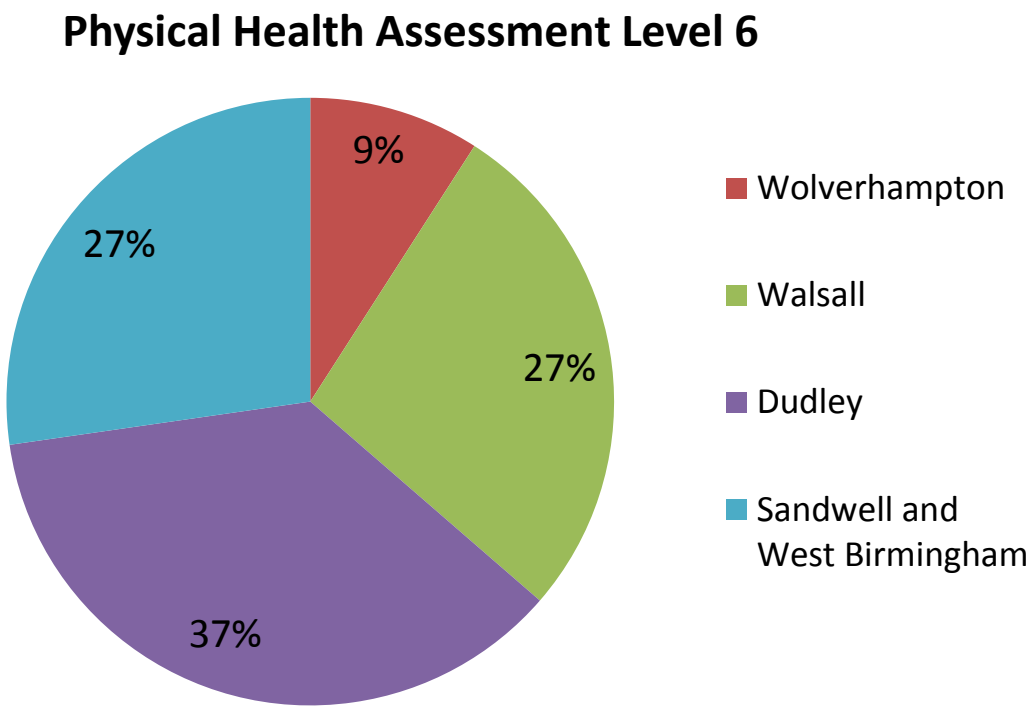
Building Healthier, Happier Communities

Physical Health Assessment Level 6

1 The staff numbers allocated are:

- Wolverhampton – 1
- Walsall – 3
- Dudley - 4
- Sandwell and West Birmingham - 3

2 The split by CCG can be found below;

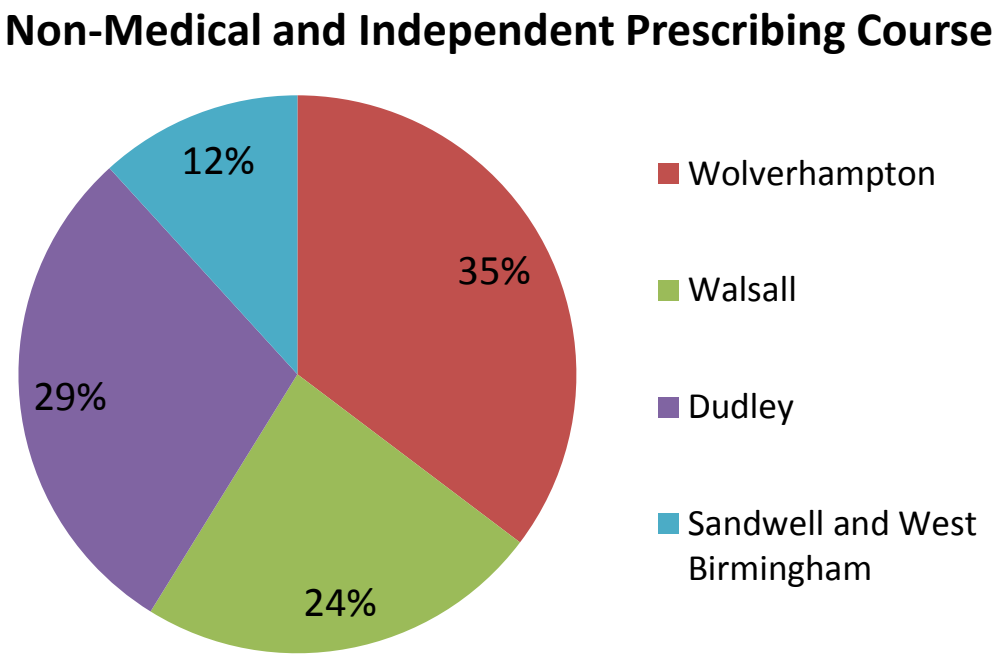


Non-Medical and Independent Prescribing

1 The staff numbers allocated are:

- Wolverhampton – 6
- Walsall – 4
- Dudley - 5
- Sandwell and West Birmingham - 2

2 The split by CCG can be found below;

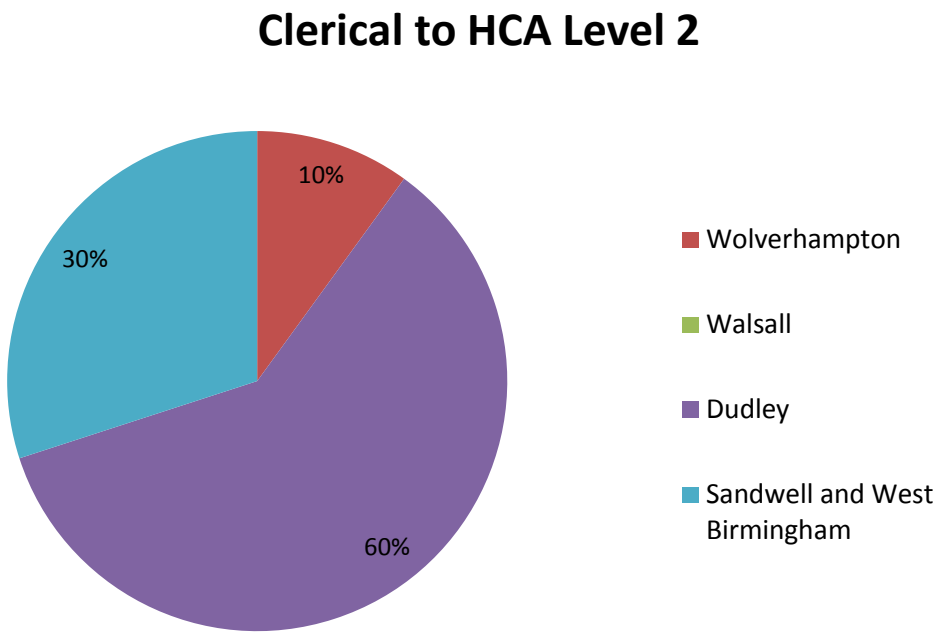


Clerical to HCA Level 2

1 The staff numbers allocated are:

- Wolverhampton – 1
- Walsall – 0
- Dudley - 6
- Sandwell and West Birmingham - 3

2 The split by CCG can be found below;

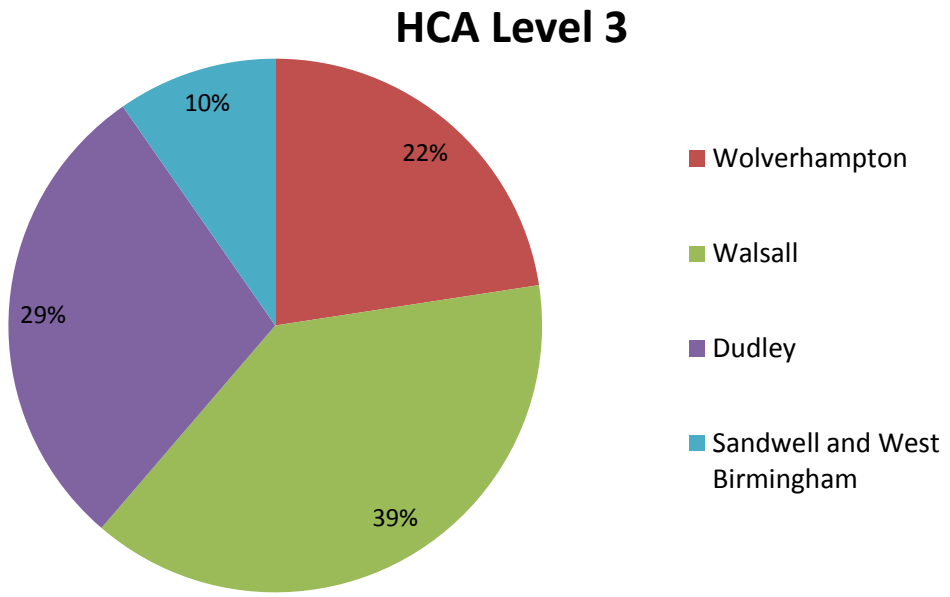


HCA Level 3

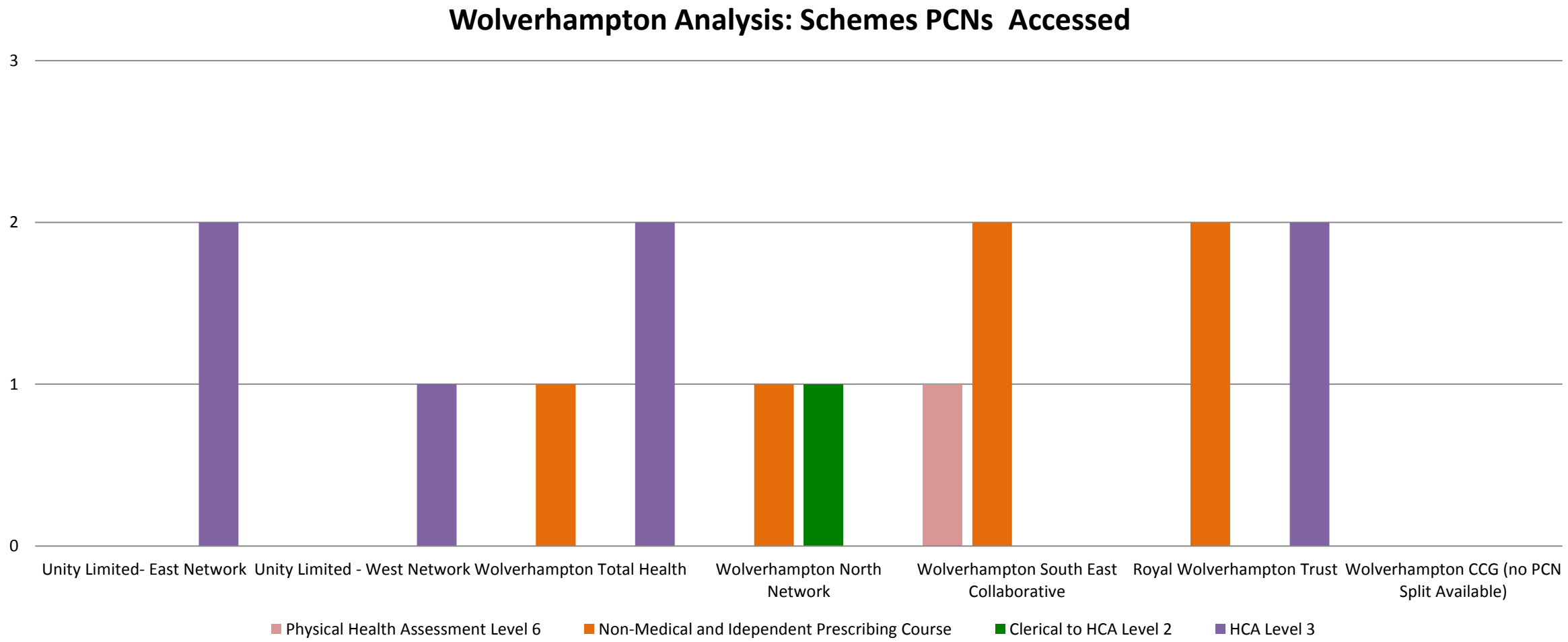
1 The staff numbers allocated are:

- Wolverhampton – 7
- Walsall – 12
- Dudley - 9
- Sandwell and West Birmingham - 3

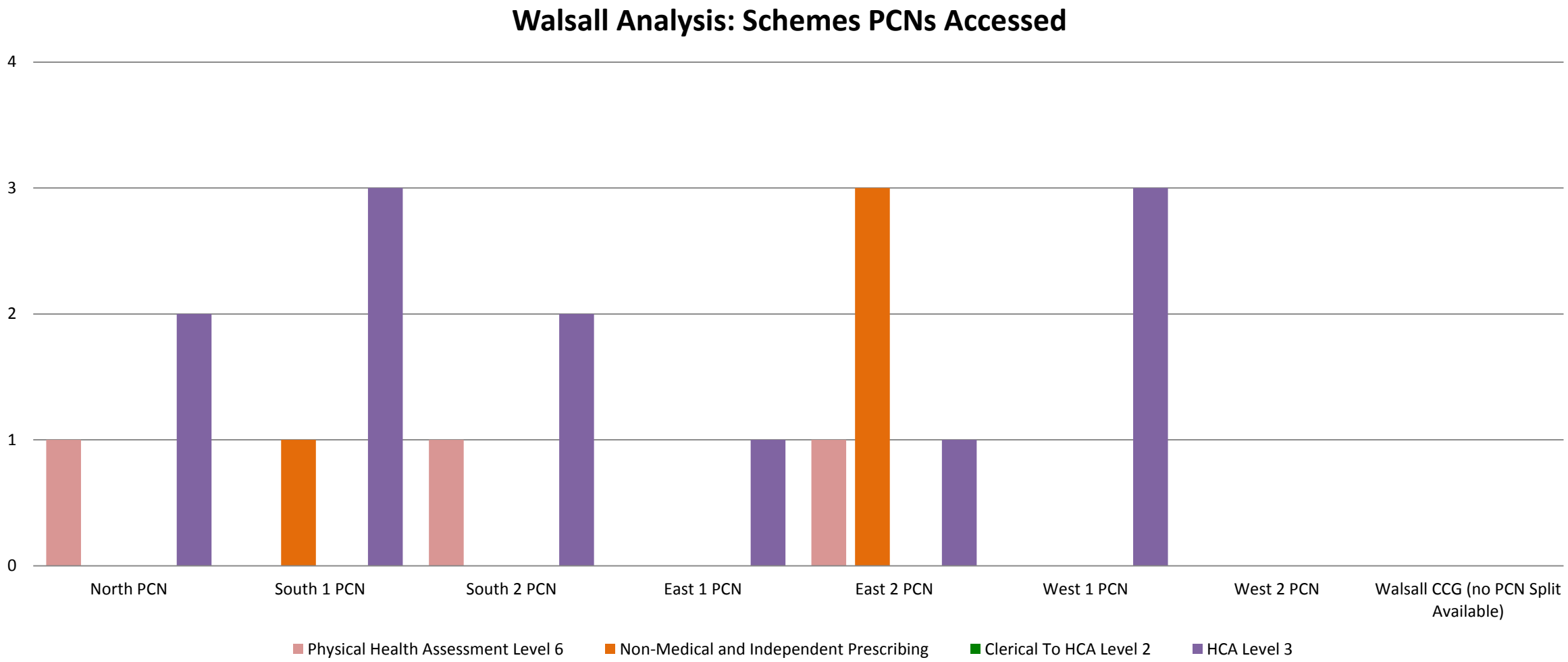
2 The split by CCG can be found below;



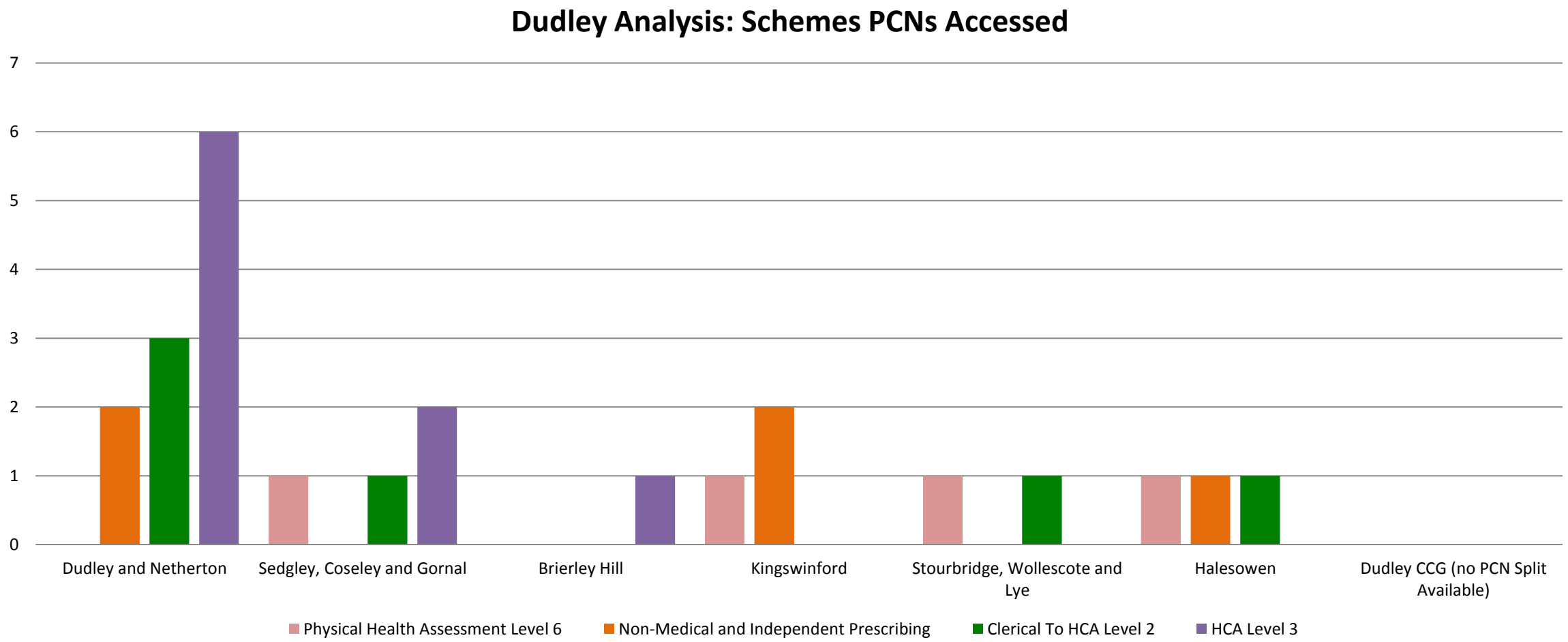
PCN Analysis - Wolverhampton



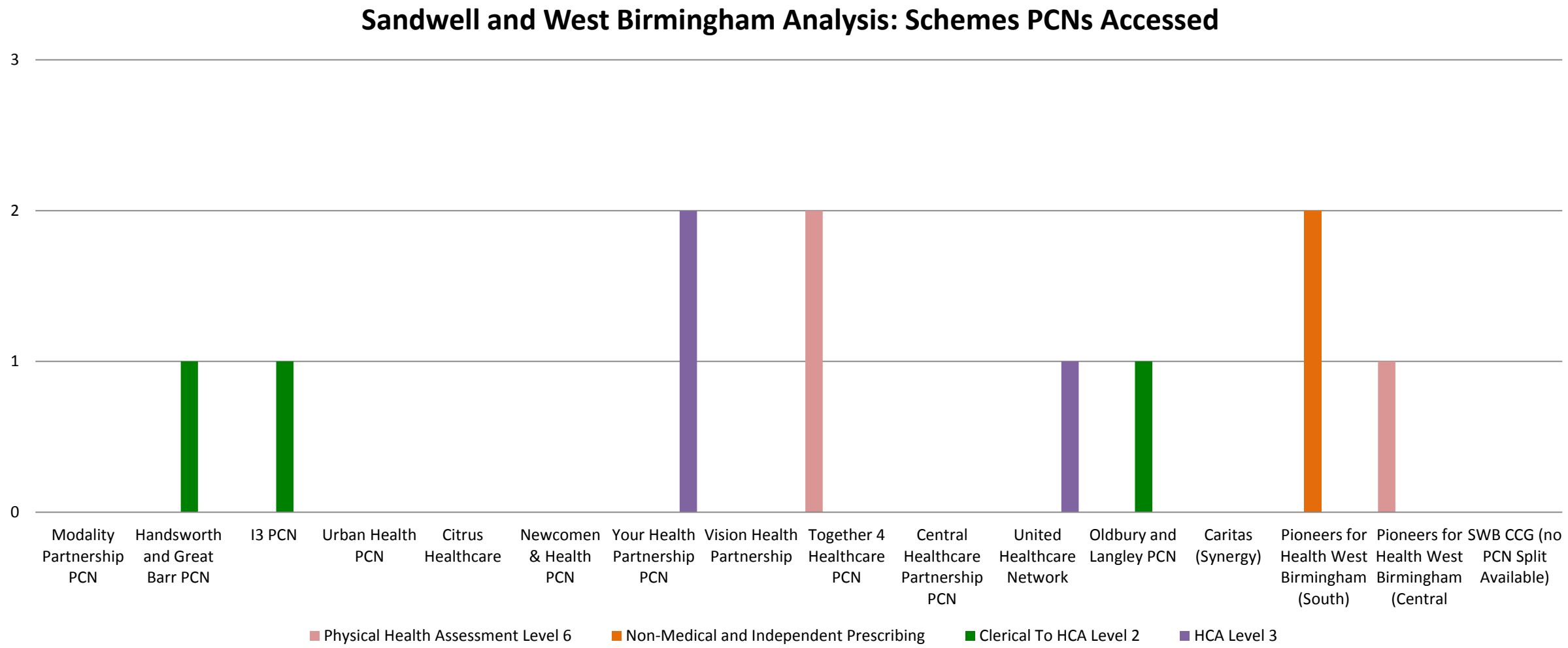
PCN Analysis - Walsall



PCN Analysis - Dudley



PCN Analysis – Sandwell and West Birmingham



Working together for healthier futures

Primary Care Operational Group (PCOG) Assurance Report

NHS Dudley Clinical Commissioning Group
NHS Sandwell and West Birmingham Clinical Commissioning Group
NHS Walsall Clinical Commissioning Group
NHS Wolverhampton Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEES IN COMMON

DATE OF MEETING: Tuesday 23rd June 2020

AGENDA ITEM: 7.5

Title of Report:	Primary Care Operational Group (PCOG) Assurance Report
Purpose of Report:	To provide assurance on Primary Issues to PCCCic
Author of Report:	Jane McGrandles, Carol Marston, Julie Robinson, Gill Shelley
Management Lead/Signed off by:	Sarah Southall/Donna Macarthur
Public or Private:	Public
Key Points:	Assurance on primary care issues provided from notes of Primary Care Operational Group Meetings from: 1.Dudley CCG 2. Sandwell and West Birmingham CCG 3. Walsall CCG 4.Wolverhampton CCG
Recommendation:	The Primary Care Commissioning Committees accept the paper as assurance on primary care issues.
Conflicts of Interest:	N/A
Links to Corporate Objectives:	
Action Required:	☐ Assurance
Implications:	
Financial	N/A
Assurance Framework	N/A
Risks and Legal Obligations	N/A
Equality & Diversity	N/A
Other	N/A

Primary Care Operation Group (PCOG) Assurance Report

1. Introduction

1.1 Each of the BCWB CCGs has a Primary Care Operational Group; these have been stood down in all areas during Covid-19 but are now being restored with the first meetings taking place in either May or June.

1.2 A review of each of the CCGs' PCOG terms of reference has been undertaken and a standardised document produced for agreement by the Primary Care Commissioning Committees. Once agreed and implemented this will support a consistent approach and generic reporting going forward.

1.3 Each of the BCWB CCGs completed a rolling programme of GP contract visits on 31 March 2020 and work was underway in each area to develop a new 3-year rolling programme from 1 April 2020 which was stood down in response to Covid-19. This work will be restored with a view to agreeing a rolling-3 year programme of deep-dive practice visits, prioritised by practices who have approached review or approaching review. If new information becomes available to the CCG which suggests high levels of variation, a visit may be required and the contract reviewing further.

1.4 A standardised approach to contract management will be agreed with the LMC and implemented across BCWB CCGs to assure the quality, safety and performance of each GP practice. The new approach will build upon individual CCG processes already in place. A transparent and consistent suite of measures, in conjunction with robust, fair and consistent guidance for the management of service and performance improvement, will help to ensure risks to quality and patient safety are addressed in a timely and proportionate manner.

2. Contract Variations

Dudley CCG

ODS Code	Practice Name	Contract Variation	Effective Date
M87024	Wychbury Medical Group	Removal of 2 partners	13 May 2020
M83041	Moss Grove Surgery, Kinver	Transfer from South Staffordshire & Seisdon Peninsular CCG to Dudley CCG	1 April 2020
Y02653	High Oak Surgery	Temporary relocation to Brierley Hill Health & Social Care Centre to provide for Red Centre site	31 March 2020

Sandwell & West Birmingham CCG

ODS Code	Practice Name	Contract Variation	Effective Date
M85176	Kirpal Medical Practice	Addition of: Two non clinical partners	2 March 2020
M85697	Church Road Surgery	Departure of: GP Partner	1 April 2020
M88004	Regis Medical Centre	Departure of: GP Partner	1 April 2020
M88639	Dr Pathak ND, Primary Care Centre	Addition of: 1 GP partner and 2 non clinical partners	1 May 2020
M88639	Dr Pathak ND, Primary Care Centre	Departure of: 1 GP partner	4 May 2020
M88639	Dr Pathak ND, Primary Care Centre	Departure of: 1 GP Partner	31 May 2020
M88616	Great Bridge Health Centre	Contract merger with M88629 Hill Top Medical Practice	1 June 2020
M85164	Newport Medical Group	Contract merger with M85085 Ann Jones Family Health Centre	1 June 2020
PCN DES	Caritas PCN	New Clinical Director	1 April 2020
PCN DES	Oldbury and Smethwick PCN	Change of Name: Formerly Oldbury and Langley PCN	1 April 2020
PCN DES	People's Health Partnership PCN	Change of Name: Formerly Pioneers for Health – West Birmingham (Central)	1 April 2020

Walsall CCG

ODS Code	Practice Name	Contract Variation	Effective Date
M91017	Northgate	Removal of partner	1 April 2020
M91017	Northgate	Addition of partner	1 April 2020

Wolverhampton CCG

ODS Code	Practice Name	Contract Variation	Effective Date
M92011	Penn Manor Medical Centre	Removal from contract	1 January 2020
M92040	Mayfield Medical Practice	Removal from contract	31 March 2020
M92044	Warstones Medical Practice	Removal from contract	31/03/2020
M920044	Warstones Medical Practice	Addition to contract	01/04/2020
M92042	West Park Surgery	Removal from contract	31/03/2020
M92042	West Park Surgery	Addition to contract	01/04/2020
M92011	Penn Manor Medical Centre	Addition to contract	01/04/2020

3. Dudley- PCOG Assurance

3.1 Dudley CCG – PCOG meeting of 3 June 2020

3.1.1 Primary Care Commissioning Committee Briefings

PCOG received copies of briefing notes that had been provided to voting members of Dudley PCCC in April and May. The briefings contained the Dudley incident room decision log relating to Primary Care and also included:

- Establishment of a red centre at Pensnett and temporary relocation of High Oak Surgery to provide alternative premises
- Changes to the GP Contract
- PCN DES for 20/21
- COVID-19 financial arrangements
- Daily sitrep of primary care undertaken
- Update on personal Protective Equipment
- Enhanced Health in Care Homes framework - key elements bought forward, lead for each care home, funded through existing Care Home LIS monies, weekly sitrep to NHSE
- Online consultation options
- Process for continuation of the commissioning of existing Local Improvement Scheme.

3.1.2 Contracting

Contract monitoring 2019/20

The outcome of the Primary Medical Services contract monitoring process for 2019/20 was presented to the group in a detailed report and PCOG was assured of compliance. In summary:

- All 43 practices have now received a face to face contract monitoring visit under a 3 year rolling programme.
- As agreed by Committee, remote monitoring was undertaken for all 43 practices and included:
    - Cold chain process including policies and procedure compliance with PHE guidelines – 1 practice rated red due to cold chain breakdown – since resolved with instruction from PHE
    - Use of Blue Stream Training – 43 practices continue to utilise;
    - CAS alert registration – 43 practices registered within deadline;
    - Practice leaflet – 9 required no changes – 34 required minor changes (generally changes to workforce);
    - Core opening hours verified; and
    - eDeclaration of compliance against core contractual requirements – 43 practices completed by the deadline, responses scrutinised.

Primary Care Network DES (PCN DES)

Participation forms received from the 6 existing PCNs.
As in 2019/20, there are 2 practices who will not participate in the PCN DES, Central Clinic and Meadowbrook Surgery. Their registered patients receive DES services under a LIS arrangement with the 'host' PCN. We are therefore able to confirm that there is 100% geographical coverage

Changes to the existing PCNs include:

- Kingswinford & Wordsley PCN now includes Moss Grove Kinver as a result of the transfer to Dudley CCG from South Staffs & Seisdon Peninsular CCG
- Stourbridge, Wollescote & Lye PCN - change of Clinical Director to Rachael Thornton

Primary Care Commissioning

Dudley Quality Outcomes for Health (DQOFH) achievement

The Dudley Quality Outcomes for Health Framework achievement for 2019/20 was discussed, and the group received assurance that the process for validating achievement had been undertaken. Access standards (contacts per thousand population per week) had been achieved by all but three practices, which will be required to submit further evidence for assurance. The CCG average achievement for all indicators was 68.61% (practice range 43.47% – 82.55%), it was noted that there was significant variation between practices and this would be further investigated.

(DQOFH) review

PCOG received an update on the work undertaken to review the DQOFH for 2020/21, in particular, work has been undertaken to review and agree the indicators in light of COVID-19 and the framework will be re-launched from 1st July. This work has been shared with the other CCG Primary Care leads and will inform the primary care restoration plan and the work being undertaken to review commissioning frameworks across BCWB CCGs.

Extended Access

The CCG has updated the extended access specification for 2020/21 and to reflect changes as a consequence of COVID -19. This has included the flexibility to move activity over 7 days to include the weekend if required.

Following consultation with the PCN Clinical Directors there is agreement to move from contracting with the existing five lead practice arrangement to contract on a six PCN footprint for 2020/21 and LIS contracts have been drawn up as per NHSE guidance. Five contracts are signed and the final PCN will confirm its participation by 30 June 2020. Costs are within the existing budget.

3.1.3 NHS England Standard Operating Procedure for General Practice

PCOG received assurance that the requirements related to the NHS England Standard Operating Procedure had been followed by all practices for example;

- All practices operating remote triage
- All practices have provided assurance that all shielded patients have been identified and contacted, with regular review
- Each care home has now been aligned to a single PCN and a lead GP has been identified
- Weekly care home sitrep data is being submitted and confirms that support is being provided to care homes

PCOG noted that Version 3 of the SOP was release on 1 June 2020 and focusses on restoration of routine chronic condition management and prevention, including vaccination and immunisation, contraception and health checks. The SOP has been distributed to practices and initial discussions have been held regarding the detail through the weekly PCN/CCG COVID-19 meeting

3.1.4 Primary Care Quality & Safety

PCOG received the primary care quality and safety matters that are set out in detail in the quality and safety report to Committee. The group was assured by the report, discussions included:

- Two CQC reports recently published. One practice moved from overall requires improvement to overall good and the other from overall good to overall requires improvement

- Support is being provided to two practices with their CQC action planning.
- CQC have introduced the Emergency Support Framework (ESF) to ensure oversight of providers during the pandemic and to understand the impact of Covid-19 on patients, staff and services
- The Q&S team have implemented a system to enable Covid-19 incidents to be monitored and appropriately escalated
- Improving immunisation uptake remains a focus of the Q&S team
    - The immunisation dashboard is being distributed monthly for practices to review immunisation uptake at a practice and PCN level
    - The GP flu questionnaire has been launched to support practices to plan for the upcoming flu season and provide the CCG with assurance.

3.2 Sandwell & West Birmingham CCG – PCOG meeting of 9 June 2020

3.2.1 NHS England Standard Operating Procedure

PCOG Members were updated regarding the content of the latest version the SOP for Primary Care and received assurance that:

- Appropriate Green, Amber and Red Site arrangements were in place within each PCN and that practices had adopted the total triage model.
- Shielded patient guidelines had been followed including contact with these patients and having appropriate processes in place for all cohorts of patients.
- All Care Homes had been allocated to PCNs and leads had been assigned to Care Homes. A Care Home LIS would be in place covering retrospectively from May 2020 until the launch of the Enhanced Care Home DES.

3.2.2 Primary Care Networks

PCOG members received assurance that all practices had signed up to the PCN DES. New configurations were now confirmed to be in place with a total of 12 networks (8 in Sandwell and 4 in West Birmingham). Further work was being conducted with PCNs around Roles Reimbursements and further updates would be offered moving forward.

3.2.3 PCCF 2019/20 End of Year Outcomes

PCOG were updated in relation to the outcome of the extraordinary PCCC meeting held on 21st May. Using the agreed process following suspension of the PCCF from 19th March; 72 practices had been paid based on 18/19 achievement and 8 based on their 19/20. Medicines Management payments would be subject to adjustment once appropriate national data and as a new standard, all Dementia Standard related payments would be based on 2019/20 performance.

3.2.4 PCCF 2020/21

PCOG were informed that the PCCF document previously approved by PCCC in March was currently under review given the nature of the ongoing COVID response. PCOG were assured that the late draft version of the document had been circulated to appropriate stakeholders for their review and feedback prior to submission to PCCC for decision.

3.2.5 Extended Access

PCOG members received details of the changes to extended access provision for 2020/21 from 1st April and were assured that 100% coverage was provided.

3.2.6 Quality and Safety Update

Shelly Price was welcomed as the new lead nurse for quality and safety. PCOG were notified of the extension of support commissioned for four practices with their CQC action plans. The team were set to continue working on a number of priorities including improved Infection Prevention support to practices and development of a quality database utilising Power BI.

3.2.7 Risk Register Review

PCOG members reviewed the Primary Care Risk Register to agree updates and recommendations.

3.2.8 Special Allocation Scheme

PCOG were assured that the Special Allocation Scheme for Birmingham patients which had been due to expire had been extended until 30th September 2020. Further work was underway to establish the next steps with a potential for the contract to be extended until the end of the financial year.

3.2.9 Summerfield Group APMS Contract

Given the contract had been set to expire on 31st March 2021 and that a suitable tender process within the current timeframe and climate was not deemed possible that this contract had been extended with the current provider until 31st March 2022.

3.2.10 Practice Mergers as of 1st June 2020

It was confirmed that previously agreed mergers of Hill Top Medical Centre (M88629) into Great Bridge Partnership for Health (M88616) and Ann Jones (M85085) into Newport Medical Practice (M85164) had come into effect.

3.2.11 Premises Review Panel Recommendations

PCOG were informed that the most recent Premises Review Panel had been held and would be sharing its recommendations with the PCCC for:

- Closure of the Central Clinic branch site of Linkway Medical Centre (M88038.

3.2.12 NHS Mail Breach

PCOG were assured that a recent NHS Mail breach experienced by a SWBCCG practice was being investigated by the national team with similar issues having been experienced in isolated sites across the country.

3.2.13 Redcentric Telephone System

Expressions of interest from the 25% of practices not using the system to explore possible further roll out.

3.3 Walsall CCG – PCOG meeting of 19 May 2020

3.3.1 Network Contract DES 2020/21

The PCN DES has been offered to all GP practices in Walsall: at 19 May 2020 only 6 out of 52 practice had accepted. Since the 19 May PCOG meeting all 52 GP practices have signed up with no change to the existing 7 PCN configuration.

A Covid Care Home services has been put in place until the PCN Enhanced Healthcare in Care Home (EHCH) arrangements commence on 1 October 2020. Care Homes and the Local Resilience Forum have been notified of the named clinical lead. PCOG has requested involvement in the PCN Enhanced Healthcare in Care Home specification development.

PCOG has requested a PCN update report on the Additional Roles recruitment plan for the next meeting.

3.3.2 Primary Care COVID-19 Response

Patient Concerns: NHS England has put a 3 month delay on responding to complaints during Covid. A number of patient concerns have been received during this time which have been addressed.

PCOG received assurance on the Primary Care Covid response to sickness/self-isolation reporting to the STP and Incident Room and stability of GP practices in Walsall during Covid.

PCOG received assurance on the operation of green, amber and red site for Walsall.

PCOG received assurance NHS111 direct bookable/CCAS nominal slots had been increased to 1 appointment per 1000 patients rather than the contractual 1 per 3000 and practices would monitor demand to ensure appropriate use of resources.

PCOG received an update on the extended access service assurance process and changes made to the service in response to COVID-19. Outstanding assurance elements have been complicated by Covid-19, it is intended that these assurance actions will be picked up in June. There had been changes to the operating model which are being discussed.

Work has been undertaken to establish Covid pay protection arrangements for locally commissioned services: outcome is awaiting approval.

3.3.3 GP Contract

Management support to Blackwood surgery ended on 31 March 2020. Merger discussions have not progressed and the provider remains a single hander.

QOF 2019/20 Practice achievement data is now available: work is in progress to review achievement against 2018/19 and agreed pay protection arrangements.

PCOG received an update on the 2020/21 LCS including proposed changes to the Primary Care Offer. There were issues with Primary Care Facilitator support which have been escalated.

PCOG received assurance that benchmarked vaccination and immunisation data had been shared with all GP practices. Agreement was given to contact those practices below the CCG average to establish what improvement plans had been put in place and how the CCG/LMC could provide support with improving uptake.

3.3.4 Quality Update

PCOG received an update from the quality team that many areas of work had been put on hold during Covid due to covering care home swabbing which were now being restored.

3.3.5 CQC Update

The CQC has stood down practice visits and annual regulatory review calls during Covid and introduced an emergency support framework that will look at four key areas which are supportive rather than regulative, starting with high risk practices.

3.4 Wolverhampton CCG – PCOG meeting of 3 June 2020

3.4.1 Network DES

The CCG has received sign up to the Network DES from all 6 PCN's (38 practices) with no changes from the previous year.

3.4.2 Primary Medical Services: Contract Reviews

This is a 3 year programme of practice contract reviews. Practices are reviewed at least once during a 3 year period and a selection of contractual and quality indicators reviewed in depth to support triangulation of the practice e-declaration.

A new programme will commence 2020/21 TEAMs will be used to engage with practices following a table top review.

3.4.3 Quality and Outcomes Framework (QOF)

QOF 2019/20

This is currently being signed off with reviews taking place of those practices that have experienced a shortfall of points from year 18/19 QOF.

QOF 2020/21

NHS E & I contracting team are managing the practice sign up on behalf of the CCG.

3.4.4 Local Quality and Outcomes Framework (QOF +)

QOF+ 2019/20

Statements have been sent out to all practices and payments in the process of being made

QOF + 2020/21

This scheme is on hold currently as there are issues around the searches which need to be rebuilt.

3.4.5 Primary Care In Reach Local Enhanced Service (PITS)

This service provides an enhanced primary care in reach (Pro Active) service to patients living in Residential Homes. As the Enhanced Health in Care Homes service commences operationally 1st October 2020 the PITs service will no longer be required and are being given 3 months notice as per the terms of the specification.

3.4.6 Special Access Scheme (SAS) enhanced service 2020/21

The special access scheme provides services for those excluded from main stream general practice usually due to the patient's violent and aggressive behaviour.

The scheme has been place with one practice that has agreed to continue to provide the service under the same terms as 2019/20

3.4.7 Out of Area Enhanced Service

There has been no activity into this service. The current provider will continue to provide this service.

3.4.8 Primary Care (PC) Counselling Service

The PC Counselling service is contracted to provide services until March 2021. Due to remodelling of BCPFT, services are now delivered within the PCN structure, and can support patients within the community. This will result in a decline in need for the PC Counselling services as a separate service, as a collaborative single service is now in place. Therefore, we will not be looking to extend or renew the PC Counselling service contract with the current provider, Relate. The provider is aware of this intention, and has worked with the CCG to produce an exit plan and identify any risks to this process through a risk assessment. Both documents were discussed at PCOG and agreed that adequate steps have been taken to mitigate any risks and impact.

3.4.9 GP Resilience Funding: Practice updates

Whitmore Reans Medical Centre

Practice Managers Association are picking up this up again with Practice and having a Teams call with the practice manager this week to agree update / deadline on actions.

One completed action to note is that the practice has brought salaries in line with national guidance as part of recruitment / retention work.

Tettenhall Medical Centre

The CCG is awaiting a decision from practice on next steps and the RCGP have contacted the practice directly.

The CCG will be looking for evidence that working action plan is in place and /or complete following the RCGP report as part of PCCC assurance.

Actions included:

- Develop 5 year business plan
- Plan to manage patient expectations
- Review of GP workload

Ashmore Park Medical Practice

Awaiting feedback from RCGP as pre COVID-19 they were finalising mentoring plan for the practice manager new in post.

Parkfields Medical Practice

Actions completed – funding was provided to support practice team with merger process with Health and Beyond partnership, which was completed at the end of November 2019.

IH Medical

Funds were initially awarded to provide mentoring and support to new Practice Manager. A local Practice Manager joined IH on a 3 month contract and as mentoring not required the funding was used to support the practice with other issues/concerns.

3.4.10 Wolverhampton CCG Red Site

Wolverhampton CCG Red Site is based at Ettingshall Medical Centre and provided by South East Network with support from the other network to provide medical services to patients with either COVID-19 symptoms or COVID-19 positive. The site is in place until the end of June 2020. A piece of work is being completed regarding this where an amendment to the Contract or close down of the contract may be needed with a view to putting something else in place. Utilisation of the RED site is now very low. It was noted that there may be a revised arrangement in each place from the beginning of July 2020.

3.4.11 Royal Wolverhampton Trust (RWT) Primary Care Network: Closed practices:

RWT closed 2 practices as a response to COVID-19: relocating these smaller practices within two larger practices. Assurance has been given by RWT PCN that the 2 practices will reopen on 29th June 2020.

3.4.12 General Medical Advice and Support Team (GMAST) 2020/21 MoU

This has been agreed and is due to be signed off by 19th June.

3.4.13 Estates / Infection Prevention Update

The Oxley hub solution Is progressing with a draft PID being finalised. GP engagement has been positive and we are now speaking to PCNs with regards to utilising potential bookable space.

Bilston Hub solution which is being driven by the council is progressing to a PID stage. A development workshop is being arranged with all the interested GP's in the Bilston area to firm up the PID before a draft version is complete.

There has been no movement on any ETTF schemes due to the COVID outbreak, hopefully a further update on progress at the GP sites In the next meeting.

Infection Prevention

Infection Prevention audits have currently been deferred due the Infection Prevention Team being deployed elsewhere due to COVID -19. RWT are addressing this as part of their restoration and recovery plan.

3.4.14 Primary Care Quality Update

A verbal update was given and the following noted:

- For May 2020 there were no Serious Incidents

- Quality Matters is working in the back ground but is not business critical
- For May 2020 there were two Primary Care reported incidents – 7 remain open from previously with 13 open in the system. MB will be completing a review of these incidents when able. The system is still working a GP reported an incident today which may be a potential SI this was sent to RWT today.
- IP audits are on hold regarding Covid-19
- Influenza Vaccines and Vaccination Programme figures are also not available.
- MRSA no incidents within Primary Care for May
- Due to Covid-19 CAS (MHRA) alerts are higher than usual – further discussion took place regarding action re these alerts.
- Complaints – NHSE has now supplied the data for the last 12 months by GP surgery level. MB discussed the details and noted that the majority were not upheld. – Communication was the main theme.