NHS
Shropshire
Clinical Commissioning Group

NHS
Telford and Wrekin
Clinical Commissioning Group

Shropshire and Telford & Wrekin CCGs Primary Care Commissioning Committee
Meetings in Common held in Public

to be held on Wednesday 2 December 2020
at 10.00 a.m. via Microsoft Teams

AGENDA – PART 1

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

Item Number	Agenda Item	Presenter	Purpose	Paper	Time
PCCC-20-12.17	Welcome and Introductions	Chair	I	Verbal	10.00
PCCC-20-12.18	Apologies	Chair	I	Verbal	10.00
PCCC-20-12.19	Members' Declaration of Interests	Chair	I	Verbal	10.05
PCCC-20-12.20	Minutes of Previous Meeting and Matters Arising:- • PCCC 7 October 2020 • Action Tracker	Chair	A	Enc.1 Enc.1A	10.10
PCCC-20-12.21	Finance Update	Claire Skidmore	I	Enc. 2	10.20
PCCC-20-12.22	Primary Care Strategy Delivery	Phil Morgan	I	Enc. 3	10.30
PCCC-20-12.23	To receive the application for Practice merger (Pontesbury/Worthen)	Steve Ellis	A	Enc. 4	10.40
PCCC-20-12.24	EDEC (Primary Care Electronic Declaration)	Corrine Ralph	A	Enc. 5	10.50
PCCC-20-12.25	Quality Outcomes Framework	Corrine Ralph		Enc. 6 To Follow	11.00
PCCC-20-12.26	Risk Register	Corrine Ralph	S	Enc. 7	11.10
PCCC-20-12.27	Any Other Business	Chair	I		11.20
PCCC-20-12.28	Date and Time of Next Meeting: Wednesday 3 February 2021 at 10.00 a.m.				

Shropshire Clinical Commissioning Group

**MINUTES OF THE PRIMARY CARE COMMISSIONING COMMITTEE (PCCC)
HELD VIA MICROSOFT TEAMS AT 10.15 A.M. ON
WEDNESDAY 7 OCTOBER 2020**

PART 1 SECTION

Present

Mr Meredith Vivian	Lay Member – Patient & Public Involvement (Deputy Chair)
Dr Julian Povey	Joint Chair, Shropshire Telford & Wrekin CCGs
Dr Andy Watts	Independent GP, Telford & Wrekin CCG
Mrs Claire Skidmore	Executive Director of Finance
Dr Colin Stanford	External GP Member
Dr Adam Pringle	GP/Healthcare Professional Governing Body Member
Mrs Zena Young	Executive Director of Quality
Mrs Nicky Wilde	Primary Care Network Programme Director
Mr Steve Trenchard	Executive Director of Transformation
Mr Steve Ellis	Head of Primary Care, Shropshire CCG
Mrs Corrine Ralph	Head of Primary Care, Telford & Wrekin CCG
Mrs Vanessa Barrett	Health Watch, Shropshire
Mr Paul Shirley	Health Watch, Telford & Wrekin

In Attendance

Mrs Donna Macarthur	Observer
Mrs Elizabeth Walker	Head of Medicines Quality & Optimisation
Mrs Andrea Harper	Head of Communications & Engagement
Ms Nicky Mott	Practice Manager, Dawley Medical Practice
Dr Hannah Bufton	Senior Partner, Dawley Medical Practice
Ms Bernadette Williams	Commissioning Manager – Primary Care
Ms Jane Sullivan	Quality Lead, Shropshire Telford & Wrekin CCGs
Mrs Chris Billingham	Personal Assistant; Minute Taker

Apologies

Apologies were received from Claire Parker, Julie Davies, Cllr. Lee Chapman and Phil Morgan.

PCCC-2020-10.01 – Welcome and Introductions

Mr Vivian welcomed everyone to the meeting.

He introduced Mrs Donna Macarthur, the newly appointed CCG Lay Member for Primary Care and incoming Chair of Primary Care Commissioning Committee who was to commence employment with the CCG on Monday 12 October 2020.

PCCC-2020-10.02 - Apologies

Apologies received were recorded as above.

PCCC-2020-10.03 - Members' Declaration of Interests

As previously declared in the Part 2 meeting, Dr Adam Pringle advised that he is a GP Partner of a Practice in Shropshire. His conflict of interest is as stated on the CCGs' website.

PCCC-2020-10.04 – Minutes of Previous Part 1 Meetings
The Minutes of the previous Part 1 meetings of the two CCGs were reviewed and approved as follows:-

- Minutes of Shropshire PCCC 5 February 2020
- Minutes of Telford & Wrekin PCCC 4 February 2020

The combined Action Tracker was reviewed and updated as appropriate.

PCCC-2020-10.05 – Terms of Reference
There were no questions or comments relating to the Terms of Reference which were noted and accepted by the Committee.

PCCC-2020-10.06 – Finance Update
Mrs Skidmore's report provided an update on the latest Primary Care financial position for both CCGs for the period ending 31 August 2020.

National funding guidance in force up to and including Month 6 provides for a retrospective allocation adjustment to force budgets to break even. The CCGs are anticipating this adjustment. For months 7 to 12, the CCG has been notified of a fixed allocation and the team are currently working through the implications of this for the forecast outturn. More information will be shared on the full year forecast position in future reports.

Early estimates are that income received will not be enough to cover forecast levels of expenditure within delegated Primary Care.

At the time of compiling her report, Mrs Skidmore awaited final confirmation of certain allocations. Forecasts are now being finalised as part of identifying the Month 6 position. The next Finance Report to PCCC will include a much more detailed report which will include a forecast outturn position and narrative around the drivers of that spend.

PCCC-2020-10.07 – Quality Report
The purpose of Ms Sullivan's report was to provide the Primary Care Commissioning Committee with current, relevant information and assurance regarding quality and safety in Primary Care.

Due to the National NHS England/Improvement Guidance regarding Covid-19, a number of measures such as the Friends and Family Test have been paused. The Primary Care Teams and Quality Lead have continued to offer remote support and have utilised sources such as Health Watch and information sharing with CQC to obtain appropriate assurances from Practices.

NHS England/Improvement has paused sharing with the CCG any information received regarding formal complaints. However, when information sharing recommences, the Committee will be updated as appropriate.

Ms Sullivan invited questions and feedback from Committee members in relation to her report.

Dr Pringle requested that future reports should contain a short narrative regarding issues and possible solutions in order to provide information regarding any concerns and what is being done to address them.

Mr Vivian asked if it is safe to assume that NHS England is handling any complaints they receive. Ms Sullivan replied that NHSE are still open to receiving complaints, but are not currently reporting back to the CCG.

However, when reporting of complaints recommences, Ms Sullivan intends to request a summary of information covering the period when no information was being received by the CCG. Mrs Young advised that NHSE/I are still communicating with the CCG in relation to any matters of particular concern.

Mr Vivian requested an update on patient experience. Mrs Young advised that she had met with both Health Watch Leads the previous day and engagement meetings had been arranged between Health Watch and the CCG going forward. Discussions had taken place in that meeting as to how the two organisations can work more closely together and triangulate information. Health Watch advise the CCG of any particular concerns, and these are then followed up by the CCG with providers.

Mrs Barrett updated the meeting with key points relating to Health Watch Shropshire activity as follows:-

- The discharge survey is ongoing and will be continued until the end of October.
- A Palliative Care Out of Hours survey is also being carried out which will continue until the end of October. Details of the survey can be accessed on the Health Watch website.
- Information and feedback received relating to telephone, video and on-line appointments is being collated into a report.
- It has been suggested that Health Watch Shropshire should host a system wide survey on out-patient appointments. There has been an indication that GP referrals over the last few months have not been accepted by Trusts and have been bounced back with the expectation that GPs will re-refer. In particular, Health Watch has been advised that the Mental Health Foundation Trust has ceased accepting referrals. It would be extremely helpful to hear from GPs whether problems do exist in this area.

Dr Watts believed that the CCG should acknowledge that, in the context of Covid, providing General Practice at the moment is extremely difficult. Meeting the levels of quality that a Practice would normally expect to achieve is virtually impossible.

Mrs Ralph had been leading the Restore work for Primary Care across the system. Whilst the system had supported Primary Care services restarting, it was known that from a QAF perspective there was a backlog of patients who had missed all of their reviews. There was also emerging evidence about the link with deprivation and health inequalities with QAF. As a result, Mrs Ralph had been reviewing some of the QAF indicators and trying to identify how they can be used to guide Practices as to where to prioritise their efforts to have the maximum benefit to patient outcomes. Discussions have taken place with Lead GPs on this work and they are supportive. The work is not yet complete.

Mrs Sullivan confirmed that the Quality team would support Mrs Ralph's work to improve patient outcomes. Dr Watts confirmed that he, too, was happy to provide any support that Mrs Ralph may require.

Mr Shirley provided an update from Health Watch Telford & Wrekin as follows:-

- The Palliative Care Out of Hours survey referred to by Mrs Barrett was a joint venture by both Health Watch organisations.
- Health Watch Telford & Wrekin has also conducted a piece of work around GP telephone lines. A report on common issues is currently being prepared.
- A piece of work has been carried out around dental services in Telford & Wrekin and a considerable amount of feedback has been received around the lack of dental practices who are accepting NHS patients, lack of communication generally, and issues around appointments.
- Enter and View has been restricted due to Health Watch being unable to go into services as a result of Covid. Face to face feedback has also been affected and reliance is being placed on social media and electronic feedback.

PCCC-2020-10.08 – Primary Care Network Report

Mrs Wilde's report, which was the first more detailed report to Primary Care Commissioning Committee regarding PCNs, was taken as read.

The report outlined some changes within the networks and indicated what they are commissioned to deliver, and an update on each area. The areas for delivery from 1 October 2020 are:-

- Structured medication reviews
- Enhanced Health in Care Homes
- Early cancer diagnosis
- Social prescribing
- Domains in the investment and impact fund around the uptake of flu vaccinations, learning disability annual checks, and medical safety indicators

Mrs Wilde drew the attention of the Committee to the work around enhanced health in Care Homes which has been a priority area due to Covid. The PCNs are very well integrated with the Care Sector Group which is a STP group addressing Care Home issues and are also working very closely with the Care Home Commissioners. Further improvements have been identified around collaborative working with colleagues across community care.

Under the Additional Roles Reimbursement Scheme, PCNs have indicated their commitment to recruit an additional 75 roles to their networks. The CCG is underspent on its allocation for the Scheme, and Mrs Wilde is currently working with providers to establish whether anything further can be done, linking in with Community Trust, Mental Health Trust and SaTH. It is proposed to implement some shorter term winter projects to support that work.

Mrs Wilde is also considering how the PCNs integrate with other work programmes such as the Shropshire Care Closer to Home programme and the Telford & Wrekin Integrated Care programme.

Mrs Wilde invited questions.

Dr Stanford requested clarification of the numbers of Care Homes in Shropshire stated within the report which appeared to be overly large. Mrs Wilde confirmed that for the purposes of her report, Care Homes were interpreted as residential homes, nursing homes and learning disability homes across the County which was why the list is larger than expected. The CCG has confirmed with the Local Authorities that all organisations are working to the same list.

Dr Pringle referred to quality monitoring, particularly to patients of Practices who are having their services delivered by an external provider who is not in a PCN as there is a risk that those populations are neglected.

Mrs Wilde replied that two PCNs are delivering services for patients of Practices who have decided this year to opt out – Wrekin PCN and North Shropshire PCN. Service provision is for all of those patients whether they are registered with the core Practices or not.

Committee members confirmed that a PCN report should be submitted to each formal bi-monthly PCCC. Mrs Wilde confirmed that she will submit an update report to the December Committee.

ACTION: Mrs Wilde to submit a PCN Update report to the December Committee.

PCCC-2020-10.09 – Pharmacy Workforce Model

Mrs Walker provided a brief background to her report, advising that some time ago, one of the priorities for Pharmacy was workforce issues and challenges across the entire STP system. Issues exist across Shropshire with recruitment and retention of pharmacy technicians in all sectors. The majority of pharmacy graduates currently are female and members of BAME communities which are not particularly widespread in Shropshire.

PCNs are also trying to recruit Pharmacists, with varied success.

The CCG is now considering how to work together to create an integrated pharmacy workforce. It is hoped that PCNs will be part of that as they will be key to delivering medicines optimisation and improving safety and quality of care in prescribing for patients in Primary Care.

Mrs Walker invited questions.

Discussion took place regarding the risks attached to employing staff and the level of funding that PCNs would receive. The Committee agreed that the CCG should not be the long term employer as it moves towards being a single strategic commissioner. However, there may be a need to make a decision in the short term as to whether the CCG is prepared to employ shared CCG posts while work is done on a long term model. Ultimately, the long term employer for the pharmacy workforce should be one of the providers, the ICP, or one of the system partners, not the CCG.

Dr Stanford expressed his support of the use of Pharmacists more widely. However, he believed that the Committee needed to understand the aims and objectives for increasing the number of Pharmacists in the Primary Care workforce. It must be clear to Pharmacists exactly what their role would be, but this was not articulated in Mrs Walker's paper.

Mrs Walker replied that the use of Pharmacists in PCNs and Primary Care is a national directive and is focused upon PCNs developing direct enhanced services. The first to be rolled out are the structured medication review and Care Homes, both of which have key roles for Pharmacists as they are very focused around medicine safety.

The Committee discussed the difference between the pharmacy workforce in General Practice, the pharmacy workforce in PCNs for which there are specific requirements, and the wider pharmacy workforce such as community pharmacists.

Mrs Wilde was unsure whether PCCC had the delegated authority to approve a joint working model or agree CCG overall workforce changes.

ACTION: Mrs Walker to review the issues, questions and feedback raised by the Committee around Pharmacy workforce and provide an update to a future Committee.

PCCC-2020-10.10 – Primary Care Strategy Delivery

Mr Ellis delivered the update on Primary Care Strategy in Mr Morgan's absence and highlighted advances made, particularly in technology and digital areas of the service. As a result of Covid, considerable progress has been made in the past six months on e-consultations and video consultations.

Both CCGs' returns have been submitted to Audit Committee. Both received significant assurance for their audit of delegated functions.

The strategy must now be updated, which will take a considerable amount of time to achieve.

PCCC-2020-10.11 – Court Street Boundary Change

This item was deferred to the next meeting.

PCCC-2020-10.12 – Shropcom Business Case: Dawley

Nicki Mott, Practice Manager, and Dr Hannah Bufton, Senior Partner at Dawley Medical Practice, joined the meeting via Microsoft Teams.

Dr Bufton referred to the many changes that had taken place at Dawley in recent years, including an increase in the numbers of staff and severe issues with space, both for staff and for the provision of additional services such as aneurism screening, diabetes services, etc.

Dawley Medical Practice has three rooms located on the first floor of the premises that are not currently in GMS use. The space was formerly occupied by the Community Trust, who vacated it in March 2020. The Practice is in desperate need of this additional space – especially considering the amount of housing development taking place within the Practice boundary – and the proposals for its future use are the subject of this paper. Primary Care Commissioning Committee is asked to consider the paper and approve the additional rent reimbursement.

Mrs Ralph confirmed that Dawley has done a huge amount of work to improve its ability to cope with demand from their patients. It has become apparent that space is preventing them from delivering the services they would wish to. A considerable amount of work has been done by the Practice to reduce emergency admissions that go from Practice into SaTH, and they were one of the Practices last year that did the most significant amount of work with managing their complex patients and their case management approach. Mrs Ralph believed that with greater capacity they would be able to continue to carry out this work and continue to maintain and manage those patients more effectively in Primary Care.

Mrs Skidmore was of the opinion that the additional rent was not a huge sum and stated that she would expect Primary Care colleagues to manage that in the totality of the budget.

Mr Vivian requested that this should be considered by the Committee in a separate forum and a decision given to Dr Bufton as soon as possible.

Dr Watts expressed his support for the proposal, which seemed a cost effective way to resolve the issues at Dawley. However, he would have preferred to see a comparator within the report, e.g. clinical rooms per head of population across the system to put into context how many clinical rooms Dawley has compared to other sites.

The Committee agreed that Dawley should be placed on the Agenda of the Extra-Ordinary Committee meeting being organised for November.

ACTION: Mr Ellis and Mr Morgan to incorporate a comparator into the Dawley Business Case as requested by Dr Watts in order to compare facilities at Dawley with those at other sites.

Mr Ellis to ensure that Dawley is placed on the Agenda of the Extra-Ordinary Committee meeting in November in order to clarify the points raised by the October Committee.

Mr Ellis to invite a representative from Dawley Medical Practice to attend the November meeting.

PCCC-20-10.13 – GP Patient Survey

Mr Vivian requested that more detailed information should be contained within the Executive Summary, highlighting strengths, weaknesses, etc. He then invited questions from the Committee.

Mrs Wilde observed that some of the information contained within the survey should be triangulated with some of the previous papers; for example, the patient access issues outlined in the Patient Survey report. It was clear that there were access issues for patients at Dawley and she believed that it would be useful to refer to the Patient Survey in order to inform other decisions being taken by the Committee.

ACTION: Mr Ellis to advise the Primary Care team of Mr Vivian's request for more detailed information to be included in the Executive Summary of any report going forward.

Dr Povey left the meeting at 11.46 a.m.

PCCC-20-10.14 – Risk Register

Mrs Ralph advised that the risk scoring methods across the two CCGs were very different, therefore it had not been possible to carry out detailed analysis or updates of the individual risks. However, she had identified shared risks that were applicable to both CCGs. Many of the elements had changed significantly since Covid and a more detailed piece of work was required in advance of the next meeting to facilitate more effective reporting.

The issue of retention of GPs and Advanced Nurse Practitioners (ANPs) was identified on both Risk Registers and this element has now been placed on the shared document.

In terms of Risk No. 4 in Telford & Wrekin, the issue around targets contained within the investment and evolution GP framework and the elements contained in that risk has now been superseded. The Strategy Report indicates that good progress is being made and the risk should not be maintained.

The issue relating to delivery of extended hours by several Practices in Telford is a PCN development issue rather than a workforce issue and Mrs Ralph suggested that this risk should also be removed.

In terms of the Shropshire risks, most of them are still relatively current and should remain on the Risk Register until work has been carried out to align them to objectives to ensure that a consistent frame work is in place.

Dr Watts commented on the fact that the Risk Register did not refer to Covid, which was the biggest risk seen by General Practice in a generation and presented a substantial threat to business continuity.

Mrs Ralph advised that another Risk Register was in place which was managed through the Primary Care Restore/Recovery Covid work that is separate to the PCCC Risk Register which manages delegated responsibilities. Mrs Ralph will visit this Register to establish whether there are any risks on that Register which are more appropriate to being aligned to the PCCC and the delegated function and leave the other Risk Register to refer to some of the more operational challenges.

ACTION: Mrs Ralph to review and align the PCCC Risk Register and the Restore/Recovery Risk Registers as appropriate in relation to the risk posed by Covid.

The Committee approved the recommendations made by Mrs Ralph relating to the Risk Registers.

PCCC-20-10.15 – Any Other Business

Mr Ellis referred to issues relating to estates which had led to Dodington handing their contracts back. There has been an ongoing need for a new estate in Whitchurch which has been delayed mainly by the planning process and a Judicial Review which is being heard next week. As a result, Dodington have handed their contract back and have resigned their partnership as of 31 March 2021.

The CCG is currently working through the options available and is working with Churchmere, the other major Practice in that area which currently covers Whitchurch. A communication was released in order to update patients and advise them that the CCG is reviewing plans to address the issue. The Locality Manager responsible for this area on behalf of the CCG is leading on this work and is in contact with NHS England colleagues in the Midlands region to ensure that all processes followed by the CCG are correct.

An options appraisal will be compiled which will be submitted to the Extra Ordinary meeting in November.

PCCC2-2020-10.16 – Date and Time of Next Meeting

An Extra-Ordinary meeting will be held on Wednesday 4 November 2020 at 9.30 a.m. via Microsoft Teams.

The next formal Primary Care Commissioning Committee will be held on Wednesday 2 December 2020 via Microsoft Teams.

Shropshire CCG Primary Care Committee Action Tracker
Part 1 Meeting – 7 October 2020

Agenda Item	Action Required	By Whom	By When	Date Completed
PCCC-2019-10.075	**Estates Strategy** Mr Brettell to:- - Amend Point 5 of the recommendations to specifically reflect the Committee's wish to receive assurance that the financial position is fully addressed in the modelling of the Estates Strategy. - Amend Point 5 of the recommendations to provide an improved explanation of the proposed delivery plan. - Include reference to proposed large scale developments within the Strategy and their potential impact on GP Practices, and incorporate all other minor amendments suggested by the Committee into his revised report.	Mr Brettell Mr Brettell Mr Brettell	February	Work is ongoing on the Estates Strategy to complete these actions. Specifically two key pieces of work have now been commissioned- a detailed utilisation study, and a data dashboard. Both of these are part of regional and national pieces of work and will enable the completion of the actions. **An update paper will be presented to December 2020 PCCC**.
PCCC-2019-10.076	**Primary Care Strategy Delivery & Progress Report** Mr Morgan to include information relating to health inequalities and risk mitigation in future reports.	Mr Morgan		**October 2020 Update:** A new report will be discussed at today's Committee.
PCCC-2019-10.079	Mrs Skidmore to feed back to Joint Exec Team details of the discussion regarding shared reports and alignment of reporting format.	Mrs Skidmore		Ongoing
PCCC-2019-10.084	**Broseley Medical Practice – Additional Space** Mr Brettell to bring to the December PCCC:-	Mr Brettell		

	A report by the District Valuer regarding Broseley Medical Practice, plus an internal CCG evaluation of the Cost Benefit Analysis to enable the Committee to make a decision. A more detailed report and updated Practice Plan including recommendations and a clearer risk assessment. Mr Brettell to be mindful of the correct format for any lease agreement which is to be submitted to the District Valuer.			Following discussion with NHSE it has been confirmed that the DV will not be able to complete the work in time for the December meeting and as such the report/ actions will be brought to the February PCCC meeting. This has been communicated with the Practice. **An update is provided to Committee in Part 2 Oct 2020.**
PCCC-2019-12.097	**Medicines Management Strategy Progress Delivery Report** Mrs Walker to report spend on dressings to PCCC on a monthly basis.	Mrs Walker	February	**October 2020 Update**: Mr Ellis and Mrs Walker to pick up.
PCCC-2020-2.005	**Estates Strategy Update** Mr Brettell to present the STP Primary Care Estates Strategy to the June Committee meeting.	Mr Brettell	June	**Updated report to be presented December 2020**
PCCC-2020-2.008	**Quality Report** Mr Ellis to bring a Triangulation Report developed by the Primary Care and Business Improvement teams to the next meeting.	Mr Ellis	April	To be completed – dashboard delayed. This will be picked up again with the BI team.
PCCC-2020-10.08	**Primary Care Network Report** Mrs Wilde to submit a PCN Update report to the December Committee	Mrs Wilde	December	
PCCC-2020-10.09	**Pharmacy Workforce Model** Mrs Walker to review the issues, questions and feedback raised by the Committee around Pharmacy workforce and provide an update to a future Committee.	Mrs Walker	Ongoing	

Agenda Item	Action Required	By Whom	By When	Date Completed
PCCC-2020-10.12	**Shropcom Business Case: Dawley** Mr Ellis and Mr Morgan to incorporate a comparator into the Dawley Business Case as requested by Dr Watts in order to compare facilities at Dawley with those at other sites. Mr Ellis to ensure that Dawley is placed on the Agenda of the Extra-Ordinary Committee meeting in November in order to clarify the points raised by the October Committee. A representative from Dawley Medical Practice to be invited to attend the November meeting.	Mr Ellis / Mr Morgan Mr Ellis Mr Ellis	November November November	
PCCC-20-10.13	**GP Patient Survey** Mr Ellis to advise the Primary Care team of Mr Vivian's request for more detailed information to be included in the Executive Summary of any report going forward.	Mr Ellis	Ongoing	
PCCC-20-10.14	**Risk Register** Mrs Ralph to review and align the PCCC Risk Register and the Restore/Recovery Risk Registers as appropriate in relation to the risk posed by Covid.	Mrs Ralph	December	

Telford and Wrekin CCG Action Tracker – Part 1 Meeting

	Meeting Date	Agenda Item	Action	Actioned By	Date
1.	03.12.19	62.19.3	**Primary Care Annual Self-Declaration (eDec):** **October 2020 Update:** Practice submissions for 2019/20 were made available to the CCG(s) in September 2020. Analysis will be completed to provide an update to the Committee in December 2020.	Corrine Ralph	December 2020
2.	04.02.20	5.20.3	**Primary Care Strategy (including Extended Access):** Mrs Ralph agreed to provide a paper to the next meeting providing an update about the training hub. **October 2020 Update:** Included in the Strategy Report.	Corrine Ralph	Complete
3.	04.02.20	5.20.3	**Primary Care Strategy (including Extended Access):** Mr Eastaugh noted the 130% increase in Junior Doctors since 2015 and suggested more could be done to encourage them to remain local on completion of training. The Committee requested that a paper be produced detailing what the CCG were doing to address the recruitment issue. Mrs Ralph agreed to provide this. **October 2020 Update:** Outstanding. If insufficient information is contained within the Strategy report, Mrs Ralph will provide a more detailed report to the December PCCC.	Corrine Ralph	Ongoing

NHS Shropshire CCG
NHS Telford and Wrekin CCG

REPORT TO : **Shropshire, Telford and Wrekin Primary Care Commissioning Committee Meetings in Common held in Public on 2nd December 2020**

Item Number:	Agenda Item:
PCCC-20-12.21	Month 7 Primary Care Finance Position

Executive Lead (s):	Author(s):
Mrs Claire Skidmore	Angharad Jones / Roger Eades

Action Required (please select): A									
A=Approval		R=Ratification		S=Assurance		D=Discussion		I=Information	x

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
N/A		

Executive Summary (key points in the report):

- This report provides an update on the latest Primary Care financial position for both CCGs for the period ending 31st October 2020.
- National funding guidance in force up to and including month 6 provides for a retrospective allocation adjustment to force budgets to break even. The CCGs are anticipating this adjustment. For months 7 to 12, the CCG has been notified of a fixed allocation and the team have now provided a full year forecast position in this report.

1.	Is there a potential/actual conflict of interest? *(If yes, outline who has the potential conflict of interest, what it is and recommendation of how this might be mitigated).*	No
2.	Is there a financial or additional staffing resource implication? *(If yes, please provide details of additional resources required).*	No
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated).* There is a risk of overspend in these budgets, this will be mitigated with the review of expenditure forecasts on a regular basis. Appropriate action will be taken where possible in order to achieve a break-even position.	Yes
4.	Is there a legal impact to the organisation? *(If yes, how will this be mitigated).*	No
5.	Are there human rights, equality and diversity requirements? *(If yes, please provide details of the effect upon these requirements).*	No
6.	Is there a clinical engagement requirement? *(If yes, please provide details of the clinical engagement).*	No
7.	Is there a patient and public engagement requirement? *(If yes, please provide details of the patient and public engagement).*	No

Recommendations/Actions Required:

Both CCG committees are asked to note the finance position at Month 7 2020/21.

1. Executive Summary

This report provides an update on NHS Shropshire CCG and NHS Telford and Wrekin CCG's primary care Co Commissioning financial position to 31st October 2020. A summary of performance against overall financial objectives is shown in the table below:-

Objective	SCCG RAG	SCCG In Month Change	TWCCG RAG	TWCCG In Month Change	Comments
Year to date position is in line with the plan trajectory		⇩		⇧	The combined year to date position is £631K overspent. This is mainly due to the year to date realignment of QOF spend in Shropshire , which will be adjusted in M8.
Year end forecast is in line with the plan trajectory		⇧		⇧	Early forecasts indicate that both CCG's are in line with the Plan that was submitted in October.

Key

On Track | Moderately Off Track | Materially Off Track

Improvement | No Change | Deterioration

2a Telford and Wrekin CCG Primary Care Delegated Commissioning

	M7 Budget Year to Date	M7 Actual Year to Date	M7 Variance Year to Date	Anticipated M6 Retro Funding	M7 Revised Year to Date Variance	2021/21 M1-12 Budget	Forecast M1-12	Forecast Variance M1-12	Anticipated M6 Retro Funding	Revised Forecast Variance M1-12
Primary Care Delegated Commissioning	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
GMS	9,947	9,969	21	17	4	17,049	17,089	40	17	22
Enhanced Services	1,037	1,167	130	96	35	1,809	1,884	75	96	(21)
QOF	1,327	1,420	94	89	4	2,321	2,435	114	89	24
Premises Costs Reimbursements	1,316	1,348	32	3	29	2,254	2,262	8	3	5
Dispensing/Prescribing Drs	159	161	2	1	0	265	279	14	1	12
Other GP Services	270	268	(2)	27	(29)	168	326	158	27	131
Reserves	144	0	(144)	0	(144)	861	0	(861)	0	(861)
Total Primary Care Delegated	**14,200**	**14,333**	**133**	**233**	**(100)**	**24,729**	**24,276**	**(453)**	**233**	**(686)**

Primary Care Delegated Commissioning

The Month 7 year to date position is an underspend of 100k after applying the anticipated retrospective top up for Month 6 of 233k.

Year to Date Variances:

- Reserves: The main year to date variance is 144k underspend on the reserves line. This is partly due to 76k (full year £453k) budget that has been aligned to the delegated budget area, where spend is allocated within the CCG core Primary Care budget and the corresponding overspend will show within those budget lines. There are plans to realign budgets for Month 8 reporting. The remaining £68k is also due to the aligning of the budget, this will be moved to the correct budget lines within Delegated Co-commissioning in Month 8.
- Enhanced Services, Premises Cost Reimbursement and Other GP Services: The reason for the year to date variances on these lines are due to the alignment of the budgets as highlighted under the section above.

The Forecast Outturn at Month 7 remains at the same level as the plan submission. At month 7 this is showing as an underspend of £686k, as explained above part of this is due to the £453k budget that should be aligned to Primary Care Other budget lines and will be moved in Month 8. Therefore the true underspend on Primary Care Delegated is 233k. This is due to the additional retrospective funding received at month 6.

2b. Shropshire CCG Primary Care Delegated Commissioning

	2020/21						2020/21	
Primary Care Delegated Commissioning	Budget	M6 Retro Adjustment	Total Budget	M12 FOT	Var Total Budget V M12 FOT	M7 YTD Budget	M7 YTD Actual	M7 YTD Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
General Practice - GMS	30,502	-	30,502	30,874	372	17,606	17,717	111
General Practice - PMS	385	-	385	385	0	220	212	(8)
Enhanced Services	3,609	-	3,609	3,609	0	1,815	1,822	7
QOF	4,557	-	4,557	4,557	0	1,949	2,574	625
Premises cost reimbursements	5,992	-	5,992	5,992	0	3,269	3,270	1
Dispensing	2,663	-	2,663	2,663	0	1,281	1,276	(5)
Other - GP Services	735	-	735	735	0	431	431	-
Net Reserves	372	95	467	0	(467)	0	-	0
Co Commissioning Total	**48,815**	**95**	**48,910**	**48,815**	**(95)**	**26,571**	**27,302**	**731**

Primary Care - Delegated Commissioning

The Month 7 year to date position shows an overall £731k overspend and a M12 forecast underspend of £95k, against the budget now provided.

The main variances in the YTD are noted below:

- General Practice – GMS. (£111k) This variance reflects global sum payments that are higher than anticipated.

- QOF (£625k) - This cost pressure consists of £780k that reflects aligning our treatment of the 20/21 year to date achievement payments to T&W, as opposed to reflecting them in the M12, as they are paid in the next financial year. The new budget will be re-profiled in M8 to replicate this expenditure. The cost pressure is partly offset by an underspend of £155k in connection with the 19/20 achievement payments made in M3.

M12 Forecast Position.

The forecast position currently remains in line with the plan submitted in October. This will be regularly reviewed with the budget holder.

Appendices

Appendix 1	Non Delegated Primary Care budget information for T&WCCG
Appendix 2	Non Delegated Primary Care budget information for SCCG

These appendices are included for information to inform the committee of financial performance in the non delegated primary care budgets of the CCGs.

Appendix 1 TWCCG Non Delegated Primary Care Budgets

Other Primary Care Commissioning

Prescribing

The Month 7 year to date position is an underspend of £744k with a forecast underspend of £705k.

The full year forecast spend for prescribing is £29m. This is £600k less than the planned position reported. This is mainly due to:

- The forecast for QIPP savings increasing by c£40k.
- The reduction of £350k in relation to Cat M and NCSO cost pressures as per the presqipp data.
- The August EPACT data coming in £200k lower than forecast.

- Assumptions around the forecasting of increased demand due to the pandemic has remained at 2% per month.

Out of Hours

This budget line is showing a year to date overspend of £990k with the forecast being an overspend of £1.7m. These variances are due to the budget sitting within the "Community Services" budget area, and therefore the corresponding underspend will be highlighted there. The aligning of budgets is planned ready for Month 8 reporting.

Enhanced Services

The Month 7 position is an underspend of £569k, with a forecast variance of £290k overspend. This is mainly due to the phasing and realignments of the budgets as discussed above.

	M7 Budget Year to Date	M7 Actual Year to Date	M7 Variance Year to Date	Anticipated M6 Retro Funding	M7 Revised Year to Date Variance	2021/21 M1-12 Budget	Forecast M1-12	Forecast Variance M1-12	Anticipated M6 Retro Funding	Revised Forecast Variance M1-12
Other Primary Care Commissioning	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Prescribing	17,428	16,787	(641)	103	(744)	29,644	29,042	(602)	103	(705)
Out of Hours	293	1,283	990	0	990	503	2,200	1,697	0	1,697
Enhanced Services	2,135	1,529	(606)	(37)	(569)	2,630	2,883	253	(37)	290
Primary Care Other										
- Commissioning Schemes	161	155	(7)	(4)	(3)	289	265	(24)	(4)	(21)
- Oxygen	208	252	44	(15)	59	404	472	69	(15)	84
- Central Drugs	507	502	(4)	1	(5)	875	871	(4)	1	(5)
- Prescribing Incentive Scheme	29	29	0	0	0	49	49	1	0	1
- GP Forward View	694	613	(82)	(86)	4	1,203	1,045	(159)	(86)	(73)
- Primary Care Other	394	411	17	7	10	651	710	59	7	52
- A&E Streaming	454	454	0	0	0	778	778	0	0	(0)
- Primary Care IT	295	385	90	(81)	172	934	1,050	116	(81)	197
- Primary Care Pay	461	501	40	(2)	42	805	796	(9)	(2)	(6)
Primary Care Other Total	3,203	3,301	99	(180)	279	5,988	6,037	48	(180)	228
Total Other Primary Care	23,059	22,900	(158)	(114)	(44)	38,765	40,161	1,396	(114)	1,510

Appendix 2 SCCG Non Delegated Primary Care Budgets

Key Messages:

Primary Care - Other Primary Care Commissioning

Primary Care currently shows a £294k YTD underspend and a £1.9m FOT overspend.

YTD Main Variances :

- Prescribing - (£589k) The M7 position is based on the Epact data for M1 to 5,plus 20/21 budget profile for M6&7. This position reflects known potential cost pressures ,e.g. estimated Covid costs for M6-7 of £179k, and NCSO/CATM £358K costs. The underspend reflects an additional non Covid budget allocation of £1,100k received in M6 ,less the M6 Retro adjustment.
- Out of Hours– £383k .We are awaiting a budget allocation from another CCG expenditure area, which will cover this variance when posted.
- Enhanced Services.- £263k This cost pressure is relating to Covid costs paid in M6/M7 to practices.Costs regarding M1-5,have been recovered in the budget.
- Oxygen - (£23K) charges are currently lower than budget and anticipated in 20/21.
- Prescribing Incentives - (£16k) This underspend position reflects savings from the 19/20 scheme that were paid out in September 20
- Primary Care Team - (£34k) Current vacancies reflect this underspend
- Primary Care IT – £21k This variance reflects system costs currently lower than anticipated.

FOT Position :

The main variance on our FOT position relates to Out of Hours, and as per note above, £2.1m will be covered by the internal budget transfer, which will occur in M8.

The variance regarding Prescribing relates to higher Wound care charges later in the year, and the Enhanced Services cost pressure is related to continuing Covid expenditure which will be covered once budgets are realigned.

	2020/21					2020/21		
Other Primary Care Commissioning	Budget	M6 Retro Adjustment	Total Budget	M12 FOT	Var Total Budget V M12 FOT	M7 YTD Budget	M7 YTD Actual	M7 YTD Variance
	£'000	£'000		£'000	£'000	£'000	£'000	£'000
Prescribing	53,187	(484)	52,703	52,900	197	30,700	30,112	(589)
Out Of Hours	866	(1)	865	3,172	2,307	1,467	1,850	383
Enhanced Services	6,949	181	7,130	7,632	502	4,657	4,920	263
Primary Care Other								
- Central Drugs	1,264	1	1,265	1,264	(1)	747	756	9
- Oxygen	536	(16)	520	536	16	334	311	(23)
- Primary Care Comm Schemes	44	(3)	41	43	2	23	23	0
- Hospice Drugs	78	-	78	78	0	45	45	0
- Prescribing Incentives	324	(16)	308	303	(5)	184	168	(16)
- Care Home Advanced Scheme	249	-	249	249	0	164	164	0
- Primary Care Team	1,798	(25)	1,773	1,686	(87)	1,064	1,030	(34)
- Primary Care IT	2,139	126	2,265	2,139	(126)	1,149	1,128	(21)
- Primary Care Reserves	922	0	922	0	(922)	266	0	(266)
Primary Care Other Total	**7,354**	**67**	**7,421**	**6,298**	**(1,123)**	**3,976**	**3,625**	**(351)**
Total Other P.C.Commissioning	**68,356**	**(237)**	**68,119**	**70,002**	**1,883**	**40,800**	**40,507**	**(294)**
Total of Co Commissioning and other P.C. Commissioning	**117,171**	**(142)**	**117,029**	**118,817**	**1,788**	**67,371**	**67,809**	**438**

NHS Shropshire CCG

NHS Telford and Wrekin CCG

REPORT TO: **Shropshire, Telford and Wrekin CCGs Primary Care Commissioning Committee**

Meetings in Common held in Public on 2 December 2020

Item Number:	Agenda Item:
PCCC-20-12.22	Primary Care Strategy Update

Executive Lead (s):	Author(s):
Claire Parker Director of Partnerships claire.parker2@nhs.net	Phil Morgan – Primary Care Manager (Shropshire CCG) philip.morgan3@nhs.net

Action Required (please select):										
A=Approval		R=Ratification		S=Assurance		D=Discussion		I=Information	✓

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**

Executive Summary (key points in the report):
The purpose of this report is to provide an update to Primary Care Commissioning Committee of progress against the outcomes from the Shropshire and Telford and Wrekin STP Primary Care Strategy. It provides details of the work undertaken since the last report and the actions to be taken in the coming weeks to provide assurance to the Primary Care Commissioning Committee and NHS England that progress is being made towards delivery. The report also highlights identified areas of risk along with relevant mitigations. Good progress is being made against all of the nine programmes in the Strategy: • Primary Care Networks and Models of Care (NB given the importance of this work a separate report on this programme is being presented to PCCC) • Prevention and Addressing Health Inequalities • Improving Access to Primary Care • Ensuring a Workforce fit for the future • Improvements to Technology and Digital Enablers • Ensuring a High Quality Primary Care Estate • Optimising Workflow and Addressing Workload Pressures

- Auditing Delegated Statutory Functions and Governance Arrangements
- Communications and Engagement

Given the current Covid-19 crisis this report, inevitably, reflects the fact that the majority of the Primary Care Teams' work over the past six months has continued to be focused on addressing the challenges of the crisis, rather than delivering against the outcomes for each of the above programmes. However, as the report details, many of the workstreams and projects have been restored recently with significant progress being made in many areas. Notwithstanding this the usual RAG ratings have not been carried out for this report – it is anticipated that this will be reinstated for the subsequent report.

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest? *(If yes, outline who has the potential conflict of interest, what it is and recommendation of how this might be mitigated).*	No
2.	Is there a financial or additional staffing resource implication? *(If yes, please provide details of additional resources required).*	No
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated).*	No
4.	Is there a legal impact to the organisation? *(If yes, how will this be mitigated).*	No
5.	Are there human rights, equality and diversity requirements? *(If yes, please provide details of the effect upon these requirements).*	No
6.	Is there a clinical engagement requirement? *(If yes, please provide details of the clinical engagement).*	No
7.	Is there a patient and public engagement requirement? *(If yes, please provide details of the patient and public engagement).*	No

Recommendations/Actions Required:
Primary Care Commissioning Committee is asked to: • Consider the content of this report and note the progress being made across the programmes within the Primary Care Strategy

Shropshire and Telford & Wrekin STP

Primary Care Strategy 2019/20 Operational Plan Progress Report**: December 2020**

This report provides an update on the Shropshire and Telford and Wrekin STP Primary Care Strategy. It sets out details of work undertaken since the last report and the actions to be taken in the coming weeks to provide assurance to the Primary Care Commissioning Committees and NHS England that progress is being made towards delivery. The report also highlights identified areas of risk along with mitigations.

Given the current Covid-19 crisis this report, inevitably, reflects the fact that the majority of the Primary Care Teams' work over the past six months has continued to be focused on addressing the challenges of the crisis, rather than delivering against the outcomes for each of the above programmes. However, as the report details, many of the workstreams and projects have been restored recently with significant progress being made in many areas. Notwithstanding this the usual RAG ratings have not been carried out for this report – it is anticipated that this will be reinstated for the subsequent report.

The report includes nine individual reports as follows:

No.	Programme	Progress Status
1	Primary Care Networks and Models of Care	
2	Prevention and Addressing Health Inequalities	
3	Improving Access to Primary Care	
4	Ensuring a Workforce fit for the future	
5	Improvements to Technology and Digital Enablers	
6	Ensuring a High Quality Primary Care Estate	
7	Optimising Workflow and Addressing Workload Pressures	
8	Auditing Delegated Statutory Functions and Governance Arrangements	
9	Communications and Engagement	

Programme 1	Primary Care Networks and Models of Care	Months covered	Nov/Dec 2020
Update by:	Steve Ellis	Progress Status	

Summary Status (update on each Anticipated Outcome)	
Anticipated Outcome	**Summary Status**
• To ensure that Primary Care Networks (PCN) are set up by 1st July 2019, including the appointment of a Clinical Director for each PCN	• Achieved by July 2019. • Requirement for all practices/practice populations to be assigned to a PCN to deliver the PCN DES has been achieved.
• To ensure that PCNs are set up in a way that enables nationally mandated community and social care services to be provided from 1st April 2020	• The new PCNs are approved and work is ongoing with community providers to deliver the national mandated services

Key Actions Planned for Next Period

- To set up 4-6 weekly meetings with PCN CDs and lead managers to ensure that they are supported to deliver the PCN DES.
- To finalise the allocation of care homes to PCNs to enable delivery of the Enhanced Health in Care Homes service specification
- To contract with relevant PCNs for the delivery of the PCN DES for non-core practices

Risks

No.	Risk	Rating	Mitigation
1	There is a risk around the availability of workforce to deliver the extended hours DES which will form part of the PCN DES.	9	This risk has been exacerbated by the Covid-19 situation. Mitigation includes telephone triage for all appointments, additional use of online consultation, telephone calls and video consultation.
2	Notwithstanding the fact that NHSE/I have delayed significant parts of the service specs there is a risk that the Covid-19 situation will continue to affect PCNs' ability to deliver.	12	Discussions will need to continue with Clinical Directors around the new plans for implementation of the service specs.

Programme 2	Prevention and Addressing Health Inequalities	Month covered	Nov/Dec 2020
Update by:	Janet Gittins	Progress Status	

Summary Status (update on each Anticipated Outcome)

Anticipated Outcome	Summary Status
• Improvements in the uptake of physical health checks for the seriously mentally ill	• The outbreak of the Covid-19 pandemic has meant that patients have not been called into practice to complete SMI checks as anticipated. Improvement plan in place and work restarted in Primary Care.
• Consideration to specific actions to support people with Learning Disabilities and Autism and delivery of the required increase in the number of health checks	• A task group is in place and an improvement plan developed to assist with raising the number of LDHCs completed. MPFT commissioned to support general practice with this work.
• Improvement in the cardiovascular disease and Type 2 Diabetes prevention and management programmes	• The NPDD programme continues remotely with the new service provider starting from 1st April 2020. • Primary Care clinician education available on the management of diabetes and cardiovascular complications (e-learning). • Prescribing Development Scheme launched in SCCG with Diabetes as one of the key priorities. Focus of prioritisation and review of high risk diabetes patients
• Improvements to Dementia diagnosis rates	• The outbreak of the Covid-19 pandemic has meant that patients have not been able to access the memory clinic only urgent and existing cases have been seen. The restarting of memory clinics and assessments is part of the restore programme.
• Introduction of prevention and management programme for respiratory disease	• COPD respiratory review service has been continuing during the pandemic to support practices with their vulnerable respiratory patients. All reviews have been conducted remotely. • This service is continuing until November 20 and it is being explored if this can be extended and also implemented across T&W.
• Programme of work to reduce Antimicrobial Resistance	• UTI audits and templates have been created to support the PDS and work around improving the diagnosis and management of UTI's. • Scoping the possibility of whether the Microguide to support antimicrobial prescribing that is currently in use for T&W CCG can be extended for use across SCCG to host the Community antimicrobial guidelines
• Improved skills and capabilities to motivate patients and support behaviour change	• The Social Prescribing programme continues to support people remotely. • For social prescribing see Programme 7 updates.
• Improved ability to recognise risky health behaviours and connect patients/ people to support in the community	• Priority has been given to support those people most vulnerable in the community during COVID-19. The Health and Social Care system is working together provide support and access to services to

	those in need

Key Actions Planned for Next Period

- Ongoing action from the Health and Social Care system to support those most vulnerable to COVI-19 across Shropshire until end March 2020
- NDPP continues supporting referrals remotely.
- National campaign on diabetes and diabetes prevention for BAME populations to be implemented locally – national resources expected autumn 2020
- Future collaborative diabetes education programmes for clinicians are being developed.
- Development of health economy COPD management plan. Aim for completion and roll out by August
- Focus on restoring services in Primary Care including LD Healthchecks and SMI Healthchecks. PCN work supports this. Improvement plans in place.

Risks

No.	Risk	Rating	Mitigation Support Requested
1	There is a significant risk regarding funding for local lifestyle services (particularly weight management and smoking cessation) given the savings required in local authority public health budgets, e.g. Shropshire Council is currently consulting on significant reductions in services	12	Discussions are taking place directly with between SCCG and Public Health through the CCC and CCC working group to understand and prioritise those at most risk. In addition, they are also part of the STP Prevention and Place cluster, and the Shropshire HWBB. In the short term SIP has been prioritised and work is underway to determine how best to utilise the remaining resources, particularly Healthchecks and Social Prescribing, as well as the NDPP and other local services to target those most in need; in the medium and longer term the system will work together to ensure a robust prevention and place based approach that supports healthy weight and smoking reduction.
2	There is a risk around the pace at which data and intelligence around population health management can be obtained, analysed and used to design and commission services. This risk also includes the need for clarity around the meaning of "Population Health Management" and the extent to which current work is overly focused on a small, specific population group.	6	Continued work with the STP Population Health Management group to ensure that there is a shared understanding of the scope and limitations of this programme.
3	This programme cannot be defined as accurately as the STP would like due to the fact that the national dashboard has not yet been delivered	9	Request update from regional NHS England team to clarify when the dashboard might be delivered. Expected autumn 2020.

Programme 3	Improving Access to Primary Care	Month covered	Nov/Dec 2020
Update by:	Darren Francis	Progress Status	

Summary Status (update on Outcomes)

Anticipated Outcome	Summary Status
• To maintain and improve 7 day access to General Practice both through face-to-face appointment and technological solutions	• Across both CCGs both Extended Access (GPFV) and the PCN DES Extended Hours continue to be delivered, albeit within the context of additional pressures as a result of the Covid-19 pandemic • From July the new PCNs were all confirmed and are now in the process of designing their provision for the PCN DES capacity
• Ensure at least 75% utilisation of extended-hours appointments by March 2020	• Utilisation improved from April (@72% T&WCCG and 15% SCCG) to August (@96% T&WCCG and 64% SCCG) • Utilisation is estimated at around 80% across the STP
• Direct booking for 111 for in-hours and extended access appointments	• NHS111 able to book into 100% of practices for In Hours and PCN DES Extended Hours appointments • A change in process for 111 direct booking is currently being proposed with changes beginning during October 2020. • Continuing to work with Regional Commissioners to implement NHS111 direct booking at GPFV Extended Access Hubs – GP Connect issues have now been resolved but some hubs still need to implement the EMIS solution at the Hub end before this service can be fully rolled out
• Increased access and patient satisfaction	• Monitoring of utilisation and delivery of both Extended Access (GPFV) and the PCN DES Extended Hours will continue with any significant changes being agreed and implemented, as required

Key Actions Planned for Next Period

- The majority of PCNs across the STP are hopeful that they can continue to deliver both the extended access and extended hours services, providing there are no significant changes in circumstance. Both CCGs are working with any networks that have expressed concerns over the provision of extended access services to understand the barriers in their delivery
- Following the formation of the new PCNs the CCG will work with all delivery groups and PCNs to address any barriers to delivery
- A technical solution has now been found to NHS111 booking into Extended Access appointments by allowing the regional Adastra system to view EA appointments at hubs and transfer all patient information correctly. Current trajectory from Regional Commissioners indicates implementation by end December 2020 (or sooner if possible)

Risks

No.	Risk	Rating	Mitigation Support Requested
1	There is a risk around the availability of workforce to deliver the extended hours DES which will form part of the PCN DES.	9	This risk has been exacerbated by the Covid-19 situation. Mitigation includes telephone triage for all appointments, additional use of online consultation, telephone calls and video consultation.

2	Notwithstanding the fact that NHSE/I have delayed significant parts of the service specs there is a risk that the Covid-19 situation will affect PCNs' ability to deliver.	12	Discussions will need to continue with Clinical Directors around the new plans for implementation of the service specs.

Programme 4	Ensuring a Workforce fit for the future	Month covered	Nov/Dec 2020
Update by:	Phil Morgan	Progress Status	

Summary Status (update on each Anticipated Outcome)	
Anticipated Outcome	**Summary Status**
• From 2019 as part of the additional roles reimbursement scheme there is funding to increase the number of clinical pharmacists in Primary Care	• To date four Clinical Pharmacists are being funded via the ARRS across the STP. Two of these are in the Shrewsbury PCN, one in the South West Shropshire PCN and the other in the Newport PCN. • The seven PCNs have submitted plans showing that they intend to recruit a further 18 CPs this financial year
• From 2020 there will be national funding from the reimbursement scheme to introduce physician associates and first contact physiotherapists and from 2021 first contact community paramedics	• The PCN recruitment plans show that they intend to recruit 7 Physician Associates and 11 First Contact Physios • In addition 5 PAs have joined local practices as part of the PA Internship scheme, joining 2 who were already in post. After the end of their internship they may be able to deliver a PCN role.
• Employment of these staff can be direct by Networks or through other NHS or voluntary organisations	• PCNs are aware of the different employment models. Notwithstanding the Covid-19 situation some of the STP's PCNs are liaising with external providers, including local Councils, to host the ARRS Social Prescribing Link Worker role.
• The work programmes initiated as part of the GPFV continue for the retention and recruitment of GPs and other clinical professionals	• A significant amount of work has been carried out to commission and deliver retention/resilience events for GPs. • Funding to support five newly-qualified GPs has been provided to their practices. • Other clinical professionals have accessed training and development using NHS England funding. • The CCGs have recently been informed of further GPFV funding for 2020/21 and plans will be developed for approval at the December PCCC meeting
• As well as retention, recruitment and increased multidisciplinary working there will be increased opportunities for flexible/ mobile working, interoperability and portfolio careers.	• As part of the GP retention funding package practices and PCNs were encouraged to bid for funding for projects/initiatives based around flexible/ mobile working, interoperability and portfolio careers – a number of such bids have been funded and are progressing as well as possible, given the Covid-19 situation.
• Clinical Directors will provide the compassionate leadership in primary care to lead the complex, practical, financial and cultural challenge ahead	• Clinical Directors have been provided with information on a range of support and development packages. • A number of CDs and lead Practice Managers have participated in training and development events
• Learning/education also remain important elements of the development of the workforce with Protected Learning Time sessions being adapted to meet the future needs of working in Networks	• Both CCGs have been continuing to develop their existing approaches to PLT to take account of the future need of PCNs and the wider workforce. • The PC Team ensures that Primary Care is a working part of wider STP system plans for a more streamlined local education provision by being active part of weekly education group
Actions Planned for Next Period	

Testing

- The management and coordination of the general practice staff/household member testing process will continue, with a specific focus on ensuring that staff are able to return to work as quickly as possible following receipt of the test results

Funded Initiatives and Projects

- Detailed delivery programmes will be developed for the workforce projects which have been brought out of hibernation, including supporting newly-qualified GPs/GPNs and improving the mentoring skills of GPs
- Further work will be carried out on the HEE-funded workstreams including the provision of CPD for Nurses and AHPs working in practice.
- Engagement approaches will be developed for the recently-announced NHSE/I GPFV funding including allocations for:
  - GP Retention - £100k
  - Training Hub - £103k
  - GP Resilience - £72K
  - Reception & Clerical Training - £85k

PCN Workforce Plans

- The CCGs will support all of the 7 PCNs across the STP in developing their workforce plans for 2021/22, 2022/23 and 2023/24 which are due by 31st October 2020. These plans should indicate the number of ARRS-funded staff that PCNs hope to recruit. In addition to the roles available in 2020/21 PCNs will be able to recruit Mental Health Practitioners and Paramedics.

Practice Nurse Facilitators/10 Point Nursing Plan

- The GPNFs' future plans include continuing with local remote meetings on specific topics including remote consultations and dermatology lesion assessment via remote consultation
- Contributing to designing GPN Fellowships 2020/2021 programme and supporting a PCN approach for this year
- Re-launching GPN 10 Point Plan STP Newsletter
- Leading on developing a workstream to promote the Advanced Nurse Practitioner role in General Practice (to include a system-recognised competency for imaging requests) and a retention focus to include leadership and coaching and extended specialist roles and research opportunities.
- Supporting the development of a GPN Strategy.
- Supporting increasing student nurse placement capacity for January 2021
- Supporting increasing Supervisors and Assessors capacity across the PCNs

Practice Workforce Recovery Plan

- Following engagement with practices in the summer over the specific workforce challenges they are facing a Practice Workforce Recovery Plan has been drafted
- Further work on the draft plan will be carried out after which it will be shared with all practices

Risks

No.	Risk	Rating	Mitigation Support Requested
1	The lack of space, and pressures on GPs around providing mentoring, are making it difficult for GP trainees and other clinical students to be placed	8	The CCGs are completing an estates review to help identify future requirements. HEE is reviewing clinical supervision funding.
2	There is a risk that the investment in training and development will put pressure on staffing in practices – i.e. some practices may be reluctant to allow staff to take on e.g. fellowships	8	Work with PCN Clinical Directors and senior partners to understand the extent of this problem and develop local solutions.
3	Development of Training Hub not fully realised with uncertainty around hosting and funding of staff. This	8	The CCG's primary care team will continue to work with HEE to finalise plans for the STW Training Humb.

	could impact on ability to deliver on national programmes		

Programme 5	Improvements to Technology and Digital Enablers	Month covered	Nov/Dec 2020
Update by:	Sara Spencer	Progress Status	

Summary Status (update on each Anticipated Outcome)

Anticipated Outcome	Summary Status
• The use of technology will enhance models of care	• There has been a greatly increased use of technology within general practice as a result of the Covid-19 situation – e.g. online consultation and video consultation
• The core level of digitisation will be met by 2024 including the withdrawal of the use of fax machines by 2020	• This is complete
• The CCGs will ensure that all GP Practices and PCNs are technically enabled to provide the required functionality and interoperability of systems	• The CCG received funding for N365 and purchased licences for primary care. Practices will start moving to N365 to meet the Office 2010 deadline.
• The NHS App will be available and promoted in Shropshire and some practices will commence online consultations from May 2019	• The NHS App is available and promoted by Shropshire CCG
• Online and video consultations across all practices by 2021	• All practices can offer their patients online consultation and video consultation
• At least 25% of appointments will be available for online booking by July 2019	• All practices have the capability to offer 25% of appointments online. This is part of the contract and is fulfilled from July 2019.
• Many patients are already able to request their repeat prescriptions electronically; however this will be a default position from April 2019	• Repeats can be requested through the NHS App and Patient Access
• There is currently limited patient access to medical reports. This will be increased with full access by 2020 and patients will be able to input their own information	• Access is available from the NHS App and Patient Access
• Improvements to electronic and integrated decision trees with direct links to create referrals so that GPs are one click away from advice and diagnostic information	• To be confirmed

Actions Planned for Next Period

- Full fibre connection for practices to continue
- Agree and begin the domain installation
- Continue to evaluate the use of VDI mobile to justify further development for practice remote working
- Ensure cyber security measures are in place in line with NHS Digital guidance
- Project initiation for the N365 install

Risks

No.	Risk	Rating	Mitigation Support Requested
1.	Windows 10 needs to be installed to meet the January 2021 deadline. There is no funding for more devices.	12	Options paper discussed at the digital health meeting to decide how to complete the install.
2.	Practices experiencing low network		Root cause analysis to be conducted to

	speeds since the HSCN migration	9	resolve this issue. On-going discussions with Redcentric, CSU and NHS Digital.

Programme 6	Ensuring a High Quality Primary Care Estate	Month covered	Nov/Dec 2020
Update by:	Tom Brettell	Progress Status	

Summary Status (update on each Anticipated Outcome)

Anticipated Outcome The completion of an Estates Strategy for Primary Care will facilitate a range of outcomes that will ensure a high quality primary care estate:	Summary Status
• Support identification of the priorities for investment • Identify opportunities for savings, efficiencies and capital receipts, both short and long term • Improve patient pathways and patient care • Create an integrated estate to support delivery of Integrated Care Teams • Support a wider range of integrated services at a community level including health and care villages • Creation of high-quality working environments that attract new healthcare staff &develop training facilities that support on-going staff development • Help develop primary care at scale via the PCN's • Support the prevention agenda through community facilities and specialist supported housing	• All of the work designed to deliver against the anticipated outcomes has been put on hold due to Covid. • This is because the work is designated as Business as Usual and, therefore, is not as high priority as previously. • Normal activity will resume once the current situation ends. • In the meantime, any progress that can be made on estates projects or work towards producing the combined estates strategy is being undertaken, wherever possible

Actions Planned for Next Period

- **Shawbirch** – Progress the financial issues and continue ongoing discussions with practice
- **Shifnal**- Progress overall project once COVID situation has settled – meeting due in July 2020
- **Riverside**- Practice has now relocated to the new premises and rent is being paid at the higher rate
- **Whitchurch** – Plan public-facing comms around the issues relating to the Judicial Review

Risks

No.	Risk	Rating	Mitigation Support Requested
1.	Possibility that current revenue funding is not sufficient to support medium to long-term estates planning.	12	Work is progressing with the Finance team to determine and forecast the level of financial risk.
2.	Risk to Whitchurch project from the Judicial Review	12	Develop a response to the Judicial Review
3.	Projects that require ETTF funding have been delayed by COVID-19 and risk losing access to the capital grants	12	Ongoing discussions with NHSE/I via Glenn Francke to ensure that the funding remains secured despite the delays.

Programme 7	Optimising Workflow and Addressing Workload Pressures	Month covered	Nov/Dec 2020
Update by:	Jenny Stevenson	Progress Status	

Summary Status (update on each Anticipated Outcome)	
Activity	**Summary Status**
• Continued support will be available via the National Primary Care Resilience programme and the Releasing Time to Care Programme, enabling GPs and Managers to think and plan to identify new ways of making better use of resources (e.g. premises, IT, workforce, HR, back office functions, staff)	• A handful of SC/TW practices have attended engagement meetings for PGP Quick Start programmes this autumn. One TW practice has recently started the programme, with 100% virtual delivery to be completed by November; other practices are aiming to take part in the New Year. • Over the past month, SE and SW localities have both started conversations with the Time for Care team regarding PCN development. SW is continuing to progress this route of support. • A Practice Manager Development Programme has been commissioned from PCC and started during February and March for SCCG. Due to the Covid-19 situation the programme was postponed - this is now due to recommence in October • 6 T&W CCG practice managers have accessed coaching & mentoring via the NHS England offer.
• Continued support to deliver the 10 high impact changes	• Ongoing training being offered to practices to support active signposting and productive workflow. • Links to IT in relation to consultation types. • See below for self-care.
• Strong public awareness campaigns explaining wider practice team roles and services provided by a range of healthcare professionals - patients will in the future be seen by a wider range of healthcare professionals	• Resources for practices have been developed by the CCG communications team.
• To promote self-care and alternative sources of advice and treatment	• Self-care campaigns and resources have been developed by the medicines management team - resources continue to be available and promoted.
• Social Prescribing, Care Coordination, and Link Workers will continue to identify and support those who lack the confidence or knowledge to get involved with community groups or to approach agencies on their own •	• We are progressing support for C&CCs with developments identified in the training delivered earlier this year (as outlined in last report) e.g. NHS Networks forum with the aim of increased county-wide peer support. • The Bureau, a community organisation as part of the West Midlands Link Worker support network are hosting regular online support sessions for C&CCs and SPLWs across the STP. Regular E-bulletins are also being sent to both roles to provide additional information and resources. • Public Health's Social Prescribing project continues to be provided in a number of SCCG practices. This continues to be provided in a different format during the Covid pandemic (i.e. over the telephone rather

	than face to face). PCN SPLWs have been recruited in both South Shropshire PCNs. • Discussions around the Link Worker/ community care coordinator and health coach roles across PCNs are ongoing with system leads. • An interactive social prescribing session took place on the 5th March 2020 for all T&WCCG practice managers including the new social prescribing link workers. The session evaluation was excellent.
• GP Practices will be supported to use the new demand and capacity tools to identify how appointments are used and the effect of seasonal variation	• Practices have been asked to confirm whether they are utilising the demand and capacity tool within EMIS. Feedback was sought at a Provider Forum meeting and experiences were mixed. • Practices encouraged to provide feedback via the NHS England/NHS Digital link • NECCS have been contacted to request engagement with STW practices on optimisation of the workload tool.

Key Actions Planned for Next Period

- Consider how the CCGs can help facilitate development work, capitalising on these new and rapid progressions – to encourage reflection and analysis on what is working and what needs changing, and to hold onto the momentum which has increased 10-fold over the space of a month.
- Consider how the development programmes on offer (e.g. Time for Care) help facilitate this, how development programmes just completed (C&CCs) or ongoing (PM development) can help consolidate the good, discard the not so good, and take the learning forward from this new position of working.
- Ensuring Primary Care is a working part of wider STP system plans for a more streamlined local education provision by being active part of weekly education group.

Risks

No.	Risk	Rating	Mitigation Support Requested
1	Capacity of practices to engage in key elements of the 10 High Impact Actions including projects within the national Time for Care Programme.	6	Information will be provided to practices about those practices that have had positive experiences of the various 10 High Impact Actions and the Time for Care programme. There is an area on TeamNet for this - need to encourage more sharing and for practices to access and make use of this space

Programme 8	Auditing Delegated Statutory Functions and Governance Arrangements	Month covered	Nov/Dec 2020
Update by:	Corrine Ralph	Progress Status	

Outcomes – Anticipated

Improvements to the full range of delegated statutory functions and governance arrangements via reviews of:

- the current compliance with statutory functions
- the internal governance processes to ensure we are fully compliant in all aspects
- the roles and responsibilities of both the CCGs and NHS England in the light of current governance arrangements
- current governance arrangements
- arrangements for procurement, financial governance and patient engagement in decision making

Summary Status (update on each Anticipated Outcome)

Anticipated Outcome – improvements to:	**Summary Status**
• Current compliance with statutory functions	• In place – audit will identify variation that can be integrated into the organisational development plans
• Internal governance processes to ensure we are fully compliant in all aspects	• Review of processes not completed in detail.
• Clarity around the roles and responsibilities of both the CCGs and NHS England in the light of current governance arrangements	• Significant changes have taken place following the reorganisation of NHSE/I Primary Care Support Hub. The CCGs Primary Care teams are building good working relationships with the relevant members of the Hub.
• Current governance arrangements	• Working ongoing
• Arrangements for procurement, financial governance and patient engagement in decision making	• Focused work remains outstanding – due to forthcoming organisational changes

Key Actions Planned for Next Period

To ensure the delivery of remedial action/monitoring as identified in the recommendations. It is important to note the reporting of progress is made to Audit Committee.

Telford and Wrekin CCG

Expected control	Recommendations
Performance and Contract Management Framework	When appropriate to do so, the CCG should take action to ensure its revised framework and arrangements developed in 2019, are consistently implemented and embedded during 2020 and monitored for effectiveness. Alongside this, development of joint quality and contract management arrangements with Shropshire CCG, including adoption of a common dashboard format, should continue.
Patient list maintenance	The CCG should formally consider whether any Practice circumstances exist for which targeted list maintenance may be appropriate.

Special Allocation Scheme	Going forward, the CCG should consider: Reporting an overview of the Special Allocation Scheme (SAS) position periodically to the PCCC Drafting and approval of a separate Terms of Reference for the Review Panel to recognise the key role the panel plays.

Shropshire CCG

Expected control	Recommendation
Performance and Contract Management Framework	When appropriate to do so, the CCG should take action to ensure its revised framework and arrangements developed in 2019, are consistently implemented and embedded during 2020 and monitored for effectiveness. Alongside this, development of joint quality and contract management arrangements with Telford and Wrekin CCG, including adoption of a common dashboard format, should continue.
Special Allocation Scheme	The CCG should monitor the scheme as laid down in the formal specification, reporting as appropriate. A review panel, with formal terms of reference, should be put in place to consider individual cases periodically in line with the contract specification. The CCG should consider inclusion of LMC representation on the scheme's panel.

No risks have been identified for this scheme.
The primary care teams do not anticipate any challenges with the delivery of the recommendations identified above.

Progress with the delivery of these recommendations has been delayed due to the general challenges/demand placed on the primary care team during the COVID period.

Risks

No.	Risk	Rating	Mitigation Support Requested

Programme 9	Communications and Engagement	Month covered	Nov/Dec 2020
Update by:	Andrea Harper	Progress Status	

Outcome – Anticipated

To develop and document communications and engagement activity strategically, and across the work streams, to support the delivery of the Long Term Plan and alignment to the Shropshire Sustainability and Transformation Partnership (STP) Primary Care Strategy 2019-2024.

Summary Status (update on the Anticipated Outcome)

- Focus has remained on supporting the Primary Care Network strategically and operationally through Covid-19
- Engagement work has been completed around governance arrangements in preparation for the formation of a joint board as we move to a single strategic commissioner organisation.
- In line with the aims of the Long Term Plan key areas including diabetes and mental health, which have come to the fore as a result of the pandemic, have been supported with dedicated comms work.

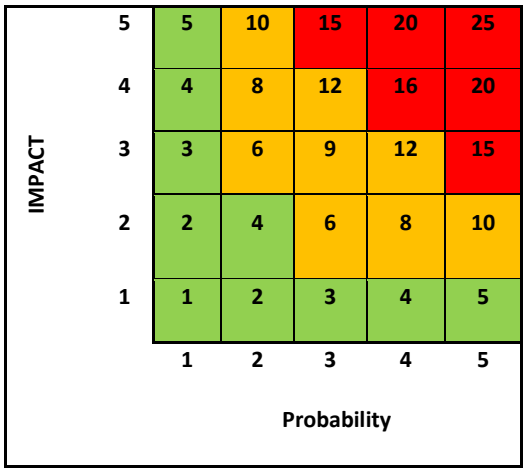
Key Actions Planned for Next Period

- PCN – new structure promotion- pending further details
- Opioid Campaign to be developed into a comms plan
- On-going work on NDPP with focus on eligibility and risk groups
- Next phase of the self-care campaign to roll out after initial launch
- Estates programme pending
- Comms and Engagement plan for the transformation work stream
- Development of channel to share main restoration listing schedule with Primary Care.

Risks

No.	Risk	Rating	Mitigation Support Requested
1.	Second wave of Covd-19	**12**	Planned comms work will be deferred to focus on pandemic wave

Risk Scoring Key	
Probability	
1. Rare	The event may only occur in exceptional circumstances (<1%)
2. Unlikely	The event could occur at some time (1-5%)
3. Possible	Reasonable chance of occurring at some time (6-20%)
4. Likely	The event will occur in most circumstances (21-50%)
5. Almost certain	More likely to occur than not (>50%)
Impact	
1. Insignificant	No impact on PC Strategy outcomes, insignificant cost or financial loss, no media interest
2. Minor	Limited impact on PC Strategy , moderate financial loss, potential local short-term media interest
3. Moderate	Moderate impact on PC Strategy outcomes, moderate loss of reputation, moderate business interruption, high financial loss, potential local long-term media interest
4. Major	Significant impact on PC Strategy , major loss of reputation, major business interruption, major financial loss, potential national media interest
5. Severe	Severe impact on patient outcomes, far reaching environmental implications, permanent loss of service or facility, catastrophic loss of reputation, multiple claims, parliamentary questions, prosecutions, highly significant financial loss



NHS Shropshire CCG
NHS Telford and Wrekin CCG

REPORT TO: **Shropshire, Telford and Wrekin CCGs Primary Care Commissioning Committee**
Meetings in Common held in Public on 2 December 2020

Item Number:	Agenda Item:
PCCC-20-12.23	Application by Pontesbury Medical Practice and Worthen Medical Practice to merge practices

Executive Lead (s):	Author(s):
Claire Parker Director of Partnerships claire.parker2@nhs.net	Izzy Culliss – Project Manager for Pontesbury & Worthen Izzy.Culliss@nhs.net Jenny Stevenson - Locality Manager, Shropshire CCG Jenny.stevenson13@nhs.net

Action Required (please select):									
A=Approval	X	R=Ratification		S=Assurance		D=Discussion		I=Information	

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**

Executive Summary (key points in the report):

The purpose of this paper is to provide Primary Care Commissioning Committee with the background and information on why Pontesbury and Worthen Medical Practices would like to merge, and to ratify and confirm the steps and processes undertaken so far.

The practices have worked together for many years and are closely aligned from a clinical, geographical and managerial perspective. It has long been the intention that eventually Pontesbury and Worthen practices would consider merging.

Engagement has taken place with staff and patients, with detail provided within the report. Websites were set up to help collate and respond to queries and concerns raised by patients.

In line with guidance, support has been given by the Primary Care Team confirming that this paper was to be presented at PCCC before any formal NHSE or CQC forms were completed and submitted.

Maps are included that provide detail of current and proposed practice boundaries.

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest? *(If yes, outline who has the potential conflict of interest, what it is and recommendation of how this might be mitigated).* Dr Julian Povey, Shropshire CCG Chair, is one of the Partners at Pontesbury Medical Practice.	Yes

2.	Is there a financial or additional staffing resource implication? *(If yes, please provide details of additional resources required).*	No
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated).* If the merger is refused by the CCG and NHSE then there would be a risk to the practices' financial and clinical sustainability.	Yes
4.	Is there a legal impact to the organisation? *(If yes, how will this be mitigated).* Only in terms of ensuring legal documents are duly processed and signed in accordance with a GP practice legal and professional structure.	Yes
5.	Are there human rights, equality and diversity requirements? *(If yes, please provide details of the effect upon these requirements).*	No
6.	Is there a clinical engagement requirement? *(If yes, please provide details of the clinical engagement).*	No
7.	Is there a patient and public engagement requirement? *(If yes, please provide details of the patient and public engagement).* A patient and public engagement process has been followed, in the absence of being able to hold open consultations as would have been "the norm" pre Covid-19. This is detailed in the paper.	Yes

Recommendations/Actions Required:

Primary Care Commissioning Committee is asked to:

- Note the detail of the application in the attached paper
- To review the boundary maps and plan proposed
- To approve the application to merge Pontesbury and Worthen Practices with effect from 1st April 2021

Application by Pontesbury Medical Practice and Worthen Medical Practice to merge practices

1. Introduction

1.1 On 18th September 2020 a notice of intention was submitted to the Primary Care team to merge Pontesbury and Worthen Medical Practices with effect from 1st April 2021. The Primary Care Team acknowledged the intention and designated Jenny Stevenson as the CCG contact to progress this alongside the practices and Izzy Culliss, Project Manager.

1.2 The intention is that the new practice will be known as Pontesbury & Worthen Medical Practice, and that both sites and both dispensaries will remain open, with the current Worthen site being used as a "branch practice". For the purposes of ODS code, CQC registration, PAYE/Tax registration, VAT registration, and Pension registration the current Worthen Medical Practice will be absorbed into Pontesbury Medical Practice.

1.3 Any required paperwork and applications will be processed once PCCC have analysed and approved this paper.

2. Context

2.1 The practices have worked together for many years, and are closely aligned from both a clinical, geographical and managerial perspective. The other practice who is close geographically is Westbury Medical Practice and they have been informed that this application and intention was being submitted.

2.2 Both practices were very influential in establishing the Rural Cluster of the Shrewsbury Primary Care Network, through which much of the future funding for Primary Care Services will be drawn.

2.3 The combined strengths in clinical care and service provision will place the practices in an extremely strong and influential position in determining how services are commissioned and implemented for their own patients, and will help secure the broad accessible service they currently provide is maintained and continually improved.

2.4 The practices' clinical and administrative teams will be combined allowing them to service their communities and provide holistic health care, and coupled with the expansion of staff through the Primary Care Network they aim to build on their current set up and enhance it.

2.5 They will work with the CCG, the PCN and their combined patient participation groups to develop a service that optimizes the resources available and meets the needs of their patients.

3. Engagement

3.1 In this challenging time staff and patient engagement had to be considered and planned carefully to ensure everyone had the opportunity to raise any concerns virtually and in the absence of actual face to face events.

3.2 With the assistance of Martin Kaye Solicitors, who both practices receive HR and Legal advice from, staff were informed of the intention to merge by letter and offering the opportunity to discuss further with either Practice Manager or any of the GPs involved. They have been reassured that there is no intention of any redundancies and that the structure will be looked at independently and carefully to ensure staff positions/salaries/roles and responsibilities are carefully considered.

3.3 Staff will effectively TUPE over to the combined practices as the employer, and with Pontesbury Medical Practice's PAYE/HMRC codes being retained for this purpose, but will see no change to their contracted terms and conditions as both practices use the same already, as provided by Martin Kaye Solicitors.

3.4 How to effectively engage with the patient populations from both practices was planned sensibly considering safety to be the main priority given the current pandemic and the need to minimize unnecessary face to face contacts.

3.5 A dedicated website www.pontesburyworthenmp.co.uk was set up, with a receiving email address info@pontesburyworthenmp.co.uk , solely for the purpose of providing information regarding the intended merger.

3.6 An information poster and letter was developed with all pertinent information and providing patients with the contact details of how to make comments and a deadline of 15th November for all comments to be received by. This went live in early October, shared first with each practice's PPG and the Worthen Village Hall Committee, thus giving patients a month to respond which was felt to be a fair amount of time. The poster and letter were published on the website, social media practice accounts, text messages with links to the online documents were sent out, and paper copies were available in each practice, or via post on request for those not able to easily use the internet.

3.7 Comments were invited via the website email address, by letter, or direct to the practices – although it was stressed that appointments should not be used to discuss these matters.

3.8 The attached spreadsheet (Appendix 1) provides details of anonymized comments received, plus the responses back to each individual and whether further comments came back. Most of the issues and concerns raised were easily resolved and patients were then reassured.

3.9 A dedicated FAQ page (Appendix 2) was created on the website to put some of the common questions on to make it easier for patients to access the answers. The website will be kept open once the 15th November has passed as an information resource for patients, before it becomes the main practice website.

3.10 The social media analytics show that "tweets" regarding the merger and sent from the Pontesbury MP account achieved over 800 hits, with 194 engagements i.e. retweets and likes. The website analytics show that in the period from 16th October to 16th November the main page has seen 605 hits, with 93% of the page loads for the main page, and 7% for the FAQ page. There were 1136 unique visitors to the website, and the patient engagement pdf document was downloaded 60 times.

4. IT and Infrastructure

4.1 Both practices use EMIS Web, Docman 10 and intend to merge their systems, appointment configuration and dispensary systems.

4.2 Through Paul Gnosill at MLCSU, EMIS have advised that the system merger should be done either two weeks prior to or after 1st April 2021. Further discussions are to be had regarding this and any housekeeping required before the systems merge.

4.3 As mentioned above a new website has been created and the intention is that this will become the website for the merged practices. Work taking information from Pontesbury and Worthen's existing websites can be done in the background prior to the 1st April. The new domain name is owned by the practices.

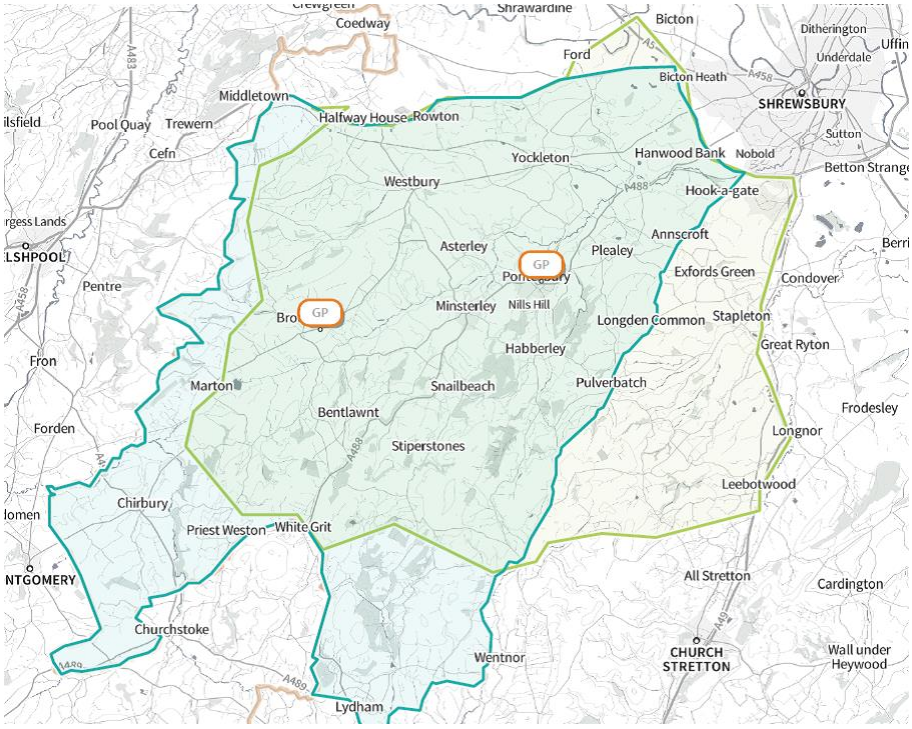
4.4 We are exploring the options with the current telephone providers; Pontesbury use Redcentric, and Worthen use Fluid, so an exercise will be done to choose which provider to transfer to, and there will be a main appointments booking line. By ringing this patients will be able to book appointments at either site.

4.5 A "best practice" approach will be taken for all other infrastructure areas, comparing what both practices have currently, and deciding which to merge and continue with based on value for money and satisfaction with the provision.

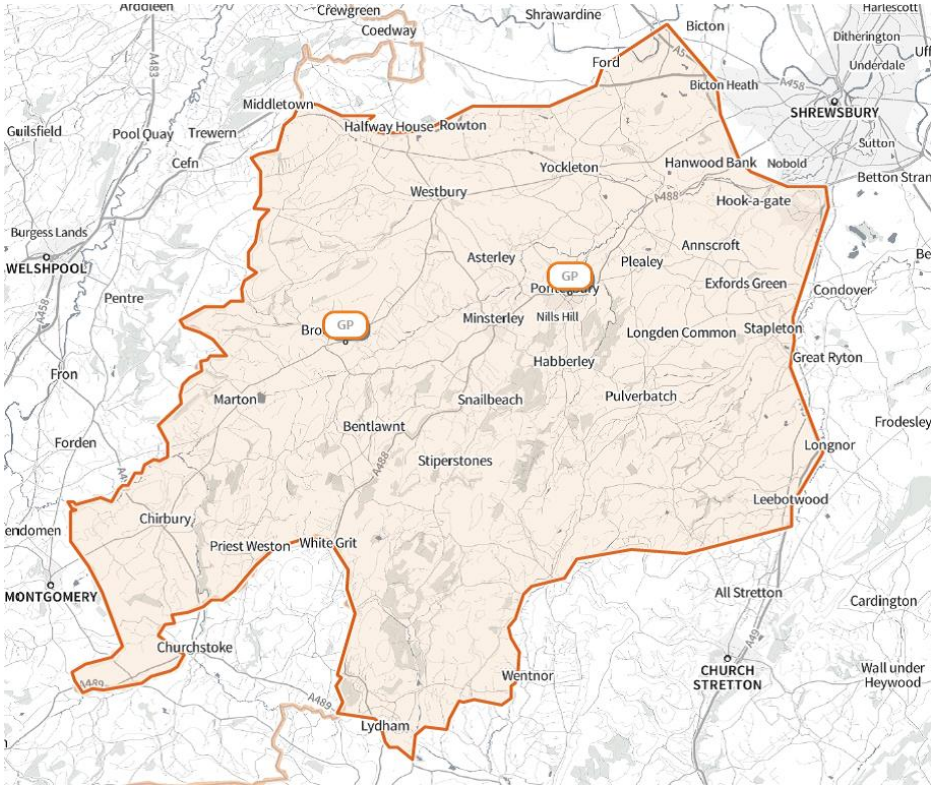
5. Practice Boundary

5.1 Geographically the practices' current boundary areas border each other, so the merging of the boundary areas is relatively straight forward. Patients will be able to choose where they are seen, subject to clinical need and appointment availability, and the intention is that there will be a good clinical mix across both sites so as to not compromise patient care.

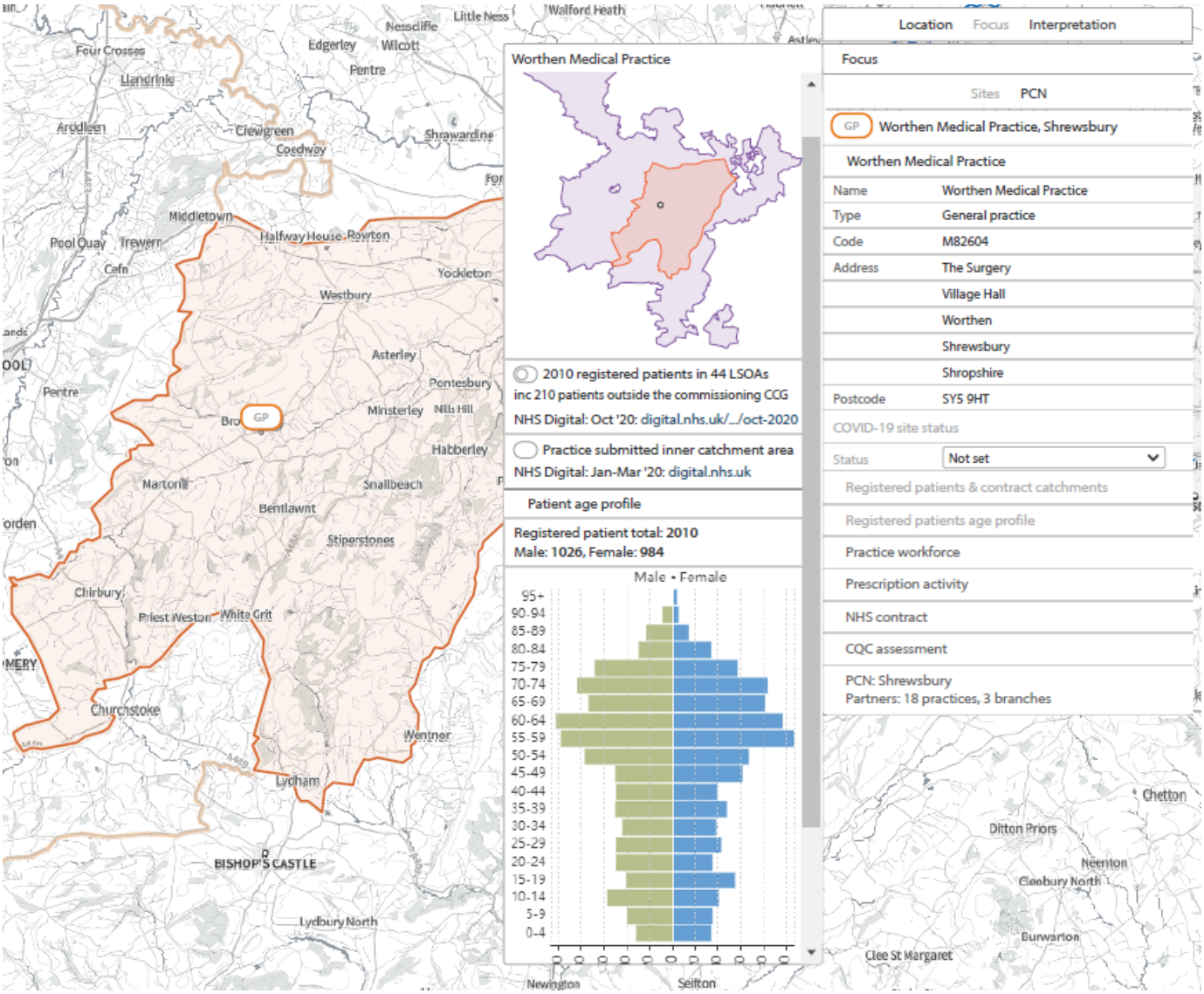
The current practice boundaries can be seen below; Pontesbury in the lime green shade, and Worthen in the teal green shade.



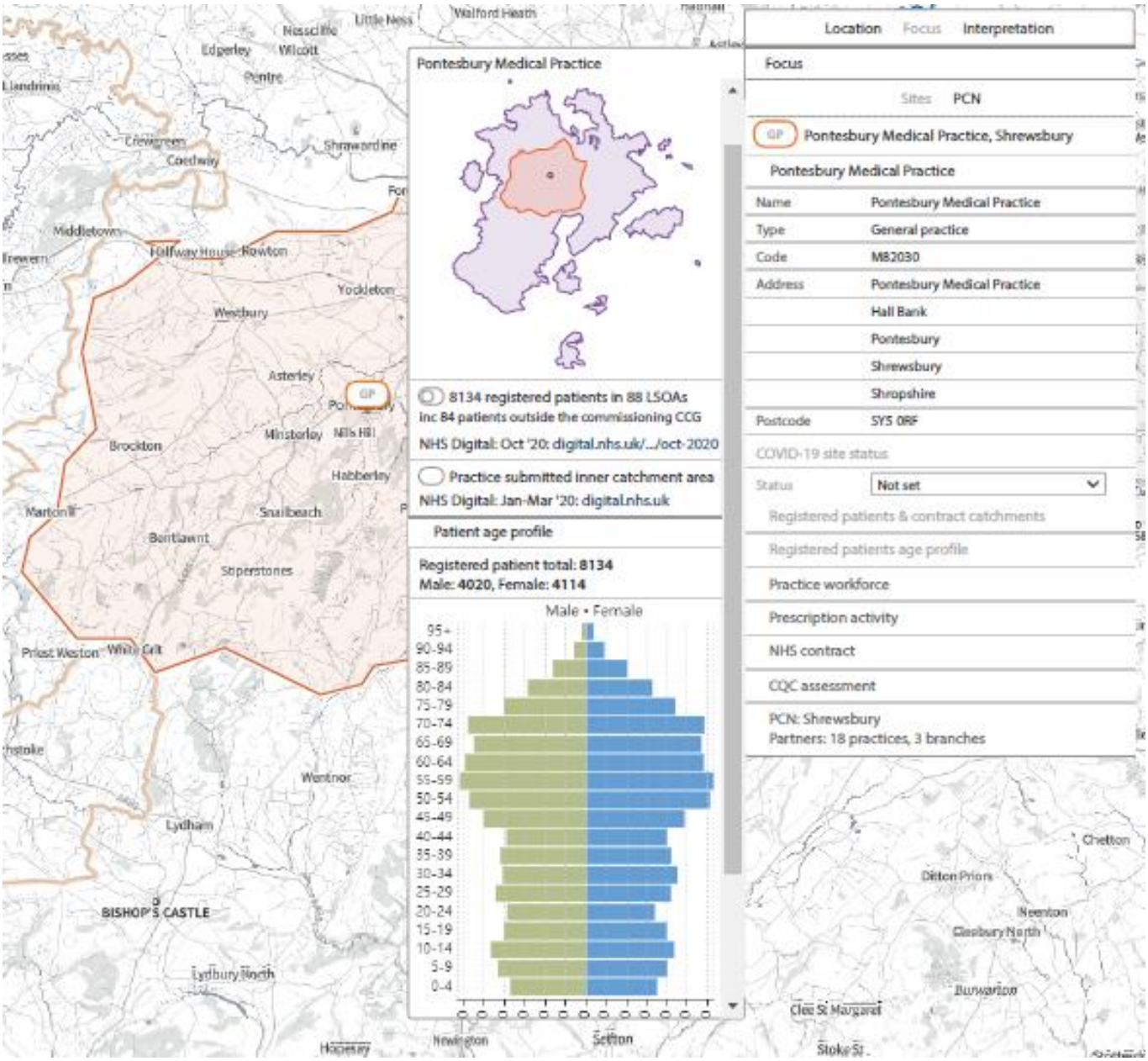
The proposed merged practice boundary is shown here in orange, encompassing the entire area both practices previously covered. On current patient figures the combined patient population will be just over 10,000.



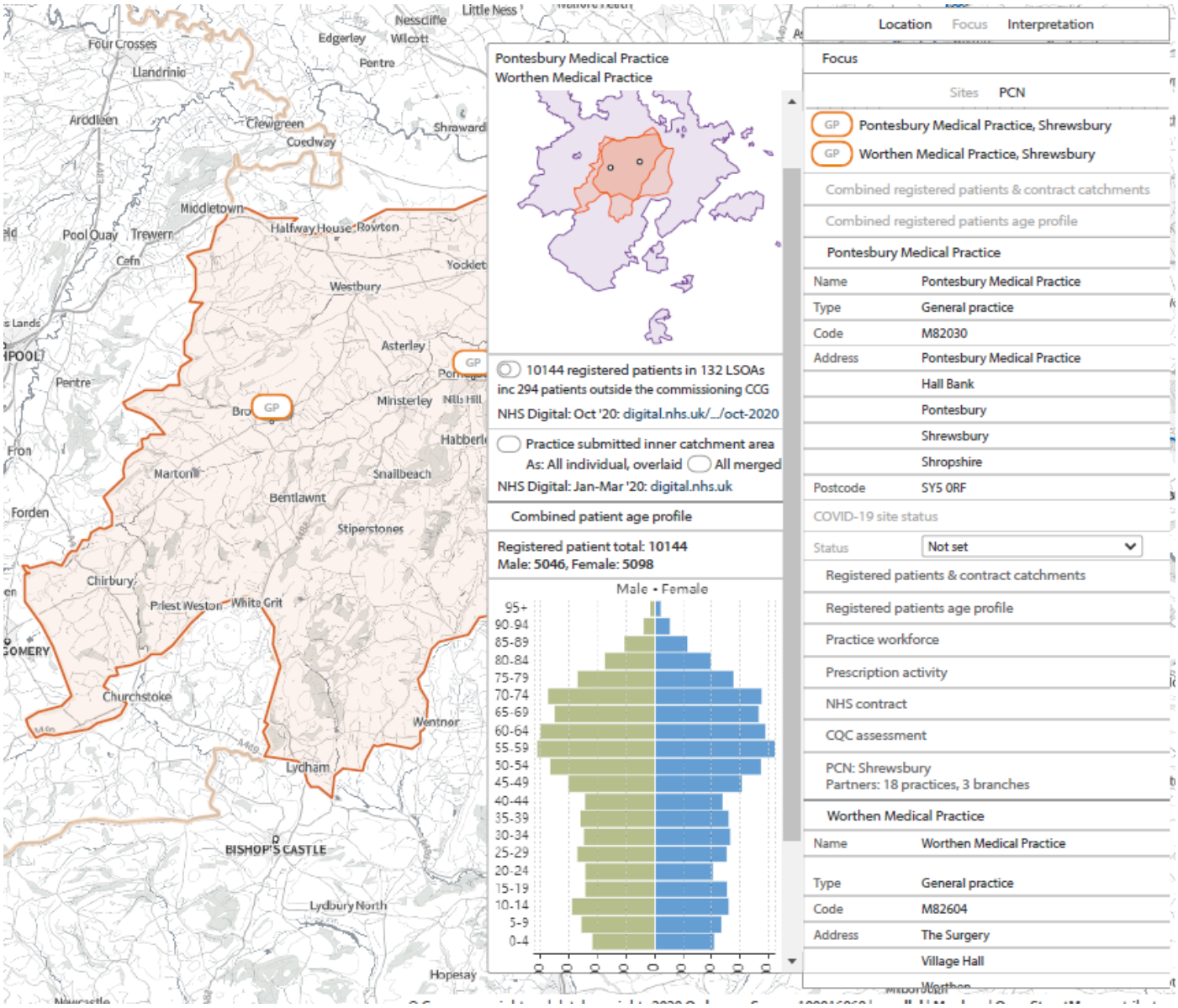
Worthen Medical Practice
Showing a snapshot of the Contract catchments and Age Profile



Pontesbury Medical Practice
Showing a snapshot of the Contract catchments and Age Profile



Pontesbury & Worthen Medical Practice
Showing a snapshot of the Contract catchments and Age Profile



6. Conclusion

6.1 It has long been the intention that eventually Pontesbury and Worthen practices would consider merging, and given the additional significant pressures general practice is facing this year and into the next financial year we feel that now is the ideal time to merge and share our resources and work together in providing the best possible care for our combined patients.

6.2 Our plan is measured and realistic and we have already taken steps to start the process towards merging pending CCG approval, so that we can go live with the new practice from 1st April 2021.

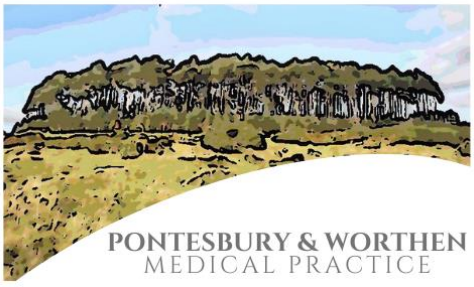
7. Actions & Recommendations

Primary Care Commissioning Committee is asked to:

- Note the detail of the application in the attached paper
- To review the boundary maps and plan proposed
- To approve the application to merge Pontesbury and Worthen Practices with effect from 1st April 2021

AUTHORS:

- **Dr Julian Povey, GP, Pontesbury MP**
- **Dr Kieran McCormack, GP, Worthen MP**
- **Izzy Culliss, Project Manager**



Practice	Date	Question	Answer	Response from	Response sent	Further reply
Worthen	02/11/2020	Will you remain a NHS practice, offering a broad range of 'private' treatment; or is this the beginnings of a 'private medical care' practice? Your announcement in the Worthen Newsletter isn't explicit	Thanks for your email. In response to your question regarding the proposed merger 'Will you remain a NHS practice, offering a broad range of 'private' treatment; or is this the beginnings of a 'private medical care' practice?' I would like to confirm that yes we will absolutely be remaining as an NHS practice, there is no intention of becoming a private medical practice. I trust this answers your question. Please let me know if you have any other queries.	CB	03/11/2020	Yes, it does. Thank you so much. I'll contact my friends and confirm this with them
Worthen	01/11/2020	I am disappointed that WMP decided to announce its merger with Pontesbury in the newsletter and that it chose not to consult with its patients.	I am sorry that you feel that is the case – it was certainly not the intention. The consultation period is now open and we would like to hear from all of our patients about specific concerns, which we will attempt to address. If you have any questions please let me know.	CB	03/11/2020	
Worthen	30/10/2020	I realise that it is national policy to amalgamate single handed practices where possible, and I note that you are 'extremely excited' to announce the agreement to form a new joint practice. It is recognised that Dr Kieran has worked extremely hard to ensure that rural communities are not adversely affected in terms of funding and I am prepared to believe that Pontesbury has also been effective in striving for patients and communities, (note the Primary Care Centre established in recent years). However, there are several general aspects/queries that I would like noted with reference to this merger. Will a satisfactory level of autonomy be maintained, both for the administration and for the medical aspects of a GP practice when you combine the clinical and administrative teams? Will there be resultant job losses when the amalgamation is finalised, (note the phrase 'forming a stronger more resilient team'). Best practice was noted in administration by the Worthen team and cited by the most recent CQC report and not apparent from the Pontesbury CQC report of roughly the same era, for example, the fact that Worthen staff implemented a system to reduce the risk of patients missing regular reviews for common conditions and the in-house community care co-ordinator. Will that best practice be implemented on the Pontesbury site? Various recommendations noted in the Pontesbury CQC report, will presumably have been addressed and will not adversely impact on Worthen's good practice? (including for DBS checks, H&S risk assessments, implementation of a documented staff induction system et al). It is interesting to note that the CQC site showing the pitifully few compliments for both Practices are responded to by Pontesbury, but not apparently by Worthen? However, the complaint on the Pontesbury site did not seemingly receive a response. With reference to 'Will I be able to see my usual doctor'? You state that there will be access to a broader range of clinicians which is self-evident given the numbers of GPs/health care professionals at the Pontesbury site, but those staffs will only have access to medical records and not necessarily 'know' the patient in front of them, which leads to the comment up and down the country that you cannot see the same professional twice running. Worthen patients are exceptionally lucky from this perspective. In times to come, will the patients of Worthen be expected to go to the Pontesbury site for some aspects of service, with no choice in the matter? This of course works in reverse, but from comments received amongst friends who are existing patients, they are very keen to retain practice provision at Worthen whilst some of the Pontesbury patients know they would receive excellent diagnosis and treatment at Worthen! This would of course put extra strain on the Worthen practice. With reference to 'Booking appointments – will I see any changes?· From comments, both documented and verbal from existing patients at Pontesbury, it is apparent that a form of triage exists, conducted by the reception staff at Pontesbury leading to appointments ultimately being granted often up to 3-4 weeks ahead, thereby potentially jeopardising patient safety. Will this practice be undertaken and apply to the Worthen Practice, (whose reception staff at present could hold in-house training workshops in good customer service and good patient management for some of the Pontesbury staffs)?	Thanks for your email and attachment. I understand your concerns and appreciate the time it has taken you to compile them. I hope that I have addressed all your concerns. Please feel free to ring me to discuss them further if you wish. I will try to answer all the points raised in the same order below:- There are no redundancies planned. The expectation is that by merging we will pool staff skills and be able to be a more resilient team when, for example, faced with staff time off or sickness – something we currently struggle with as a small team at Worthen. With regard to the 'best practice' question, we will be looking at all our processes at both sites with the plan to take the best from each practice going forwards. We have already started to identify areas where each practice has strengths and how we implement them across both sites. By merging, the expectation is that services will be strengthened for patients. Patients will still be able to access the health care they need at either site and should have a greater degree of flexibility of when or where they are seen and a greater choice of clinicians. Thank you for the compliment about how good the reception staff are – they do try hard and it is appreciated. Standardising processes is part of the merger but with an eye on improving standards where needed. With covid we have had to adapt to a very different way of working in order to keep patients safe and this has meant a big change to how we run our appointments system. This has been accepted by patients and we have found that telephone triage is working well. This is something Pontesbury have been doing for a while so should not be too big a change for patients when we merge.	CB	03/11/2020	
Pontesbury	24/10/2020	I have no real comments to make , but I do worry that Worthen patients will monopolise our excellent G.Ps and getting an appointment will be much more difficult than it is at present.	Thank you so much for your feedback, we really appreciate you taking the time to do this. The demand at Worthen and Pontesbury is roughly similar, and given that we will be working with the same number of clinicians, it is unlikely that anyone clinician will be 'monopolised'. Patients will have a wider choice of both clinicians and access opportunities in the merged practices. However, we envisage that we will be able to offer patients appointments with their preferred GP in most situations and understand that the long-standing trust and professional relationships are very important to both patients and their doctors.	HB		
Pontesbury	30/10/2020	From a patient viewpoint there is so little on which to comment. "The Practices" need to thrash out the operational systems, which you say will in most respects be similar to today's, meaning we patients should see virtually no change (there is a likelihood that the Covid problems will outweigh the integration complexity). If your main computer is bug-free then only some essentially logical extra system rules for the practice personnel would be needed. If a live-and-well patient group is sought then some integration of "enthusiastic" folk from the P and from the W must be sought (sounds simple, but I bet it will not be). I have made some straightforward comments above, but I should be happy to attend a 6 foot spaced meeting (!) or answer questions or offer further comment if patient involvement is being considered.	We really want to get the patients on board from both practices, I have had enquiries from Pontesbury patients that wanted to become involved with our group, so hopefully these exciting times ahead might be the opportunity to get some life back in to our PPG and work together for the good of all. We look forward to working with you and thank you for your kind offer.	HB	02/11/2020	
Pontesbury	02/11/2020	Having read through your proposals on the website, would you please confirm that we would be able to stay with the Pontesbury Doctors, even though we live in Worthen.	Thank you for your enquiry. As the practices are merging all doctors will be working for the new "Pontesbury and Worthen Medical Practice", but you are perfectly entitled to be seen by whichever doctor you choose, subject to availability and your clinical need at the time, and you will have greater choice of appointment and location being able to be seen at either site.	HB	02/11/2020	
Worthen	08/11/2020	For those with transport issues,will it be possible to aee a Pontesbury G.P at the Worthen Medical Centre? What sort of service is envisioned for the Worthen practice?	Thank you for your email about the proposed merger. In response to your question, both sites will run as part of the merged practice, and GPs will run surgeries at both sites, though obviously Worthen can only house one GP surgery at a time, patients will be able to attend either site. There will however be occasions where demand is high, and choice at either site may be limited. As such we would, on occasion, be likely to have urgent assessments being done on one site. Home visiting is only available for patients who are bedbound, or housebound for medical reasons. Generally patients who can attend hospital outpatients would also be expected to have arrangements in place to allow them to attend the surgery. I trust this answers your question. Please let me know if you have any further queries.	CB	09/11/2020	

Worthen	15/11/2020	Although I fully understand that this is not going to be possible until the present pandemic is well behind us are there any plans to return to some walk in surgeries.	Thank you for your question regarding the proposed merger. We have not been able to do our walk-in surgery in Worthen since March, but continue to see patients face to face as appropriate. It is difficult at the moment to imagine a time where having large numbers of patients waiting in the same room would be acceptable. I suspect it may take a number of years for patients to feel comfortable being in close proximity to others, particularly in a surgery waiting room. In the new joint surgery, we will not be able to offer a walk-in surgery in the way Worthen has done. We do however recognise how strongly some patients feel about the value of this service. We will work tirelessly to offer an equivalent level of accessibility through telephone and video triage, e-Consultations and on-the-day appointments. I hope this has answered your query. Please let me know if you have any further questions.	CB	16/11/2020	
Pontesbury	15/11/2020	We were previously unhappy with the service at Worthen and consequently moved over to Pontesbury. Please can you provide assurance that we will still be able to access the Pontesbury surgery, even though we live in Worthen, and that it is the Pontesbury values that will be implements in the new organisation, not the Worthen ones?	Thank you for taking time to respond to our engagement about the planned merger between Pontesbury and Worthen Practice. The planned merger will create a larger practice and build on the positive from both practices. With regard to the 'best practice' question, we will be looking at all our processes at both sites with the plan to take the best from each practice going forwards. We have already started to identify areas where each practice has strengths and how we implement them across both sites. By merging, the expectation is that services will be strengthened for patients. Patients will still be able to access the health care they need at either site and should have a greater degree of flexibility of when or where they are seen and a greater choice of clinicians. I hope this answers your question please don't hesitate to contact me if you would like to discuss this further.	HB	16/11/2020	

Appendix 2

Pontesbury & Worthen Medical Practice

FAQs

- Will you remain a NHS practice, offering a broad range of 'private' treatment; or is this the beginnings of a 'private medical care' practice?

Yes we will absolutely be remaining as an NHS practice, there is no intention of becoming a private medical practice.

- Will a satisfactory level of autonomy be maintained, both for the administration and for the medical aspects of a GP practice when you combine the clinical and administrative teams?

The structure is being looked at so everyone has appropriate line management, but as in any practice a degree of autonomy is required to carry out day to day duties.

- Will there be resultant job losses when the amalgamation is finalised?

There are no redundancies planned.

- Will best practice be implemented across both sites?

We will be looking at all our processes at both sites with the plan to take the best from each practice going forwards. We have already started to identify areas where each practice has strengths and how we implement them across both sites. By merging, the expectation is that services will be strengthened for patients. Patients will still be able to access the health care they need at either site and should have a greater degree of flexibility of when or where they are seen and a greater choice of clinicians.

- Will telephone triage be undertaken and applied when booking appointments?

With the Covid-19 pandemic we have had to adapt to a very different way of working in order to keep patients safe and this has meant a big change to how we run our appointments system. This has been accepted by patients and we have found that telephone triage is working well.

- Will we be able to a doctor of our choice e.g. the one we are used to seeing?

As the practices are merging all doctors will be working for the new "Pontesbury and Worthen Medical Practice", but you are perfectly entitled to be seen by whichever doctor you choose, subject to availability and your clinical need at the time, and you will have greater choice of appointment and location being able to be seen at either site.

- For those with transport issues, will it be possible to see a Pontesbury G.P at the Worthen Medical Centre? What sort of service is envisioned for the Worthen practice?

Both sites will run as part of the merged practice, and GPs will run surgeries at both sites, though obviously Worthen can only house one GP surgery at a time, patients will be able to attend either site. There will however be occasions where demand is high, and choice at either site may be limited. As such we would, on occasion, be likely to have urgent assessments being done on one site.

Home visiting is only available for patients who are bedbound, or housebound for medical reasons. Generally patients who can attend hospital outpatients would also be expected to have arrangements in place to allow them to attend the surgery.

NHS Shropshire CCG
NHS Telford and Wrekin CCG

REPORT TO: **Shropshire, Telford and Wrekin CCGs Primary Care Commissioning Committee**
Meetings in Common held in Public on

Item Number:	Agenda Item:
PCCC-20-12.24	**GP Practice Annual Declaration report 2019-20**

Executive Lead (s):	Author(s):
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Action Required (please select):									
A=Approval	✓	R=Ratification		S=Assurance		D=Discussion		I=Information	

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**

Executive Summary (key points in the report):

The General Practice Electronic Declaration (eDec) is an annual contractual requirement in which practices provide answers to a series of questions with the purpose of providing assurances of contract compliance.

The return period is usually from the last week of October until the first week of December.

The eDec is submitted by a senior member of the practice staff usually the practice manager and/or senior partner.

The 2019/20 eDec was prepopulated with responses from 2018/19 practice collection. A number of questions are voluntary but all practices were encouraged to provide an answer.

There were no concerns identified from the practice submissions albeit a number of anomalies.

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest? *(If yes, outline who has the potential conflict of interest, what it is and recommendation of how this might be mitigated).* -	No
2.	Is there a financial or additional staffing resource implication? *(If yes, please provide details of additional resources required).*	No
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated).*	No
4.	Is there a legal impact to the organisation? *(If yes, how will this be mitigated).*	No
5.	Are there human rights, equality and diversity requirements? *(If yes, please provide details of the effect upon these requirements).*	No
6.	Is there a clinical engagement requirement? *(If yes, please provide details of the clinical engagement).*	No
7.	Is there a patient and public engagement requirement? *(If yes, please provide details of the patient and public engagement).*	No

Recommendations/Actions Required:
Primary Care Commissioning Committee is asked to: • Consider the content of this report. • Receive this update and accept the assurance of practice compliance with the contract. • Receive an update on the 2020/21 submissions as soon as possible after the information has been released.

1. Introduction

1.1 The electronic self-declaration (eDEC) is a mandatory collection which all GP practices in England must complete every year. The eDEC forms an integral part of the CCGs delegated responsibilities.

2. Background Information

2.1 NHS England Policy and Guidance Manual book of primary medical services states that delegated CCGs have a statutory duty to conduct a routine annual review of every primary medical care contract it holds. This is covered through the annual GP Practice self-declaration (eDec) collection which NHS England has established with providers. Therefore, commissioners should ensure they review the practices eDec returns following submission and any subsequent national analysis produced (e.g. NHS England's eDec outlier report which will be made available 6-8 weeks following eDec close)

2.2 The collection usually starts in October each year with final submissions completed December. The submission is undertaken by a senior member of the practice, most likely to be the practice manager.

2.3 CCGs are able to review these submissions albeit this year it has been delayed; we will be able to use them to triangulate with other information we have about the practices as part of any future practice visit programme.

3. Findings

3.1 All except one practice submitted their responses as required. The practice that didn't submit was asked to complete a manual declaration.

3.2 There are 118 questions within the declaration, some of which are voluntary. This includes information regarding practice staff, premises and equipment, opening hours, practice services, practice procedures, governance, catchment area, CQC and general practice IT. The responses have been reviewed and found a few anomalies within the mandatory questions. Once the declaration has been submitted it is not possible to correct any errors. It will be up to the primary care team to bring to their attention to action and amend in the following years submission to action as necessary.

3.3 Some examples of the anomalies are;

- Question 2L: 5 practices have declared No that the *healthcare workers employed by the practice familiar with the Government's Prevent strategy and have all GPs (partners and salaried) participated in PREVENT training in the past 3 years?*
- Question 4M: 10 practices were unable to confirm that during core hours, patients were aware of how to access essential services during core hours in case of emergency.
- Question 6G: 3 practices have declared No when asked if the practice have a lead for vulnerable adults.

3.4 Points to note;

- All practices confirmed their premises were suitable for the delivery of services and sufficient to meet the reasonable needs of the practice's patients.
- All practices confirmed to have access to interpreting services.
- All practices confirmed that staff have been subject to the necessary Disclosure and Barring service checks
- All practices confirmed engagement with their patient participation group throughout the year.

4. Submission 2020-21

4.1 NHS Digital have advised that the dates for the 2020/21 submission have not been finalised and there are still some changes being made to the eDec. As soon as the submitted information becomes available, the contents will be reviewed and a report will be presented at the earliest possible PCCC meeting.

Primary Care Committee should be aware of the following appendices to support this information:

Appendix A: List of questions

Annual Electronic Practice Self-Declaration (eDec)

Paper Format

Practice Details		
1D	Practice Contract Type	(GMS/PMS/APMS/other)
1E	Organisation Type	(Social Enterprise/NHS body/Non NHS body)
1F	Since your practice last completed this declaration, have you changed configuration or structure? (e.g. the practice is declaring under the same organisation code as for last year's declaration and since this time, the practice has merged or divided from another practice).	Yes / No/ N/A
1G	Contract start date/ end date (where applicable)	DD/MM/YY
1H	Practice telephone number (for patients)	
1I	Practice telephone number (other, if different)	
1J	Does the practice have any branches? If so, how many and what are their names?	

Practice Staff (Numbers and Suitability)		
2A	The practice can evidence and make available the needs analysis and risk assessment it has used for deciding sufficient staff levels. Recognising the need to have the right knowledge, experience, qualifications and skills for the purpose of providing services in the practice and demonstrating capacity to respond to unexpected service changes.	Yes/No
2B	All health care professionals working in the practice are registered with the relevant professional body, and that this registration is checked on employment (along with satisfactory references) and where applicable annually thereafter, and that health care professionals that are required to revalidate do so and that for GPs, inclusion on the performer list is checked. *(GMS Regulations Part 7, PMS Regulations Part 8, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18(2)(c))*.	Yes/No
2C	All relevant staff have been subject to the necessary Disclosure and Barring Service (DBS) checks. The DBS has replaced the Criminal Records Bureau https://www.gov.uk/government/organisations/disclosure-and-barring-service/about) See also the CQC myth buster on DBS checks. http://www.cqc.org.uk/content/nigels-surgery-2-who-should-have-disclosure-and-barring-service-dbs-check	Yes/No
2D	*The following question relates to locum use and associated cost to the practice. This is an indicative figure only and does not represent what a practice must or should pay. Neither will it be used for performance management purposes.* Total number of locum sessions, between 1st of July 2019 through to 30th September 2019, where pay has exceeded the maximum indicative rate of £77.57 per hour.	
Practice Staff (Training and Suport)		
2E	All health care professionals employed in the practice have annual appraisals and where applicable personal development plans and that this is aligned to revalidation for doctors and also for registered nurses and midwives (according to requirements issued by the Nursing and Midwifery Council) (GMS Regulations Part 7, Regulation 54, PMS Regulations Part 8, Regulation 47), CQC GP handbook	Yes/No
2F	Practice staff have written terms and conditions of employment conforming to or exceeding the statutory minimum *(relevant employment law and GMS Regulations Part 7, Regulation 49).*	Yes/No
2G	The Practice can demonstrate that it is compliant with Equal Opportunities legislation on employment and discrimination. *(Equality Act 2010)*	Yes/No
2L	*Are all healthcare workers employed by the practice familiar with the Government's Prevent strategy and have all GPs (partners and salaried) participated in PREVENT training in the past 3 years?* *Guidance note: participation could be either in person or on-line training.* *Ref. 10.143 page 88 Prevent Strategy:* *https://assets.publishing.service.gov.uk/government/uploads/system/uploa*	Yes/No

	ds/attachment_data/file/97976/prevent-strategy-review.pdf	
2M	The practice has policy(ies) for safeguarding both children and adults which includes: Domestic Violence, Mental Capacity, FGM and the requirement for mandatory reporting, information sharing, freedom to speak up information. (This is a legal requirement to have policies and fits with CQC inspection regulations and Children Act 2004.) Supporting resources/ links: http://www.gpnotebook.co.uk/simplepage.cfm?ID=x20140305071001216972 Royal College toolkits: Child http://www.rcgp.org.uk/clinical-and-research/resources/toolkits/the-rcgp-nspcc-safeguarding-children-toolkit-for-general-practice.aspx Adult http://www.rcgp.org.uk/clinical-and-research/resources/toolkits/safeguarding-adults-at-risk-of-harm-toolkit.aspx)	Yes/No

Practice Premises and Equipment		
3A	The premises used for the provision of services under the contract are suitable for the delivery of those services and sufficient to meet the reasonable needs of the practice's patients. (GMS Regulations Schedule 3 Part 1, Paragraph 1, PMS Regulations Schedule 2 Part 1, Paragraph 2) and must meet Minimum Standards as defined in Schedule 1 of the Premises Costs Directions (2013)	Yes/No
3B	The premises used for the provision of services under the contract are subject to a plan that has been formally agreed with the NHS England (GMS Regulations Schedule 3, Part 1, Paragraph 1, PMS Regulations Schedule 2, Part 1, Paragraph 2) if rectification actions are required; or in order to comply with Minimum Standards as of the current Premises Costs Directions	Yes/No
3C	The practice is able to demonstrate that it complies with arrangements for infection control and decontamination in accordance with the Health & Social Care Act 2008 code of practice on the prevention and control of infections. (GMS Regulations Schedule 3 Part 1 Paragraph 14, PMS Regulations Schedule 2 Part 1, Paragraph 9). In addition the practice will want to be aware of related guidance, such as the National Specifications of Cleanliness in the NHS. Appendix D: examples of interpretation for primary medical care, including carrying out annual audits as set out in the code. National specifications for cleanliness in the NHS: primary care medical and dental premises	Yes/No
3D	The practice can demonstrate that it meets the requirements of the Health & Safety at Work Act 1974 and Fire Safety Regulations [this might include for example evidence of regular review or audit of any policies or procedures adopted by the practice. (Health & Safety at Work Act) The Regulatory Reform (Fire Safety) Order 2005. (http://www.legislation.gov.uk/uksi/2005/1541/contents/made)	Yes/No
3E	Does the practice have at least one consulting room which is accessible to wheelchair users?	Yes/No
3F	If answering No to question 3E, what arrangements are in place to meet the reasonable needs of patients who are wheelchair users?	Select all which apply: 1. Home visit 2. Other (free text)

Practice Services		
Opening Hours (reception and phone lines open)	Question 4A. Details of opening hours for reception	Question 4B. Details of opening hours for phone lines
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Closing Hours		
4C	Are there any regular periods during each week that the practice is closed to patients between the hours of 8.00 and 6.30pm Monday to Friday (except bank holidays)?	Yes/No
4D	If yes, please provide details of days and times	
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
4E	Are there any other intermittent periods during each month that the practice is closed to patients between the hours of 8.00 and 6.30pm Monday to Friday (except bank holidays)?	Yes/No
4F	If responding yes to question 4E, please indicate frequency of intermittent closure period and provide details of days and times	

Day	Frequency of intermittent closure time: select from list: fortnightly / once every three weeks / once a month / once every other month / other (free text)	Time:
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

Question 4Fb: Is the practice closed each week for half a day during core contract hours?	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	

Extended Opening Hours – where the practice provides outside of core contract hours		
4G. Hours per week (not within 08:00-18:30 Mon-Fri)	4H. Funding mechanism (e.g. Network DES, Incentive Scheme, PMS growth, other)	4I. Contract/agreement end date

New Out of Area patients (GMS Regulations, part 5, Regulation 30, PMS Regulations, part 5, Regulation 25)	
4L. Does the practice offer primary medical services (excluding home visits) to new patients who are seeking to register with the practice and reside outside their usual practice boundary area? (Guidance Note: Provision of out of area registration by practices is optional).	Yes / No

In case of Emergency (during core contract hours) The contract states that "the Contractor must provide the services described in Part 8 (namely essential services) at such times, within core hours, as are appropriate to meet the reasonable needs of its patients, and to have in place arrangements for its patients to access such services throughout the core hours in case of emergency" (2014, NHS England, Standard GMS Contract)		
4M	During the preceding 12 months, the practice can confirm, that it can evidence (if requested), how it is meeting the reasonable needs of its patient population and the practice has arrangements in place for its patients to access such services throughout the core hours (08:00 – 18:30 Monday to Friday) in case of emergency?	1. The practice can confirm with evidence which has been obtained from patient sources in the preceding 12 months from: (select all that apply from list) • Patient Participation Group, • GP Patient Survey, • Local Survey, • Combination of PPG/GPPS/Local Survey, • Other: FREE TEXT entry: 2. The practice is not able to confirm
4N	The practice can confirm it has arrangements in place for its patients to access essential services in case of emergency if the practice is not open during core contract hours.	Yes/No
4O	If practice services are not available to patients during core contract hours what arrangements are in place?	Select response from list: • Same OOH provider as that commissioned by CCG, • Sub contracted provider: (enter name and select from list provided), • Provided directly by the practice, • Other free text entry:, • None
Out of Hours		
4P	Is the practice responsible for the provision/commissioning of care in the Out of Hours period? (i.e. care which is provided by the practice or commissioned by the practice. This does not refer to Out of Hours Care commissioned by the CCG).	Yes/No (opted out)
4Q	If 'Yes' and the practice sub-contracts the provision	Enter name of OOH provider

	of out of hours care, please provide the name of the accredited provider.	
4R	If 'Yes' the practice can evidence that it has in place arrangements to monitor its contract with its OOH provider, including: frequency of meetings with the provider, and any action it has taken against its provider through non-compliance or complaints.	Yes/No
4S	If 'No (opted out)' the practice can evidence that it has in place arrangements to monitor and report on any patient or practice concerns about the quality of local OOH services. (GMS Regulations Part 5 Regulation 18, PMS Regulations Part 5 Regulation 22)	Yes/No
4T	If 'No (opted out)' the practice can evidence that it also has in place arrangements to promptly review the clinical details of OOHs consultations made by its patients and for dealing with information requests from the OOH provider. (GMS Regulations Part 5 Regulation 18, PMS Regulations Part 5 Regulation 22)	Yes/No
Access to interpreting Services		
4U	Does the practice provide access to interpreting? Guidance note: Interpreting means: spoken word or British Sign Language.	Select all which apply Telephone Face to face interpreter (inclusive of British Sign Language) Video interpreting (inclusive of British Sign Language) Yes – other No
4V	If yes, who funds the interpreting service?	Select all that apply: i) Practice ii) CCG iii) NHS England iv) Other
Maintaining up to date information on the GP practice website		
4W	Does the practice review and update (where appropriate) the content of the practice website on at least two separate occasions, or more, per year?	Yes/No

Communicating with Patients		
5A	The practice produces a leaflet that includes all of the requirements set out in its contract. (GMS Regulations Part 10, Regulation 78, PMS Regulations, Part 11, Regulation 71).	Yes/No
5B	The practice reviews and updates its leaflet at least once every 12 months. (GMS Regulations Part 10, Regulation 78,PMS Regulations Part 11 Regulation 71).	Yes/No
5C	The practice leaflet is made available for patients/prospective patients. (GMS Regulations Part 10, Regulation 78, PMS Regulations Part 11, Regulation 71)	Yes/No
5D	The practice has a complaints policy which complies with the NHS complaints procedure and it is advertised to patients. (GMS Regulations Part 11, Regulation 79, PMS Regulations Part 12, Regulation 72).	Yes/No
5E	The practice can demonstrate reasonable grounds where it has refused an application to register and keeps a written record of refusals and the reasons for them. (GMS Regulations Schedule 3, Part 2, Paragraph 21, PMS Regulations Schedule 2, Part 2, Paragraph 20).	Yes/No
5F	When removing patients from its list the practice can demonstrate that it does so in accordance with contractual requirements and provides the required notice, including providing an explanation of the reasons in writing to the patient. (GMS Regulations Schedule 3, Part 2, Paragraph 21, PMS Regulations Schedule 2, Part 2, Paragraph 20)	Yes/No
5G	The practice can evidence that they have engaged with their PPG throughout the year and make available such feedback to the practice population including actions and reports, including where they have acted on suggestions for improvement. (GMS Regulations Part 5, Regulation 26, PMS Regulations Part 5, Regulation 20).	Yes/No
5H	The practice is able to show that the PPG is properly representative of its practice population or that it has made and continues to make efforts to ensure it is representative of its local population. (GMS Regulations Part 5, Regulation 26, PMS Regulations Part 5, Regulation 20)	Yes/No
5I	When undertaking call/recall activities as part of delivering vaccination programmes please specify when required how the practice's eligible population are contacted?	Selection all options that apply: Poster in waiting room Notification on practice website Letter to patient Text message to patient

		Phone call to patient During consultation/ appointment Other electronic technical solution (free text) Other non-electronic technical solution (free text) n/a practice does not undertake call/recall
5U	Has the GP practice updated their whistleblowing policy in light of published guidance? Ref: https://www.england.nhs.uk/2016/11/support-whistleblowers-pc/	Yes/No
5V	Has the practice identified someone external to the practice staff can raise concerns with in confidence (e.g. freedom to speak up guardian, local whistleblowing lead)?	Yes/No
5X	Practice confirms it is not advertising the provision of private GP services either by itself or through any other person (via the practice leaflet, practice website or any other written or electronic means)?	Yes/No

Medication		
5J	The practice has a written policy and procedures in line with the requirements of the Medicines Act (GMS Regulations Part 14 Regulation 87, PMS Regulations Part 14 Regulation 79) which will be made available if requested.	Yes/No
5K	Practice stores vaccines in accordance with the manufacturer's instructions (GMS Regulations Schedule 3, Paragraph 13, PMS Regulations Schedule 2 Paragraph 8).	Yes/No
5L	The practice has a procedure to ensure all batch numbers and expiry dates are recorded for all vaccines administered and that all immunisations, vaccinations and consent to immunisations are recorded in the patient record (GMS Regulations Schedule 1 Paragraph 4, PMS subject to local agreement).	Yes/No
5M	The Practice stores its Vaccines in fridges which have a max and min thermometer and can demonstrate, if asked, that readings are taken on all working days. (GMS Regulations Schedule 3, Part 1, Paragraph 13, PMS Regulations Schedule 2, Part 1, Paragraph 8).	Yes/No
5N	All staff involved in administering vaccines are trained in the recognition of anaphylaxis and able to administer appropriate first line treatment when it occurs (GMS Regulations Schedule 1, Paragraph 4, PMS subject to local agreement).	Yes/No
5O	With regard to dispensing doctors: the practice can demonstrate it has clear procedures, that are followed in practice, monitored and reviewed, for controlled drugs, unless they are taken by the person themselves in their own home, including: investigations about adverse events, incidents, errors and near misses; sharing concerns about mishandling.	Yes/ No/ N/A
5P	With regard to dispensing doctors: The practice has systems in place to ensure they comply with the requirements of the Controlled Drugs (Supervision of Management and Use) Regulations 2006, relevant health technical memoranda and professional guidance from the Royal Pharmaceutical Society of Great Britain and other relevant professional bodies and agencies.	Yes/ No/ N/A
5Q	With regard to dispensing doctors: The practice declares it complies with the terms of service of dispensing doctors outlined in schedule 6 of The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and; The practice can demonstrate that for all patients which it dispenses to it is satisfied that they would have serious difficulty in obtaining any necessary	Yes/ No/ N/A

	drugs or appliances from an NHS pharmacist by reason of distance or inadequacy of means of communication (colloquially known as the “serious difficulty” test which can apply anywhere in the country); or A patient is resident in an area which is rural in character, known as a controlled locality, at a distance of more than one mile1 (1.6 km) from pharmacy premises (excluding any distance selling premises). The pharmacy premises do not have to be in a controlled locality.	

Consent, Including Children		
5S	The practice records patients’ consent for minor surgery including curettage and cautery and, in relation to warts, verrucae and other skin lesions, cryocautery (GMS Regulations Schedule 1 Paragraph 8, PMS subject to local agreement)	Yes /No
5W	The practice has a policy for patients to request chaperones, this policy includes children and young people as well as adult patients. **Addenbrooks Hospital NHS Trust has example of best practice**: https://www.cuh.nhs.uk/about-us/our-profile/policies-and-procedures **Further references of note, learning from:** **Myles Bradbury investigation report:** https://www.verita.net/wp-content/uploads/2016/04/Independent-investigation-into-governance-arrangements-in-the-paediatric-haematology-and-oncology-service-at-Cambridge-University-Hospitals-NHS-Foundation-Trust-following-the-Myles-Bradbury-case.pdf **Savile investigation recommendations:** https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/407209/KL_lessons_learned_report_FINAL.pdf	Yes /No

Information and Clinical Governance		
6A	The practice has a protocol to allow patients access to their records on request in accordance with current legislation (Data Protection Act 2018 and GMS Regulations Part 10, Regulation 71,PMS Regulations Part 11, Regulation 64)	Yes/No
6B	The practice has a nominated person who has responsibility for ensuring the effective operation of the system of clinical governance. (GMS Regulations Schedule Part 14, Regulation 87, PMS Regulations Part 14, Regulation 79).	Yes/No
6C	The practice is registered under the Data Protection Act 2018 (Data Protection Act 2018).	Yes/No
6D	The practice has a procedure for electronic transmission of patient data in line with national policy (Data Protection Act 2018 and GMS Regulations Part 10, Regulation 69,PMS Regulations Part 11, Regulation 62) including mechanisms to ensure that computerised medical records/data are transferred to a new practice when a patient leaves.	Yes/No
General Data Protection Regulation: GDPR general guidance include advise for general practice: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/information-governance-alliance-iga/general-data-protection-regulation-gdpr-guidance Additional support references on DPO: https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/accountability-and-governance/data-protection-officers/ http://pwc.blogs.com/data_protection/2017/02/data-protection-officer-do-you-need-to-appoint-one.html https://edps.europa.eu/data-protection/data-protection/reference-library/data-protection-officer-dpo_en		
6K	The13r practice has either appointed a Data Protection Officer or has plans to do so?	Yes/No
Interoperable Patient Records		
6F	The practice has arrangements in place to ensure a validated NHS number is used in all NHS clinical correspondence, including referrals, generated by the practice, except in exceptional circumstances where the number cannot be ascertained.10 (GMS Regulations Part 10, Regulation 70, PMS Regulations Part 11, Regulation 63).	Yes/No
Network Contract DES data sharing		
6N	For practices signed up to the Network Contract DES, if applicable does your PCN have in place suitable data sharing and data processing arrangements?	Yes/No/N/A

Clinical Leads for Vulnerable Groups		
6G	Does the practice have a lead for vulnerable adults? The broad definition of a vulnerable adult referred to in the 1997 consultation 'who decides' issued by the lord chancellor department	Yes/No

	is: 'A person who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation'	
6L	Does the practice have procedures and information sharing agreements to ensure information sharing with the multiagency teams for safeguarding vulnerable adults and children. (Children Act 2004) Supporting links: Royal College toolkits: Child http://www.rcgp.org.uk/clinical-and-research/resources/toolkits/the-rcgp-nspcc-safeguarding-children-toolkit-for-general-practice.aspx Adult http://www.rcgp.org.uk/clinical-and-research/resources/toolkits/safeguarding-adults-at-risk-of-harm-toolkit.aspx	Yes/No
6M	Does the practice have clear training agreements for safeguarding and records of training retained within the practice for audit requirements? Notable reference learning from Savile investigation recommendations: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/407209/KL_lessons_learned_report_FINAL.pdf Children Act 2004 requirements: http://www.gpnotebook.co.uk/simplepage.cfm?ID=x20140305071001216972 Supportive tool kits: Royal College of General Practice: Child http://www.rcgp.org.uk/clinical-and-research/resources/toolkits/the-rcgp-nspcc-safeguarding-children-toolkit-for-general-practice.aspx Adult http://www.rcgp.org.uk/clinical-and-research/resources/toolkits/safeguarding-adults-at-risk-of-harm-toolkit.aspx	Yes/No
6J	Mental Capacity Act Background: The House of lords select committee on the Mental Capacity Act 2005 (published 25/2/14) found that statutory services were often failing in their obligations in relation to the MCA. There is patch availability of training resource on the MCA, - but with increasing prevalence of dementia, NHS England wants to ensure that practices have access to appropriate training and support. Assessment of capacity is highlighted in BMA's guidance 'Safeguarding vulnerable adults – a tool kit for general practitioners. CQC inspectors will want GPs and other practice staff to demonstrate their competence in safeguarding adults at risk. Whilst not a contractual requirement, NHS England is keen to ensure all practices have access to the required level of support to ensure that practices are aware of good practice in relation to adult safeguarding and the issues regarding the MCA. The outcome will help	Yes/No

	to inform future training requirements. Question 6J: Within the last 3 years, has the practice provided for training on mental capacity / Mental Capacity (Amendment) Act for practice staff health care professionals and/or other staff (where relevant) and got a system for assessing staff competency?	

Registering with CQC		
7A	'Does your CQC registration accurately reflect the regulated activities you provide, and is each location where you provide them listed' Published guidance available here: Scope of registration What is a location: Guidance for providers and inspectors	Yes/No
7B	Have you notified CQC of any change relating to regulated persons and any of the events listed in the regulations13, put in an application if required and are in in receipt of an up to date registration certificate?	Yes/No?N/A

General Practice IT					
8A	The practice promotes and offers the facility for patients nursing and residential homes to receive consultations electronically, either by email, video, telephone consultation or other electronic means.				Tick all that apply
	Patients	Nursing Homes	Residential Homes	None or N/A	
Email					
Video					
Telephone					
Online Consultations (e.g. Electronic questionnaires, text messaging systems, etc.)					
8B	The practice & its registered patients have access to a shared online system which allows patients to engage with their GP by:			Yes / No: 1. Patients can record their personal health data which is accessible online by the GP 2. Patients and GPs can online collaboratively set goals and care outcomes and track progress against these 3. None or N/A	
8C	The practice principle clinical system is accessible outside the practice for the following purposes:			Yes / No: 1. Access at all routine locations for GP service point of care delivery (eg out of surgery locations such as hospitals, nursing homes and community using mobile technologies)	

		2. Access remotely e.g. home for administrative & maintenance purposes 3. Access from patient homes using mobile technologies (subject to local provider network coverage) 4. None or N/A
8D	Where the practice works within a federation it is able to use its principal clinical system and its IT infrastructure to support shared working between practices in the following ways	Yes / No: 1. Clinical system (records) 2. Appointment booking and management 3. Integrated telephony systems across practices 4. Reporting on activity & coded clinical data 5. Morbidity Registers across aggregated (federation) populations 6. None or N/A
8F	Local acute trust discharge letters/summaries received by the practice electronically in the following ways: (Reference: NHS Standard provider contract Everyone Counts: Planning for Patients 2014/15 to 2018/19)	Yes / No: 1. The majority of local acute discharge summaries/letters are received electronically for out patients 2. The majority of local acute discharge summaries/letters are received electronically for in patients 3. The majority of local A&E discharge summaries are received electronically None or N/A
8G	The practice routinely electronically orders or receives the following diagnostics tests with their main acute provider (Reference: NHS Standard provider contract Everyone Counts: Planning for Patients 2014/15 to 2018/19)	Yes / No: 1. Place orders for common laboratory diagnostic tests 2. Place orders for common imaging & diagnostic tests 3. Receive diagnostic reports for common imaging & diagnostic tests 4. None or N/A
8H	Where there is legitimate access and consent the practice and other local health & social care providers are able to share electronic patient data by view access to records in the following ways: (Ref: NIB framework)	Yes / No: 1. Other local health providers can access practice records 2. Local social care providers can access practice records 3. Practice can access records from other local health providers 4. Practice can access records

		from local social care providers 5. None or N/A
8J	The practice is enriching the Summary Care Record of patients who have given their consent, including those living with severe frailty? NB. The response is not limited to those who have severe frailty and aged 65 and over, instead it refers to all the patients in a practice who have consented for their records to be enriched.	Yes/No
8K	Where the practice has directly purchased IT services, infrastructure or systems (connected to the managed GP IT infrastructure), the practice as contract holder, has reviewed these arrangements for compliance with the ten NDG data security standards and applicable legal requirements and appropriate certification ie ISO/IEC 27001: 2013, Cyber Essentials (CE) and CE+, where appropriate. National Data Guardian Standards 2017	Yes/ No Not Applicable
8L	Does the practice have a process in place to systematically review all locally developed Templates and Searches to ensure alignment with the transition to SNOMED CT?	Yes/No
8M	The practice have completely digitised all of its paper records (Lloyd George)? Guidance note: for practices who have commissioned the digitisation of all their records (with the process underway but not yet completed), including offsite storage and scanning on demand, should respond Yes. We expect most practices will response no to this question.	Yes/No
8N	If NO, the practice uses off-site storage for its paper patient records?	Yes/No
8O	The practice makes 25% of their appointments available for booking online (this relates to the complete range of appointments practices offer to patients)?	Yes/No
8P	The practice can process directly booked appointments from NHS 111? *Guidance note: No applies for circumstances where the capability has not been enabled or is not in use.*	Yes/No

Supporting Information		
10A	Link to practice website	
10B	Link to practice Facebook page	
10C	Opening and closing times of branch practices (if different to main practice).	
10D	Other Supporting information. This section allows you to submit information which may be relevant to your declaration. E.g. practice leaflet, copy of action plan, other information about branch practices.	
10E	To support an assessment of the time burden to practices on completing this data return. Please can you state how long has it taken the practice to complete the declaration?	

NHS Shropshire CCG
NHS Telford and Wrekin CCG

REPORT TO: **Shropshire, Telford and Wrekin CCGs Primary Care Commissioning Committee**
Meetings in Common held in Public on 2 December 2020

Item Number:	Agenda Item:
PCCC-20-12.26	Risk register

Executive Lead (s):	Author(s):
Claire Parker Director of Partnerships Ext: 2492 claire.parker2@nhs.net	Corrine Ralph – Head of Primary Care Ext: 2360 corrineralph@nhs.net

Action Required (please select):									
A=Approval		R=Ratification		S=Assurance	✓	D=Discussion		I=Information	

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**

Executive Summary (key points in the report):

This document contains updated, reviewed risks using the templates from the interim board assurance framework.

It contains three different schedules: individual registers for the respective CCGs and a third that contains risks that are shared across both organisations.

There are three moderate Shropshire risks with a further two moderate risks on the shared register. A high risk was added following Primary Care Commissioning Committee in October 2020.

Implications – does this report and its recommendations have implications and impact with regard to the following:

1.	Is there a potential/actual conflict of interest? *(If yes, outline who has the potential conflict of interest, what it is and recommendation of how this might be mitigated).*	~~Yes~~/No
2.	Is there a financial or additional staffing resource implication? *(If yes, please provide details of additional resources required).*	~~Yes~~/No
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated).*	~~Yes~~/No
4.	Is there a legal impact to the organisation? *(If yes, how will this be mitigated).*	~~Yes~~/No
5.	Are there human rights, equality and diversity requirements?	~~Yes~~/No

	(If yes, please provide details of the effect upon these requirements).	
6.	Is there a clinical engagement requirement? *(If yes, please provide details of the clinical engagement).*	~~Yes~~/No
7.	Is there a patient and public engagement requirement? *(If yes, please provide details of the patient and public engagement).*	~~Yes/~~No

Recommendations/Actions Required:

Telford and Wrekin CCG Primary Care Commissioning Committee is asked to:

- To receive the shared risk register
- To note the review of all risks as part of the transfer into the template from the interim board assurance framework
- To note the addition of the high risk related to COVID and support the completion of the associated mitigating actions

Shropshire CCG Primary Care Commissioning Committee is asked to:-

- To receive both the Shropshire and the shared risk register
- To note the review of all risks as part of the transfer into the template from the interim board assurance framework
- To support the removal of the risk relating to neighbourhood working
- To note the addition of the high risk related to COVID and support the completion of the associated mitigating actions

Primary Care Commissioning Committee - Risk Registers

1. Introduction and context

A risk register is a log which records elements and their potential to threaten the achievement of an organisation's objectives. It is a living document which is populated through an organisations risk assessment and evaluation processes.

This document contains the risk register relating to the delivery of primary care delegated functions. Risks that were consistent across both risk registers have been merged and included in a shared register.

2. Key points

This document contains updated, reviewed risks using the templates taken from the interim board assurance framework.

There are three moderate Shropshire risks with a further two moderate risks on the shared register.

The Shropshire CCG register contains a risk that relates to neighbourhood working. The advent of the COVID pandemic has brought practices and other providers together to collaborate more effectively. Additionally, the requirements set down in contracts that are in place with PCNs (replicated in community contracts) support joint working across sectors. It is therefore proposed that this risk is removed.

In view of the above, the Telford CCG risk relating to PCN joint working is potentially applicable to both CCGs therefore it has been updated and transferred to the shared register.

A high risk was added following Primary Care Commissioning Committee in October 2020. Work has commenced on developing a local SITREP process for primary care, which has now been superseded by the requirement for a regional return.

Whilst practices have received additional national resources "COVID expansion fund" to support practices manage any additional demand, the CCG intends to do complete a framework that links practice business continuity plans, and sets out how the CCG will respond and support practices under extreme, sustained pressure. (Attached for information)

3. Recommendations

Telford and Wrekin CCG Primary Care Commissioning Committee is asked to:

- To receive the shared risk register
- To note the review of all risks as part of the transfer into the template from the interim board assurance framework
- To note the addition of the high risk related to COVID and support the completion of the associated mitigating actions

Shropshire CCG Primary Care Commissioning Committee is asked to:-

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- To note the review of all risks as part of the transfer into the template from the interim board assurance framework
- To support the removal of the risk relating to neighbourhood working
- To note the addition of the high risk related to COVID and support the completion of the associated mitigating actions

Primary care risk register - Shropshire CCG

1	2	3	4	5	6	7	8	9	10	11	12	13
Risk ID	**Objective**	**Opened / added by**	**Risk and description**	**Opportunity**	**Existing key controls**	**Existing sources of assurance**	**Gaps in controls or assurances**	**Risk score (consequences x likelihood)**	**Action plan / cost / action lead /(target date) /sufficient mitigation**	**Target risk score for end of financial year**	**Executive Lead and Risk Owner**	**Amendments: name and date**
S-01		PCCC 02/19	Failure to develop neighbourhood working/integrated models of care across Shropshire will affect delivery of new services following the Out of Hospital services review.		1. Part of GPFV programme and also connected with the STP out of hospital programme 2. Closer working between commissioning team and Primary care team is enabling a plan to deliver integrated primary care networks. 3. This workstream is a key part of the NHS Long Term Plan and the new STP Primary Care Strategy will have specific actions and plans around Network development.	Minutes of Shropshire Care Closer to Home Programme Board and Working Group. Minutes of GPFV Umbrella Group (NHSE Region) and Checkpoint (STP Area) meetings with CCG, NHSE and PMO representatives.					Exec: C.Parker Owner: S.Ellis/C.Ralph	26/11/20 C.Ralph Data transferred onto new template. All fields not completed. RECOMMEND REMOVAL
S-02		PCCC 03/19	There is not an agreed process for the completion of practice visits. There is a risk therefore that there may be emerging issues affecting quality that the CCG is not aware of/cannot support improvement. This means that there is a potential for variation/poor quailty of care or ineffeicient systems and processes.	1. Potential to share good practice across the system. 2. Potential to save process improvements and reduce hand-offs/inefficiencies in practices	1. Maintain and build relationships with GP practices to monitor quality standards. 2. Update quality dashboard regularly. 3. Primary Care to develop a dashboard and process for more effective monitoring of Primary Care Quality.	1. CQC reports and regular meetings with CQC. Regular liaison with NHSe. 2. Quality dashboard updated and presented to PCCC quarterly. 3. Regular reporting to Quality and Audit Committee on risks and achievements	1. Infrequent opportunities to review/work with practices 2. Inconsistent opportunities - levels of engagement with practices	3x3=9 Moderate	1. Maintain focus to identify triggers/early signs of issues 2. Triangulate data from multiple sources 3. Close liason with other professionals/agencies 4. Review complaints/GPPS 5. Work to standardise practice visit approach across the emerging new CCG	3x3=9 Moderate	Exec: Z. Young Owner: S.Ellis/C.Ralph	26/11/20 Actions updated
S-03		PCCC 04/19	There is a risk that forecasted expenditure in relation to estates and other delegated functions will adversely affect the CCGs ability to deliver financial balance within the primary care directorate in the medium term	1. To ensure the financial stability of practices by ensuring rent reviews and completed on time	1. Premises Cost Directions 2. Scheduled programmes of rent reviews 3. Clear approvals process for new business cases	1. Accurate record keeping 2. Regular contact/liaison with NHSE (GMAS team)	1. Changes in the primary care team at NHSE	3x3=9 Moderate	1. Ensure the completion of a review of estates and the completion of estates strategy 2. Ensure business cases in development contain innovation to change models of care to deliver a return on investment. 3. Ensure pro-active record keeping/review of rent reviews. 4. To have clear records and monitoring systems that set out when abatements are ending predicting the impact on	3x3=9 Moderate	Exec: C. Skidmore Owner: R. Eades/S.Ellis	26/11/20 Risk updated

Primary care risk register - Telford CCG

1	2	3	4	5	6	7	8	9	10	11	12	13
Risk ID	**Objective**	**Opened / added by**	**Risk and description**	**Opportunity**	**Existing key controls**	**Existing sources of assurance**	**Gaps in controls or assurances**	**Risk score (consequences x likelihood)**	**Action plan / cost / action lead /(target date) /sufficient mitigation**	**Target risk score for end of financial year**	**Executive Lead and Risk Owner**	**Amendments: name and date**

Primary care risk register - shared risks (Shropshire, Telford and Wrekin CCGs)

1	2	3	4	5	6	7	8	9	10	11	12	13
Risk ID	**Objective**	**Opened / added by**	**Risk and description**	**Opportunity**	**Existing key controls**	**Existing sources of assurance**	**Gaps in controls or assurances**	**Risk score (consequences x likelihood)**	**Action plan / cost / action lead /(target date) /sufficient mitigation**	**Target risk score for end of financial year**	**Executive Lead and Risk Owner**	**Amendments: name and date**
STW-01	T+W 4+5 Shrop	C/F Telford 24/06/19 C.Ralph	**Primary Care Networks (PCN)** Seven PCNs established July 2020. These new organisations will have to establish how they will work together as a network and share resources. There is a risk of potential delay and/or conflict as the new roles and the new ways of working are established. This would mean that their is inconsistent development of PCNs across the CCG which may affect service provision and access to our	1. There is a potential opportunity for PCNs to create additional competition in the market for services traditionally provided by acute/community services. 2.Opportunity to increase the resilience of practices by sharing resources and effort overtime	1. National guidance for PCN development and the associated network agreements signed by all practices 2. Clinical leadership identified by members of each PCN PCNs to follow guidance from NHSE in regards to their establishment. 3. Guidance on the delivery of DES' for 2020 released	Notes of PCN meetings/assurance meetings	1. Knowledge of the level of engagment between partners within PCNs. 2. Formal assurance process under development.	3x3=9 Moderate	1. Take opportunities to seek out the views of practices on the PCN development processes (ongoing) 2. Establish regular meetings with CDs to enable monitoring of progress by August 2020 3. Support PCNs to complete/re-visit baseline assessments as part of the developmental programme by September 2020	1x3=3 Low	Exec: C.Parker Owner: S.Ellis/C.Ralph	26/11/2020 C.Ralph
STW-02		Shrop 19/01/19 T+W 18/05/19	**Workforce** There is a risk that the system fails to recruit and retain workforce clinical staff, reflecting the challenge nationally. This will impact on local GP workload and the delivery of transformational primary care in	1. GPFV monies enables practices to create new creative roles 2. The emerging training hub can prioritise additional training to upskill training	1. Primary care workforce plan is in place. 2. Delivery board and operational groups in place to support delivery in line with practice priorities.	1. PCN assurance meetings 2. PCN workforce plans aligned to priorities 3. Recruitment in line with ARRS financial envelope	1. Workforce plans do not use full resource envelope.	3x3=9 Moderate	1. Promote PCNs to have staff responsible for workforce. 2. Integration of clincial staff/representation on the operational workforce groups 3. Attendance at regioanl workfoce groups to share learning.	3x3=9 Moderate	Exec: C.Parker Owner: S.Ellis/C.Ralph	26/11/2020 C.Ralph
STW-03		07/10/20 C.Ralph	**COVID-19** There is a risk that the COVID-19 pandemic will increase the demand on practices and may also increase the levels of sickness. This means that practices may not be able to maintain access to their services/or to deliver high quality clinical care.	1. Pressures promote practices and the system to collaborate more effectively.	1. Changes in contractual requirements to relieve practices/support service delivery 2. Additional investment	1. Regular engagement with practices through weekly calls.	Limited formal SITREP reporting	4x4=16 High	1. Support practices to review business continuity plans 2. Support practices to link plans together/buddy practices 3. Commence work to develop SITREP 4. CCG to identify thresholds and triggers for system response 4.	3x3=9 Moderate	Exec: C.Parker Owner: S.Ellis/C.Ralph	26/11/2020 C.Ralph

Audit Committee Meeting - Appendix B

RISK MANAGEMENT MATRIX

	Likelihood				
Consequence	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost Certain**
1 Negligible	**1 VERY LOW**	**2 VERY LOW**	**3 VERY LOW**	**4 LOW**	**5 LOW**
2 Minor	**2 VERY LOW**	**4 LOW**	**6 LOW**	**8 MODERATE**	**10 MODERATE**
3 Moderate	**3 VERY LOW**	**6 LOW**	**9 MODERATE**	**12 HIGH**	**15 HIGH**
4 Major	**4 LOW**	**8 MODERATE**	**12 HIGH**	**16 HIGH**	**20 EXTREME**
5 Catastrophic	**5 LOW**	**10 MODERATE**	**15 HIGH**	**20 EXTREME**	**25 EXTREME**

	1 – 3	Very Low risk
	4 – 6	Low risk
	8 – 10	Moderate risk
	12 – 16	High risk
	20 – 25	Extreme risk

	Consequence score (severity levels) and examples of descriptions				
Domains	**1. Negligible**	**2. Minor**	**3. Moderate**	**4.Major**	**5. Extreme**
Impact on the safety of patients, staff or public (physical/psychological harm).	**Minimal injury or illness, requiring no/minimal intervention or treatment. No time off work.**	**Minor injury or illness, requiring minor intervention. Requiring time off work for >3 days. Increase in length of hospital stay by 1-3 days.**	**Moderate injury requiring professional intervention. Requiring time off work. Increase in length of hospital stay by 4-15 days. RIDDOR/agency reportable incident. An event which impacts on a small number of patients.**	**Major injury leading to long-term incapacity/disability. Requiring time off work for >14 days. Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects.**	**Incident leading to death. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.**
Quality/complaints/audit	**Peripheral element of treatment or service suboptimal. Informal complain/injury.**	**Overall treatment or service suboptimal. Formal complaint. Local resolution. Single failure to meet standards. Minor implications for patient safety unresolved. Reduced performance rating if unresolved.**	**Treatment or service has significantly reduced effectiveness. Formal complaint. Local resolution (with potential to go to independent review). Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on.**	**Non compliance with national standards with significant risk to patient if unresolved. Multiple complaints/independent review. Low performance rating. Critical report.**	**totally unacceptable level or quality of treatment/ services. Gross failure of patient safety if findings not acted upon. Inquest/ombudsman inquiry. Gross failure to meet national standards.**

Human resources/organisational/ development/staffing/ competence	Short term low staffing that temporary reduces services quality (1< day).	Low staffing level that reduces the services quality.	Late delivery of key objectives/service due to lack of staff. Unsafe staffing level or competence (>1 day). Low staff morale. Poor staff attendance for mandatory/key training.	Uncertain delivery of key objective/service due to lack of staff. Unsafe staffing level or competence (>5 days). Loss of key staff. Very low staff morale. No staff attending mandatory/key training.	Non-delivery of key objectives/service due to lack to staff. On-going unsafe staffing levels or competence. Loss of several key staff. No staff attending mandatory training /key training on an on-going basis.
Statutory duty/inspections	No or minimal impact or breach or guidance/statutory duty.	Breach of statutory legislation. Reduced performance rating if unresolved.	single breach in statutory duty. Challenging external recommendation/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low performance rating. Critical report.	Multiple breaches in statutory duty. Prosecution. Complete systems change required. Zero performance rating. Severity critical report.
Adverse publicity	Rumours. Potential for public concern.	Local media coverage. Short term reduction in public confidence. Elements of public expectation not being met.	Local media coverage - long-term reduction in public confidence.	National media coverage with >3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions raised in the House). Total loss of public confidence.
Business objectives/projects	Insignificant cost increase/schedule slippage	<5 per cent over project budget. Schedule slippage.	5-10 per cent over project budget. Schedule slippage.	Non-compliance with national 10-25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including claims	Small loss. Risk of claim remote.	Loss of 0.1 - 0.25 per cent of budget. Claim less than £10,000.	Loss of 0.25-0.5 per cent of budget. Claim (s) between £10,000 and £100,000.	Uncertain delivery of key objective/loss of .5 - 1.0 per cent of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objectives/loss of >1 per cent of budget. Failure to meet specification/slip page. Loss of contract/payment by results. Claim(s) > £1 million.
Service/business interruption/environmental impact	Loss/interruption of >1 hour. Minimal or no impact on the environment.	Loss/interruption of >8 hours. Minor impact on environment.	Loss/interruption of >1 day. Moderate impact on environment.	Loss/interruption of >1 week. Major impact on environment.	Permanent loss of service or facility. Catastrophic impact on environment.

Publications approval reference: 001559

Copy: ICS leaders

An electronic copy of this letter, and all other relevant guidance from NHS England and NHS Improvement can be found here:
https://www.england.nhs.uk/coronavirus/primary-care

9 November 2020

Dear CCGs, GPs and general practice teams,

SUPPORTING GENERAL PRACTICE – ADDITIONAL £150 MILLION OF FUNDING FROM NHS ENGLAND

Thank you for the work you have done and continue to do. It is recognised, valued and appreciated.

Across England, patients are now accessing general practice as much as they were before the pandemic, with overall national activity levels above 6 million appointments a week. This is an important achievement reflecting the work of everyone in general practice.

Patients and the public are now hearing and responding to the message that general practice everywhere is and will continue to remain fully open for them safely during this second wave of COVID-19 and second national lockdown. Every possible measure should be taken by practices, PCNs and CCGs to maintain and expand general practice capacity, to address the continued needs of patients as practices respond to COVID-19, deal with the backlog of care, and improve services.

Progress is being made. Nearly 6,000 full-time equivalent (FTE) staff have been employed on the Additional Roles Reimbursement Scheme (ARRS). CCGs should continue to prioritise maximum support to PCNs, to ensure that PCN recruiting intentions are fully delivered. This could mean that over 9,000 PCN staff are in place nationally by spring. The funding entitlement for the PCN workforce has already been guaranteed now and it will continue to remain protected for the future.

Full use should also be made of the GP recruitment and retention initiatives and dedicated funding, including the new to partnership payment, returners scheme, mentorship scheme and fellowship scheme, with ICS and CCG support.

General Practice Covid Capacity Expansion Fund

NHS England is today establishing a new General Practice Covid Capacity Expansion Fund. £150 million of revenue is being immediately allocated through ICS to CCGs for general practice, for the purpose of supporting the expanding general practice capacity up until the end of March 2021. Allocations by ICS are attached in Appendix 1.

The fund is ringfenced exclusively for use in general practice. It will be for ICSs and CCGs to determine how best it is spent within general practice, with a focus on simplicity and speed of deployment, within the following parameters. CCGs should not introduce overly burdensome administrative processes for PCNs and practices to secure support.

Expanding capacity

Accessing the fund will be conditional on practices and PCNs continuing to complete national appointment and workforce data in line with existing contractual requirements. Where an individual practice is not yet accurately recording activity that is broadly back at its own pre-COVID levels, it is expected to do so as part of accessing the fund. CCGs should seek to understand and support the relatively small number of practices that are finding restoration of their activity most difficult.

Systems are encouraged to use the fund to stimulate the creation of additional salaried GP roles that are attractive to practices and locums alike. The fund could also be used for the employment of staff returning to help with COVID, or to increase the time commitment of existing salaried staff. And in line with commitments already made in the GP contract, support will be available to establish flexible pools of employed GPs (including returners) and other staff to deploy across local communities.

The following will also be made available to support systems to increase GP capacity:

- financial support (up to £120k) in addition to the £150m to each STP/ICS to support the process of recruiting and deploying employed GPs on the basis above
- an optional flexible GP employment contract template;
- a digital suppliers framework to assist GP workforce deployment by matching sessional capacity to local demand.

Expectations

Subject to the above requirement about returning activity to at least prior levels, the £150 million funding will be expected to support seven priority goals:

1. Increasing GP numbers and capacity
2. Supporting the establishment of the simple COVID oximetry@home model, arrangements for which will be set out in a parallel letter shortly
3. First steps in identifying and supporting patients with Long COVID
4. Continuing to support clinically extremely vulnerable patients and maintain the shielding list
5. Continuing to make inroads into the backlog of appointments including for chronic disease management and routine vaccinations and immunisations
6. On inequalities, making significant progress on learning disability health checks, with an expectation that all CCGs will without exception reach the target of 67% by March 2021 set out in the inequalities annex to the third system letter. This will require additional focus given current achievement is one fifth lower than the equivalent position last year; and actions to improve ethnicity data recording in GP records
7. Potentially offering backfill for staff absences where this is agreed by the CCG, required to meet demand, and the individual is not able to work remotely.

ICSs and CCGs will be expected to achieve these goals, and confirm they have spent the money fully within general practice. The funding is non-recurrent and should not be used to fund commitments running beyond this financial year.

The £150m fund represents the total available additional COVID funding for general practice until March 2021, except for arrangements for potential COVID vaccine delivery which would be in addition.

With our appreciation and thanks for everything you are doing.

Ian	Nikki	Ed
		
National Director of Primary Care Community Services & Strategy	Medical Director for Primary Care	Director of Primary Care

Appendix 1: Fair shares allocation at STP level weighted by primary care 20/21 allocation

STP	Fair shares allocation of the CSF H2 (£150m) weighted by 20/21 primary care allocation
Bath and North East Somerset, Swindon and Wiltshire STP	2.26m
Bedfordshire, Luton and Milton Keynes STP	2.78m
Birmingham and Solihull STP	3.40m
Bristol, North Somerset and South Gloucestershire STP	2.40m
Buckinghamshire, Oxfordshire and Berkshire West STP	4.43m
Cambridgeshire and Peterborough STP	2.40m
Cheshire and Merseyside STP	7.02m
Cornwall and the Isles of Scilly Health and Social Care Partnership (STP)	1.53m
Coventry and Warwickshire STP	2.71m
Cumbria and North East STP	9.35m
Devon STP	2.62m
Dorset STP	2.03m
East London Health & Care Partnership (STP)	4.49m
Frimley Health & Care ICS (STP)	2.40m
Gloucestershire STP	1.58m
Greater Manchester Health and Social Care Partnership (STP)	8.00m
Hampshire and the Isle of Wight STP	4.26m
Healthier Lancashire and South Cumbria STP	4.61m
Herefordshire and Worcestershire STP	2.17m
Hertfordshire and West Essex STP	3.69m
Humber, Coast and Vale STP	5.40m
Joined Up Care Derbyshire STP	1.33m
Kent and Medway STP	4.71m
Leicester, Leicestershire and Rutland STP	2.54m
Lincolnshire STP	2.16m
Mid and South Essex STP	2.95m
Norfolk and Waveney Health & Care Partnership (STP)	2.94m
North London Partners in Health & Care (STP)	4.11m
North West London Health & Care Partnership (STP)	7.19m
Northamptonshire STP	1.87m
Nottingham and Nottinghamshire Health and Care STP	2.73m
Our Healthier South East London STP	4.98m
Shropshire and Telford and Wrekin STP	2.43m
Somerset STP	1.43m
South West London Health & Care Partnership (STP)	3.99m
South Yorkshire and Bassetlaw STP	2.94m
Staffordshire and Stoke on Trent STP	3.31m
Suffolk and North East Essex STP	2.64m
Surrey Heartlands Health & Care Partnership (STP)	2.54m
Sussex Health and Care Partnership STP	4.60m
The Black Country and West Birmingham STP	2.67m
West Yorkshire and Harrogate Health & Care Partnership (STP)	6.41m
Grand Total	150m