AGENDA

Meeting Title	Primary Care Commissioning Committee – Part 1	**Date**	6 October 2021
Chair	Mrs Donna Macarthur	**Time**	12.45 p.m.
Minute Taker	Mrs Chris Billingham	**Venue/ Location**	Via Microsoft Teams

Reference	Agenda Item	Presenter	Time	Paper
PCCC-21-10.47	Welcome and Introductions	Chair	12.45	Verbal
PCCC-21-10.48	Apologies	Chair	12.45	Verbal
PCCC-21-10.49	Declarations of Interests	Chair	12.45	Verbal
PCCC-21-10.50	Estates • Whitchurch Pauls Moss	Darren Francis	12.50	Enc. No. 1
PCCC-21-10.51	Minutes of Previous Meeting and Matters Arising:- • PCCC 4 August 2021 • Action Tracker	Chair	1.00	Enc. No. 2 Enc. No. 2A
PCCC-21-10.52	Finance Update	Claire Skidmore	1.10	Enc. No. 3
PCCC-21-10.53	Primary Care Report • Workforce • Estates • IT • Contracts	Tom Brettell / Janet Gittins / Jenny Stevenson	1.20	Enc. No. 4
PCCC-21-10.54	GP Flexible Pools	Phil Morgan	1.30	Verbal
PCCC-21-10.55	eDec	Bernie Williams	1.40	Enc. No. 5 / 5A
PCCC-21-10.56	Rebranding of Stirchley Medical Practice	Bernie Williams / Tracie Craddock	1.50	Enc. No. 6
PCCC-21-10.57	Risk Register	Claire Parker	2.00	Enc. No. 7
PCCC-21-10.58	Any Other Business • Committee Evaluation Form	Chair	2.05	Enc. No. 8
PCCC-21-10.59	Date and Time of Next Meeting: Wednesday 1 December 2021 at 11.00 a.m.			

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG**
Primary Care Commissioning Committee in PUBLIC
Meeting held on 6 October 2021

Item Number:	**Agenda Item:**
PCCC-21-10.50	Whitchurch Pauls Moss Development – Full Business Case

Executive Lead (s):	**Author(s):**
Claire Parker Director of Partnerships	Darren Francis – Primary Care Estates Lead Whitchurch Pauls Moss Project Team
Presenting: Claire Parker / Tom Brettell (CCG)	

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

History of the Report :		
Committee	**Date**	**Purpose (A,R,S,D,I)**

Executive Summary :

Overview

The primary care landscape in Whitchurch is changing due to the recent closure of two GP practices. This scheme focuses on a purpose built primary care facility in the centre of Whitchurch, developed in collaboration with Wrekin Housing Trust and Shropshire Council, to provide services to the patients of Whitchurch from one location. The proposed development is in line with the national strategy to modernise the NHS and has the potential to enable some services, currently based in hospitals and the community, to be delivered in a primary care setting.

An Outline Business Case was considered by Primary Care Commissioning Committee in May 2018 and approval was given to proceed to the Final Business Case. The designs were brought forward and a Full Business Case was bought to PCCC in March 2020. The project then stalled for a period due to a Judicial Review.

The project is now progressing at pace and the purpose of this paper is to confirm the outcome of the decisions made in the earlier private section of this meeting with regards to approval of the recurrent and non-recurrent revenue costs contained in the latest business case for which the CCG will become liable and to confirm if the project has been given final approval by Committee in public to progress to the build phase of the project (pending final approval being given by NHS England).

Recommendations/Actions Required:

Primary Care Commissioning Committee is asked to:

- confirm the outcome of the decisions made in the earlier confidential session of the meeting with regards to:
    - payment of the recurrent costs outlined in the business case for which the CCG will be liable
    - payment of the non-recurrent costs outlined in the business case for which the CCG will be liable
    - approval being given by Committee for the project to proceed to the build phase (subject to final approval being given by NHS England)
- agree to receiving regular updates as the project progresses (over the period to September 2024)

Report Monitoring Form

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).* Any GP or member of an STW GP practice may have a conflict of interest with this paper	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).* The impact of recurrent and non-recurrent revenue costs are described in section 6.4 of the Full Business Case (discussed in the confidential section of this meeting)	Yes
4.	Is there a legal impact to the organisation? *(If yes, how will this be mitigated).* None anticipated	No
5.	Are there human rights, equality and diversity requirements? *(If yes, please provide details of the effect upon these requirements).* None anticipated - Updated EQIAs will be provided as the project progresses	No
6.	Is there a clinical engagement requirement? *(If yes, please provide details of the clinical engagement).* Engagement has already been completed on this project. Any further engagement will be undertaken, as required	No
7.	Is there a patient and public engagement requirement? *(If yes, please provide details of the patient and public engagement).* Engagement has already been completed on this project. Any further engagement will be undertaken, as required	No

Strategic Priorities – does this report address the CCG's strategic priorities, please provide details:		
1.	To reduce **health inequalities** by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities. *(If yes, please provide details of how health inequalities have been reduced).* Further details can be found in the Full Business Case (discussed in the confidential section of this meeting)	Yes
2.	To identify and improve **health outcomes** for our local population. *(If yes, please provide details of the improved health outcomes).* Further details can be found in the Full Business Case (discussed in the confidential section of this meeting)	Yes
3.	To ensure the health services we commission are **high quality**, safe, sustainable and value for money. *(If yes, please provide details of the effect on quality and safety of services).* Further details can be found in the Full Business Case (discussed in the confidential section of this meeting)	Yes
4.	To improve **joint working** with our local partners, leading the way as we become an Integrated Care System. *(If yes, please provide details of joint working).* Further details can be found in the Full Business Case (discussed in the confidential section of this meeting)	Yes
5.	To achieve **financial balance** by working more efficiently. *(If yes, please provide details of how financial balance will be achieved).* Further details can be found in the Full Business Case (discussed in the confidential section of this meeting)	Yes

MINUTES

SHROPSHIRE, TELFORD AND WREKIN PRIMARY CARE COMMISSIONING COMMITTEE
PART 1 MEETING
HELD VIA MICROSOFT TEAMS
AT 12.45 P.M. ON WEDNESDAY 6 OCTOBER 2021

Present

Mrs Donna Macarthur	CCG Lay Member – Primary Care (Chair)
Mr Mark Brandreth	STW CCG Interim Accountable Officer & ICS Executive Lead
Mrs Claire Skidmore	Executive Director of Finance
Ms Claire Parker	Director of Partnerships
Mr Steve Ellis	Assistant Director of Primary Care
Mr Meredith Vivian	CCG Lay Member – Patient & Public Involvement
Ms Jane Sullivan	Senior Quality Lead
Dr Andy Watts	Independent GP

In Attendance

Dr John Pepper	Chair, STW CCG
Dr Adam Pringle	GP/Healthcare Professional; Governing Body Member
Dr Deborah Shepherd	Interim Medical Director
Dr Julie Davies	Director of Performance
Chris Billingham	Corporate PA; Note Taker

Apologies

Mr Steve Trenchard	Interim Executive Director of Transformation
Mrs Zena Young	Executive Director of Nursing & Quality
Ms Emma Pyrah	Head of Primary Care Commissioning
Mrs Vanessa Barrett	Chair, Healthwatch Shropshire

PCCC 21-10.47 Welcome and Introductions
Mrs Macarthur welcomed everyone present to the meeting.

PCCC 21-10.48 Apologies
Apologies received were as recorded above.

PCCC 21-10.49 Members' Declaration of Interests
Mrs Macarthur requested any further declarations of interests relating to items on the Agenda which were in addition to those already declared.

Dr Pringle advised the meeting that he was working as a Partner at Churchmere Medical Practice and was therefore conflicted on the Agenda item relating to Pauls Moss.

Dr Pepper advised the meeting that he was not part of the Whitchurch Practice or the Pauls Moss development and is not in the same Primary Care Network. However, he is a local GP and believed that there may be a degree of conflict.

PCCC 21-10.50 Estates – Whitchurch Pauls Moss
Ms Parker advised the meeting that this item referred to the Full Business Case for the Pauls Moss development, extra care housing and Medical Centre in Whitchurch. Members who had been involved in the Confidential Part 2 Committee had an opportunity to discuss some of the commercially sensitive information contained in the Full Business Case. This paper is to enable the Committee to make a decision in public following the Confidential Part 2 meeting to enable the Full Business Case to be taken forward.

Ms Parker invited questions but no further questions or observations were received.

Primary Care Commissioning Committee was asked to:

- Confirm the outcome of the decisions made in the earlier confidential session of the meeting with regard to:
    - payment of the recurrent costs outlined in the Business Case for which the CCG will be liable
    - payment of the non-recurrent costs outlined in the Business Case for which the CCG will be liable
    - confirm approval being given by Committee for the project to proceed to the build phase (subject to final approval being given by NHS England)

    All of the above points were confirmed in the Confidential Part 2 meeting and were now formally confirmed in the Part 1 meeting.

- Agree to receiving regular updates as the project progresses (over the period to September 2024).

    Ms Parker confirmed that a regular Project Board is in place and will continue, and regular updates on the progress of the Pauls Moss development will take place as the project moves forward subject to approval by NHS England.

    Ms Parker will report into the Part 1 Public meeting. Any confidential matters will be discussed in Part 2.

Mrs Macarthur reiterated comments made in the Part 2 meeting which formally acknowledged the significant work carried out by all involved to reach the current position. She looked forward to seeing the project develop over the next few years, subject to NHS England approval.

PCCC 21-10.51 Minutes of Previous Meetings and Matters Arising
The minutes of the meeting held on 4 August 2021 were reviewed and members requested that the following amendments should be made in the interests of accuracy:-

Page 5 – GP Practice Survey
The figure quoted in the minutes regarding “Ease of Getting Through” on the telephone stated that in one Practice 80% of people felt they could get through to the Practice. This figure should be 18%.

Page 5 – GP Practice Survey
Dr Shepherd referred to her comments which highlighted the significant achievement of Practices in terms of high scores and the figures relating to use of online services and an increased number of people calling NHS 111.

Her point was that a specific Comms campaign had taken place to encourage people to access 111, so in some ways a higher number of people calling 111 may well reflect the success of that campaign.

The Committee approved the minutes of the meeting which took place on 4 August 2021 as a true and accurate record, provided the above amendments are made.

The Action Tracker was reviewed and updated as appropriate.

PCCC 21-10.52 Finance Update

Mrs Skidmore reported on the Month 5 position and advised that at the point the report was produced, the Finance team were still only working to a half year position.

However, the H2 guidance had now been received and the CCG had been given an allocation for the remainder of the year. The Finance team are currently mapping the CCG's Month 6 position and considering the H2 allocation figure.

The delegated budget is as anticipated, and spend for the first half of the year is forecast to be very close to the allocation.

The Committee were aware from previous discussions of the underlying recurrent position where there is an over-commitment which must be reviewed. With regard to non-delegated spending – mainly the Prescribing budget – the CCG will conclude Month 6 with an under-spend, predominantly driven by the release of accruals provided for last year that do not need to be utilised this year.

Based on the early data received from April and May, the CCG appeared to have a sizeable increase in prescribing spend when year-on-year comparators are utilised. Forecast so far is based on an assumption that this will continue throughout the year. The Finance team are working with Pharmacy colleagues and Medicines Management colleagues to monitor the situation.

The Chair invited questions.

Dr Pepper referred to the QOF underspend of £500k referred to on Page 4 of the report, and requested further details as he believed that QOF was suspended for 2020/21. He also referred to Page 6 Paragraph 13 which stated that the control total had moved, with an increase of £6.77m and requested further details as he believed that control totals were fixed. The report also stated that the unidentified efficiency plan cannot be realistically delivered this year and he queried whether that meant in its totality or in part?

Mrs Skidmore replied to Dr Pepper's questions in reverse order.

In terms of the unidentified efficiency plan that cannot be delivered, the position was reviewed throughout the year. As part of that review, the total efficiency plans across all areas for the year were reviewed and in resetting that recurrent baseline, a reasonable assumption was made about what will not be delivered because we are all in agreement that this does not merely relate to the CCG, but also the providers who were unlikely to deliver recurrently the totality of our efficiency plans for this year. It was likely that the recurrent impact would not manifest until next year and that is the reason for the reference to the control total moving – the figure has been reviewed and updated to keep the CCG at the sustained position.

The explanation is the same for the question relating to QOF. Final adjustments and final payments to the Practices have enabled the CCG to release the balance of that accrual to assist the bottom line this year.

Mrs Macarthur referred to the Role Reimbursement underspend and the discrepancy across PCNs as to how much they have used. She wished to determine whether PCNs are expected to spend all of that resource, or whether it would be lost to the system if they do not.

Ms Parker replied that the ideal scenario is that all of the PCNs recruit to all additional roles and receive reimbursement of the funding. A piece of work has been carried out to review allocations to PCNs and how those allocations are being spent. However, recruitment is difficult.

Mr Morgan confirmed that full numbers of current and proposed recruitment for each of the eight PCNs had been submitted to NHS England, and he awaits a feedback meeting. The CCG's full entitlement was not used last year and this had been noted by NHSE.

The Committee noted the information contained in the report and the need to focus all efforts on delivery of the recurrent efficiency target in order to meet the requirements of the Sustainability Plan.

PCCC 21-10.53 Primary Care Report

The purpose of Mr Brettell's report was to provide the Committee with an overview of the key programmes of work within the Primary Care Team, namely Estates, Contracts, GP IT and Workforce. The report was taken as read, but key points were highlighted as outlined below.

Estates

- Shawbirch:
  Project has commenced on site. Completion 2022.

- Shifnal:
  The land for the project has now been secured and legal documents have been signed. On target to bring Full Business Case to Committee in December.

- Shrewsbury Health & Wellbeing Hub:
  May be timely to submit a full report to the December PCCC.

Estates Strategy

The inputs to the strategy have provided a useful tool that can be utilised by the CCG, the ICS, Practices and PCNs. Full report to be submitted to the December PCCC.

Contracts Update

A Contract Variation has been requested relating to Teldoc Partners joining Shifnal & Priorslee.

Boundary Changes

Work was being done to address the issue of several very small geographical areas having no Practice cover. A further update will be provided to a future meeting.

ACTION: Mr Brettell to submit a full report on Shrewsbury HWB Hub to the December Committee.

Mr Brettell to submit a full report on the Estates Strategy to the December Committee.

Mr Brettell to update a future meeting regarding Practice boundaries.

The Chair invited questions.

Dr Shepherd referred to the information provided regarding the Teldoc Partners joining Shifnal & Priorslee and questioned whether this was a merger. Mr Brettell confirmed that advice had been sought from NHS England. This was not a merger. The existing Teldoc partners had become partners of Shifnal & Priorslee.

Dr Shepherd also referred to the item regarding boundary changes. She was aware that this had not been received well when discussed at the LMC meeting and believed that the reason for this was that it was not clearly understood by Practices what was being asked. She suggested that in future, if such requests were made of Practices, more groundwork was required to help them understand why the question was being asked.

Dr Shepherd then referred to Primary Care Domain implementation and reports of very positive feedback being received and advised that in the two Practices she works in this was definitely not the case. To make even minor changes the assistance of IT must be requested, it creates extra work, and is not very practical.

Dr Pepper referred to pages 11 – 13 of the report relating to the GP Workforce Dashboard and the 13% drop in FTE GPs from a total of 282 to 245 over the past 5 years. This is a stark reduction in FTEs, the impact of which must be recognised.

Mr Morgan advised that he was currently drafting a GP Strategy in order to reassure stakeholders that the CCG knows and understands the position and is working on a range of activities around recruitment and retention, specifically of GPs.

The Committee noted the contents of the report and the work being undertaken by the Primary Care team in relation to the areas identified.

The Committee supplied very positive feedback to Mr Brettell regarding his report and will continue to identify potential improvements going forward.

PCCC 21-10.54 GP Flexible Pools

Mr Morgan provided a brief verbal update and will provide a written report to the December meeting.

The recommendation to the August Committee was that the funding provided by NHSE should be used to procure a digital booking platform, initially for GP Locums. This is not optional – the CCG is required to do this by NHSEI.

The Committee asked for local solutions to be investigated, possibly by discussions with Shropdoc. This was done, and discussions are ongoing with a potential supplier who will be working in partnership with Shropdoc to carry out some of the administrative work that the CCG does not have the capacity to do.

A joint meeting and presentation from the potential supplier will take place later in October, attended by Mr Morgan, Mr Ellis, and possibly several Practice Managers, to look at the functionality of the digital staffing platform. NHSE had made it clear to all systems that a solution must be in place by December.

Mr Morgan fed back to the Regional Workforce Lead that STW CCG almost certainly will not have a solution in place by December, but will have made a decision by then as to how to progress. He anticipated submitting a written report to the December Committee for approval of the recommended course of action.

Ms Parker believed that this was an opportunity to provide Practices with support for winter. She asked the Committee if the decision could be deferred downwards to the Primary Care Operational Group in order to move it forward more quickly and support Practices with some of their workforce challenges.

Dr Pepper agreed with Ms Parker's suggestion, but asked if the funding was recurrent funding.

Mr Morgan replied that the funding is the same as all GP Forward View funding - technically, it is not recurrent but is money that NHSE have confirmed the CCG will also receive next year.

Dr Watts was in support of Ms Parker's proposal.

The Committee agreed that the decision regarding a digital booking platform could be made by Primary Care Operating Group.

ACTION: Mr Morgan to provide a written report on GP Flexible Pools to the November PCOG meeting.

PCCC 21-10.55 eDec

Mrs Williams provided an update on the eDec (Electronic Declaration) that Practices are required to make every year. Responses were analysed and some anomalies were found which were checked with Practice Managers. Some have been confirmed as errors. One slight anomaly existed where a Practice declared that they had not completed a risk assessment. This Practice is on our list of Practices to be visited on the visit programme which is due to start imminently. Support will be offered to Practices if needed.

The Chair invited questions.

Mrs Macarthur referred to the fact that this requirement is self-declaration and asked if the CCG proposed to carry out spot checks as part of the Practice visit.

Mrs Williams advised that spot checks were not in the plan although they had been carried out in the past. She agreed to include spot checks as part of Practice visits.

The Committee received and noted the update provided regarding eDec and the subsequent action taken by the CCG.

PCCC 21-10.56 Rebranding of Stirchley Medical Practice

Mrs Williams was joined by Dr Mike Innes and Ms Tracie Craddock, both from Stirchley Medical Practice, to present this item.

Dr Innes advised that Sutton Hill Medical Practice and Stirchley Medical Practice had merged 18 months previously. The Practice is now in a strong position and is considering how they can expand and improve services further.

One of the limits had been the name, which relates to one neighbourhood covered by the Practice but does not cover all of the neighbourhoods now covered by the merged Practice. The Practice had been keen to change its name for some time but this was delayed because of pressures caused by the pandemic. However, they are now at a point where they would like to change their operating name to Silkin Health, which is a much more inclusive name for the area covered by the Practice.

Dr Innes referred to discussions around Practice boundaries and stated that his Practice would be happy to alter their boundaries to include Orphan Area No. 5, whose boundary was on the edge of Stirchley's southern boundary.

The Chair invited questions.

There were no questions. Several members of the Committee expressed their support for the proposal, and the proposed name of the Practice.

The Committee approved the change of the operating name of the Practice from Stirchley Medical Practice to Silkin Health.

PCCC 21-10.57 Risk Register
Ms Parker confirmed that the Risk Register had been updated and circulated for information.

Further to the discussion regarding Practice boundaries, Ms Parker confirmed that a piece of work would be carried out regarding changes to Practice boundaries. Any identified risks would be added to the Register.

PCCC 21-10.58 Any Other Business
Committee Evaluation Form
As a result of discussions between Dr Pepper and Alison Smith, a Committee Evaluation form was circulated at the request of the Chair which was intended to assist in terms of Committee development and provide a mechanism for Committee members to provide their feedback as to how the meeting was run.

ACTION: All present at the October Committee to complete the Committee Evaluation form and return to Chris Billingham.

GP Access
Ms Parker asked the Committee to consider placing GP Access on the Agenda of the December Committee. She suggested that the Committee should discuss the data collected.

Dr Davies supported this suggestion, advising that she, too, had been focusing on this from a performance perspective and hoped to submit a report to the December Committee. She agreed that there were issues around access and was happy to support a conversation and share the data in her possession.

Mr Vivian supported Ms Parker's suggestion and asked what actions the information would support.

Ms Parker replied that the data linked into many areas. For example it underpins information received via the GP Survey and links to activities such as Practice visits. The whole topic of patient access is part of our delegated responsibilities and links into many elements about improving quality and patient experience, estates, improving telephone systems, and what can be done to support Practices around some of those issues.

Dr Pringle believed that there clearly needed to be a review of performance with a view to establishing why people are performing to a different standard.

Ms Parker stated that it is not proposed to single out individual Practices but to have a wider conversation. However, she believed it to be a conversation that should take place in public.

Dr Watts supported the proposal and believed that it would be remiss of the CCG not to consider this question. He did, however, believe that the analysis of the figures should include consideration of the figures relative to last year, and relative to different areas – the data must be considered in a variety of different ways.

The Chair summarised discussions and believed that the Committee were supportive of Ms Parker's proposal. However, she also believed that the Agenda for the December Committee would be lengthy and consideration may need to be given to clashes with other meetings.

ACTION: GP Access to be placed on the Agenda of the December Committee.

Ms Parker and Mrs Macarthur to consider the December Agenda, length of the meeting, and timings.

PCCC 21-10.59 Date and Time of Next Meeting

The next meeting will take place on Wednesday 1 December 2021 at 11.00 a.m. via Microsoft Teams.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Primary Care Commissioning Committee Meeting held on 6th October 2021**

Item Number:	Agenda Item:
PCCC-21-10.52	2021/22 Month 5 Primary Care Financial Position

Executive Lead (s):	Author(s):
Claire Skidmore Director of Finance claire.skidmore@nhs.net	Ben Banks Finance Business Partner Ben.Banks@nhs.net

Action Required (please select):									
A=Approval		R=Ratification		S=Assurance	X	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):

The financial performance reported in this paper is for month 5 of 2021/22.

H1 Year to Date- M5:
For Primary Care this is split into two sections. The first is Co-Commissioning (or Delegated) which is currently showing a £21k overspend year to date on a budget of £31,547k. The second section called Primary Care Services (Or Non Delegated) which is currently showing a year to date underspend of £1,794k on a budget of £43,975k. The main driver of this underspend is a £1,245k prior year benefit in relation to Prescribing which is non recurrent in nature.

H1 Forecast- M6:
For the Delegated spending we are currently forecasting an overspend of £107k for H1, for Non-Delegated spending we are forecasting for H1 an underspend of £1,628k, again this is mainly driven by the prior year prescribing benefit.

Recommendations/Actions Required:

The committee is asked to:

Note the information contained in this report and the need to focus all efforts on delivery of the recurrent efficiency target in order to meet the requirements of the sustainability plan.

Report Monitoring Form

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).* *Yes, financial cost pressures to the CCG are described throughout the report. Overall financial risk is highlighted in the Governing Body Assurance Framework. Sufficient staff resources to identify and deliver the required efficiency plan is crucial to the achievement of the required financial position.*	Yes
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated).* *Yes, implications to the financial position and longer term financial sustainability of the CCG are described throughout the report*	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

Strategic Priorities – does this report address the CCG's strategic priorities, please provide details:		
1.	To reduce **health inequalities** by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities. *(If yes, please provide details of how health inequalities have been reduced).*	No
2.	To identify and improve **health outcomes** for our local population. *(If yes, please provide details of the improved health outcomes).*	No
3.	To ensure the health services we commission are **high quality**, safe, sustainable and value for money. *(If yes, please provide details of the effect on quality and safety of services).*	No
4.	To improve **joint working** with our local partners, leading the way as we become an Integrated Care System. *(If yes, please provide details of joint working).*	No
5.	To achieve **financial balance** by working more efficiently. *(If yes, please provide details of how financial balance will be achieved).* *The CCG financial position contributes to the System wide performance discussions to ensure that the System sustainability financial plan is monitored. Key variances and risks to the System position are highlighted.*	Yes

Tables included in this report:

Graphs included in this report:

Appendix 1

Table A

2021/22 Month 5 Financial Position

Introduction

1. The financial performance reported in this paper is for Month 5 - August 2021.

H1 Year to Date Position and H1 FOT

Table 1: M5 YTD & H1 Position Delegated

Primary Care Delegated	Budget Year To Date M05 £'000	Actual Year To Date £'000	Variance Year To Date £'000	2021/22 M1-6 Budget £'000	Forecast M1-6 £'000	Forecast Variance M1-6 £'000
General Practice - GMS	20,579	20,581	(2)	24,694	24,675	19
General Practice - PMS	156	151	5	187	182	5
Enhanced Services	2,787	2,739	48	3,665	3,655	10
QOF	3,056	2,534	522	3,667	3,075	592
Premises cost reimbursements	3,582	3,582	0	4,383	4,383	0
Dispensing	1,201	1,094	107	1,441	1,334	107
Other - GP Services	886	887	(1)	1,316	1,316	0
Total	**32,247**	**31,568**	**679**	**39,353**	**38,620**	**733**

2. When submitting the H1 plan we had planned to overspend the ring fenced delegated budget by £840k. Please see Appendix 1 showing the planned overspend and the offsetting budget for Non Delegated.

3. Year to date within the delegated budget we are reporting underspend of £679k against the budget. This is primarily driven by two non-recurrent benefits which are £500k in relation to QOF payments as well as £82k in relation to dispensing charges. This is due to the final data received in 21/22 for these areas being lower than the estimate in the year end accounts.
4. For H1 we are forecasting underspend of £733k with the drivers the same as the year to date.

5. There are currently no efficiency schemes in relation to the Delegated budget for H1 however work is underway to look at where efficiencies and/or improved outcomes can be delivered within this area with the target of reducing our expenditure to match the Delegated Allocation received by the system.

Table 2: M5 YTD & H1 Position Non Delegated

Primary Care Non Delegated	Budget Year To Date M05 £'000	Actual Year To Date £'000	Variance Year To Date £'000	2021/22 M1-6 Budget £'000	Forecast M1-6 £'000	Forecast Variance M1-6 £'000
Prescribing	35,095	34,077	1,017	42,239	41,411	828
Central Drugs	952	959	(7)	1,143	1,167	(24)
Oxygen	379	381	(3)	454	454	(0)
Prescribing Incentive Schemes	155	98	57	187	129	58
Enhanced Services	3,448	3,448	0	4,138	4,138	0
Primary Care Pay	932	908	24	1,118	1,118	0
Primary Care Other	35	33	1	186	186	0
Primary Care IT	789	785	4	947	947	0
GP Forward View	1,490	1,490	0	1,791	1,788	3
Primary Care Reserves	0	0	0	2,802	2,881	(79)
Total	**43,275**	**42,181**	**1,094**	**55,005**	**54,217**	**788**

6. In relation to the Non Delegated section we are currently showing a year to date underspend of £1,094k. This is primarily driven by a prior year benefit of £1,245k in relation to Prescribing for 20/21 which is non recurrent in nature. In year we have seen growth of 5.8% in Quarter 1 for prescribing against a planned average growth of 3.8% which has created a year to date cost pressure of £218k.

7. For H1 we are forecasting an underspend of £788k, this again is primarily driven by the prior year benefit in prescribing, however due to in year growth being higher than planned, this benefit is reduced.

8. Within H1 we have several efficiency schemes in relation to prescribing which are as follows (table 3); we have seen several of the schemes perform better than planned year to date. Several of these (Drug Switch and Care Home) are driven by prior year benefits. In year POD (Prescription Ordering Department) is reporting savings in excess of plan as well as Optimise which covers the Telford practices.

Table 3: M5 YTD and H1 Efficiency Schemes

QIPP Scheme	M5 YTD Plan £000s	M5 YTD Actual £000s	M5 Variance £000s	M1-6 Plan £000s	M1-6 Forecast £000s	M 1 - 6 Variance £000s
Drug Switches	180	245	64	180	280	100
Respiratory	0	4	4	0	9	9
Scriptswitch (Shropshire Practices only)	155	183	28	186	196	10
Optimise (Telford Practices only)	40	104	65	47	126	79
Diabetes	26	42	15	26	42	15
Care Homes	104	138	34	104	147	43
POD	207	343	136	263	369	107
Self Care	6	0	(6)	8	0	(8)
DOLVC	31	27	(4)	38	34	(4)
Wound	10	0	(10)	12	0	(12)
Continence (Urotomy)	26	0	(26)	31	0	(31)
Optum	0	0	0	0	45	45
Total	**786**	**1,086**	**300**	**895**	**1,249**	**354**

Additional Allocations for Primary Care in H1

9. As part of the allocations received in H1 there was a significant number in relation to Primary Care. Due to NHS guidance on reporting these schemes they are not fully reflected in the ledger. This guidance states that we should only be forecasting to the allocation currently in the CCG ledger, however a summary of them are in table 4 below.

Table 4: Summary of Primary Care Transformation Funding

Primary Care Scheme	Indicative 21/22 Budget £'000	Forecast 21/22 Spend £'000	Variance £'000
PCT LOCAL GP RETENTION	103	103	(0)
PCT TRAINING HUBS	103	103	1
PCT FELLOWSHIPS	471	220	250
PCT FLEXIBLE STAFF POOLS	120	120	0
PCT SUPPORTING MENTORS SCHEME	69	68	1
PCT PRIMARY CARE NETWORKS	250	249	1
PCT PRACTICE RESILIENCE	72	72	0
PCT ONLINE CONSULTATION SYSTEMS	136	136	0
PCT DIGITAL FIRST SUPPORT	557	557	0
PCT INFRASTRUCTURE AND RESILIENCE	111	111	(0)
Total	**1,992**	**1,739**	**253**

10. The only scheme we are forecasting not to fully utilise at Month 5 is the Fellowship scheme. This is due to a lack of applicants for the scheme. Whilst work is underway in the system to maximise this scheme it

is an issue that is facing the wider West Midlands region with there not being the number of new GPs in the system to fully utilise the funding.

ARRS Funding

11. As part of the multiyear scheme on the Additional Roles Reimbursement scheme for Primary Care, the Primary Care Networks (PCNs) have submitted plans on how they will spend their notional budgets in 21/22 of which a summary is in table 5 below. As you can see there is currently a notional underspend of £1,351k which the PCNs are currently looking at whether additional staff would be available. One area they are currently looking at is Admiral Nurses.

Table 5: Summary of expected ARRS expenditure by PCN

PCN	Allocated Funding £000s	Anticipated Expenditure £000s
North Shropshire	1,195	739
Shrewsbury	1,603	1,369
South West Shropshire	530	382
South East Shropshire	798	767
Teldoc	703	471
Wrekin	383	326
Newport & Central Telford	682	669
South East Telford	469	289
Total	**6,364**	**5,012**

Sustainability and Underlying Position

12. The CCG is currently working with system partners and NHSEI on the development of the system sustainability plan. Although the system as a whole is currently forecasting a £6m deficit against the H1 envelope this position remains in line with the system sustainability plan projected expenditure for 2021/22.

13. For the CCG the control total for 21/22 underlying expenditure with non-system providers has moved from £453.369m to £460.145m, an increase of £6.776m. The main reason for the movement is a recognition that the unidentified efficiency plan cannot be realistically delivered this year. The other movements relate to the approved system winter spend plan and the service transfer of neurology in year from SATH to Royal Wolverhampton.

Table 6: Forecast performance against sustainability non system expenditure control total

Category	Sustainability £000s	Recurrent FOT £000s	Variance £000s
Acute	78,975	79,848	-873
Community	13,088	12,886	202
Ind Comm / Mental Health	154,902	153,072	1,830
Primary Care (inc Presc & Co Com)	177,051	178,038	-987
Other	26,952	28,540	-1,588
Running Costs	9,178	9,965	-787
Total	**460,145**	**462,349**	**-2,203**

Table 7: ***Forecast performance against sustainability for Primary Care Expenditure***

Category	Sustainability £000s	Recurrent FOT £000s	Variance £000s
Prescribing	85,873	86,514	-641
Primary Care	13,272	13,588	-316
Co-commissioning	77,906	77,936	-30
Total	**177,051**	**178,038**	**-987**

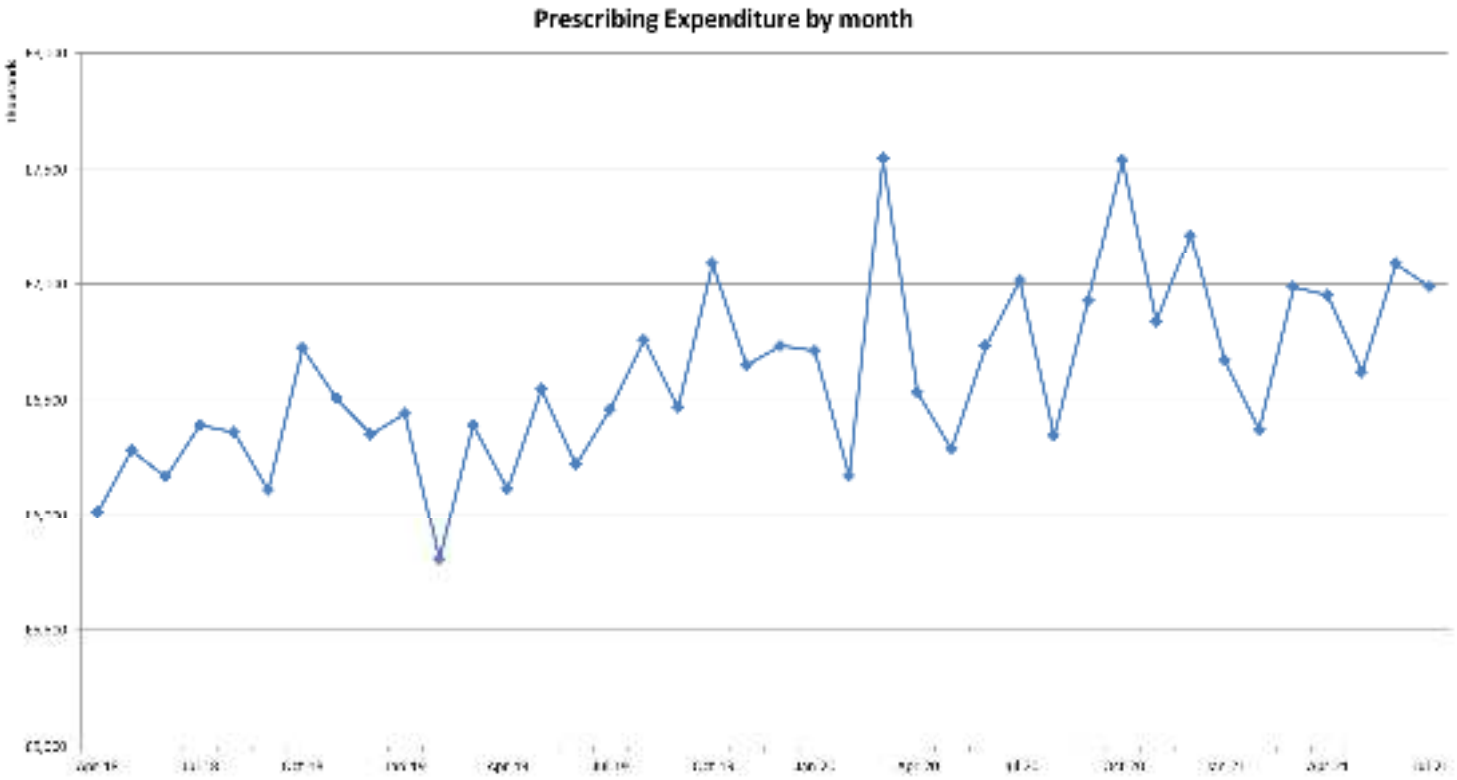
14. In relation to table 7 we are currently forecasting our prescribing recurrent FOT to be £641k greater than our sustainability figure. This is being driven by the higher growth than planned seen in Q1 this year.

15. For Primary Care the main driver of our recurrent position being higher than our sustainability plan is the enhanced services being higher than originally planned due to reviews of service provision within the system which has highlighted some pockets of inequality. Here the CCG has made some estimates in relation to adapting new models whilst the reviews progress.

Prescribing Deep Dive

16. As the Prescribing spend is one of the largest areas of expenditure as well as one of the areas with the highest growth, additional work has been undertaken looking at this area. As you can see on the graph below, as well as seeing an increase in expenditure over the last few years there has also been an increase in the volatility of the monthly movements over the last 12 months.

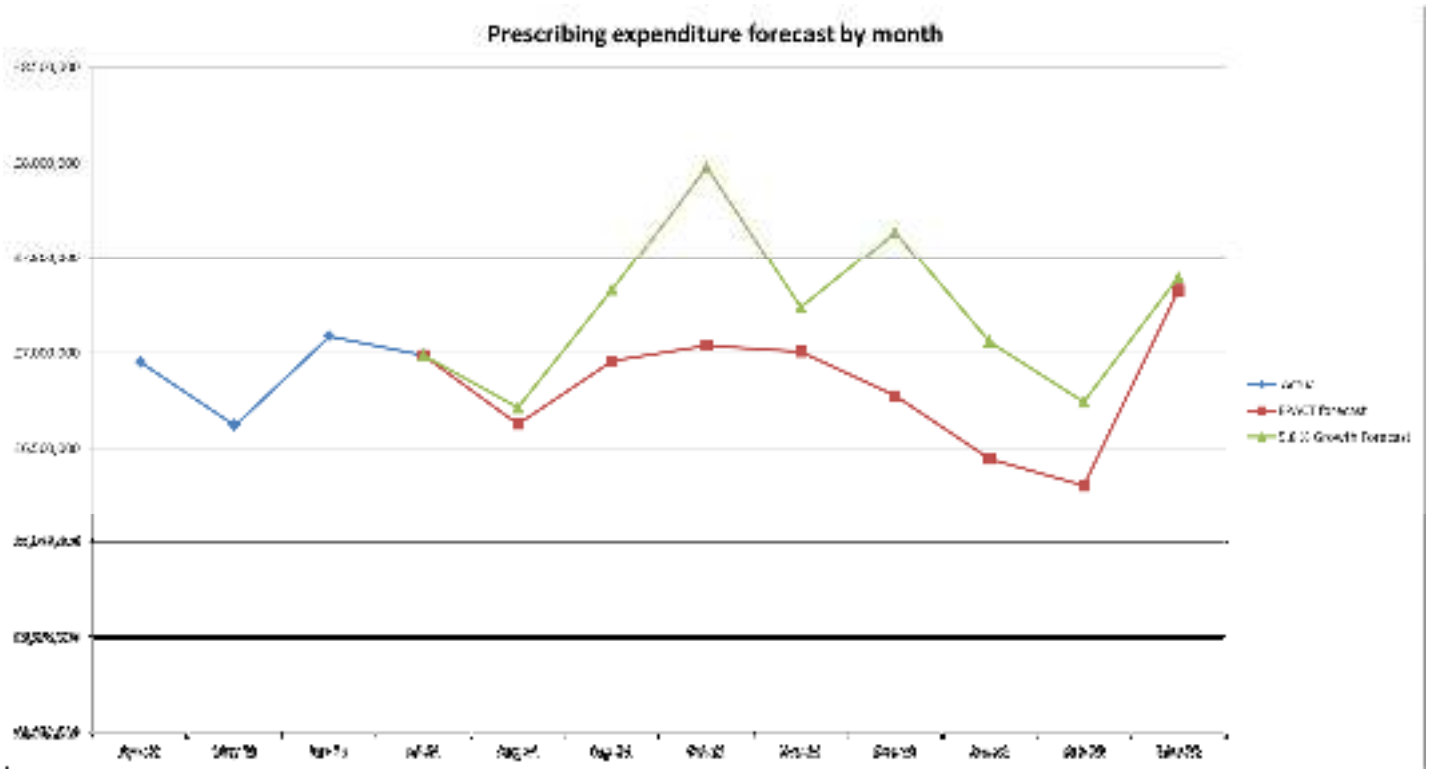
Graph 1: Historic Prescribing Expenditure



17. As highlighted earlier in the report, at month 5 we had three months of data from the Epact2 software, which was showing significant growth above the planned 3.8%. Since that time however we have received July's data which has brought us more into line with expectations as part of the budget process.

As such you can see below the difference between Epact2s forecast based on phasing and the 5.8% growth we were seeing in Q1 which was a significant risk to the financial position as the difference between the two is £3,602k.

Graph 2: Forecast 21/22 Prescribing Expenditure



18. Work continues with the Medicines Management team as in H2 we are also expecting several additional efficiency schemes to start delivering recurrent benefits with the value for H2 of these being £754k.

H2

19. Formal guidance for the second half of the financial year has not yet been received but Directors of Finance were updated recently on a national meeting to expect similar arrangements to those in H1 and a return to published allocations to be delayed until April 22.

Long Term Financial Plan

20. The long term financial plan assumptions were discussed at a recent Board workshop in early September. Following feedback from that workshop a separate paper has been completed to go to all organisation finance committees and governing bodies.

Conclusion

21. In H1 the Primary Care section is currently seeing underspend due to one off prior year benefits however as we move into H2 several pressures within Primary Care will decrease the benefit of this.

22. For the underlying sustainability plan the Primary Care expenditure is currently £987k away from the recurrent plan. This is primarily driven by prescribing growth being greater than the sustainability plan model as well as additional cost pressures due to phlebotomy.

Appendix 1

Table A

Total as per Non IFSE

Primary Care Delegated	Budget Year To Date M05 £'000	Actual Year To Date £'000	Variance Year To Date £'000	2021/22 M1-6 Budget £'000	Forecast M1-6 £'000	Forecast Variance M1-6 £'000
General Practice - GMS	20,579	20,581	(2)	24,694	24,675	19
General Practice - PMS	156	151	5	187	182	5
Enhanced Services	2,787	2,739	48	3,665	3,655	10
QOF	3,056	2,534	522	3,667	3,075	592
Premises cost reimbursements	3,582	3,582	0	4,383	4,383	0
Dispensing	1,201	1,094	107	1,441	1,334	107
Other - GP Services	886	887	(1)	1,316	1,316	0
Net Reserves	(700)		(700)	(840)	0	(840)
Total	**31,547**	**31,568**	**(21)**	**38,513**	**38,620**	**(107)**

Primary Care Non Delegated	Budget Year To Date M05 £'000	Actual Year To Date £'000	Variance Year To Date £'000	2021/22 M1-6 Budget £'000	Forecast M1-6 £'000	Forecast Variance M1-6 £'000
Prescribing	35,095	34,077	1,017	42,239	41,411	828
Central Drugs	952	959	(7)	1,143	1,167	(24)
Oxygen	379	381	(3)	454	454	(0)
Prescribing Incentive Schemes	155	98	57	187	129	58
Enhanced Services	3,448	3,448	0	4,138	4,138	0
Primary Care Pay	932	908	24	1,118	1,118	0
Primary Care Other	35	33	1	186	186	0
Primary Care IT	789	785	4	947	947	0
GP Forward View	1,490	1,490	0	1,791	1,788	3
Primary Care Reserves	700	0	700	3,642	2,881	761
Total	**43,975**	**42,181**	**1,794**	**55,845**	**54,217**	**1,628**

Total of both tables	75,522	73,749	1,773	94,358	92,837	1,521

Total as per PCCC (excluding reserve adjustment as per NHSE guidance)

Primary Care Delegated	Budget Year To Date M05 £'000	Actual Year To Date £'000	Variance Year To Date £'000	2021/22 M1-6 Budget £'000	Forecast M1-6 £'000	Forecast Variance M1-6 £'000
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QOF	3,056	2,534	522	3,667	3,075	592
Premises cost reimbursements	3,582	3,582	0	4,383	4,383	0
Dispensing	1,201	1,094	107	1,441	1,334	107
Other - GP Services	886	887	(1)	1,316	1,316	0
Total	**32,247**	**31,568**	**679**	**39,353**	**38,620**	**733**

Primary Care Non Delegated	Budget Year To Date M05 £'000	Actual Year To Date £'000	Variance Year To Date £'000	2021/22 M1-6 Budget £'000	Forecast M1-6 £'000	Forecast Variance M1-6 £'000
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Primary Care IT	789	785	4	947	947	0
GP Forward View	1,490	1,490	0	1,791	1,788	3
Primary Care Reserves	0	0	0	2,802	2,881	(79)
Total	**43,275**	**42,181**	**1,094**	**55,005**	**54,217**	**788**

Total of both tables	75,522	73,749	1,773	94,358	92,837	1,521

REPORT AND MONITORING

Agenda item	PCCC-21-10-53
Enclosure No	4
Committee:	Primary Care Commissioning Committee
Date:	6th October 2021

Title of report:	Primary Care Report
Responsible Director:	Claire Parker
Author of report:	Tom Brettell, Darren Francis, Berni Williams, Antony Armstrong, Phil Morgan
Presenter:	Tom Brettell, Partnership Manager

Purpose of the report:

To provide PCCC with an overview of the key programmes of work within the Primary Care Team, namely Estates, Contracts, GP IT and Workforce. This report highlights where further detail is given in supplementary reports.

Key issues or points to note:

- The Primary Care Team continues to manage a complex and demanding workload
- The Team is managing this demand well and is on track/ target across all workstreams- there are currently no significant deliverability concerns.
- This paper highlights work on Estates, IT, Workforce and Contracts however additional reports will be continue to be provided to PCCC meetings to provide members with assurance of the plans and progress of the work of the Partnership Managers and wider Primary Care Team.

Actions required by Primary Care Commissioning Committee:

- PCCC are requested to note the contents of the report and the work currently being undertaken by the Primary Care Team in relation to these areas.

- We would like the Committee's views on improving this report to include a method of reporting on this overall work programme in a more structured way including rag ratings etc.

Monitoring Form
Agenda item: Enclosure Number

Does this report and its recommendations have implications and impact with regards to the following:

1	Additional staffing or financial resources implications Not applicable as this is a high level summary programme progress report	No
2	Health inequalities As above	No
3	Human Rights, equality and diversity requirements As above	No
4	Clinical engagement As above	No
5	Patient and public engagement As above.	No
6	Risk to financial and clinical sustainability None specifically identified from this progress update	No

1. Estates Update

There is a wide range of activity underway to support the development of improved Primary Care estates. These are summarised below:

1.1. Business as Usual (BaU) Capital Funding:

2019/20 Projects

- All schemes formerly approved by Primary Care Commissioning Committee in 2019/2020. One scheme still to complete due to delays in getting final quotes for the works required. Expected completion by December 2021.

2020/2021 Projects

- No capital funding available so no BaU schemes approved in this year.
- As reported in detail at the June PCCC, funds were diverted from the Whitchurch Estates & Technology Transformation Fund (ETTF) project to carry out necessary works to support improvements at Ellesmere and Whitchurch premises to accommodate patients following the closure of Dodington MP. Works still not completed due to delays in getting contractors and materials on site. Expected completion by December 2021.

2021/2022 Projects

- All 8x schemes recently given approval to proceed. One of the schemes has already been completed. Remaining schemes expected to be completed by December 2021. No risks identified and no impact on revenue line expected from increased rent reimbursement as works are to existing GMS space.

- All works need to be completed by end Jan 2022 at the very latest. Further updates on these schemes will be made to PCCC as they progress if any risks are identified.

1.2. Key Estates Projects:

Shawbirch New Build (ETTF)

- Full Business Case approved by Primary Care Commissioning Committee in Feb 2021
- Build has commenced – completion due in 2022

Shifnal New Build (ETTF)

- Full Business Case (FBC) to be developed and presented to PCCC in December 2021 – delays due to planning and land purchase this date is critical to the deliverability of the project as without approval the ETTF funding is at high risk.
- FBC will then go to NHSE for their final approval also in Dec 2021
- Assuming all approved, all documents will need to be officially sealed in Jan 2022
- Build likely to start Feb 2022 - Completion is expected by April 2023

Whitchurch Pauls Moss (ETTF)

- Final Business Case being presented at PCCC October 2021
- FBC will then go to NHSE for their final approval in Oct 2021
- Assuming all approved, all documents will need to be officially sealed in Nov/Dec 2021
- Estimated build start date by March 2022
- Completion estimated by September 2024

Shrewsbury Health and Wellbeing Hub

- Project has now moved on to production of the FBC which has several workstreams overseen by a formal Project Board chaired by Claire Parker:
    - Clinical modelling work being undertaken – Led by GPs and CSU (Strategy Unit). This will help define the overall clinical needs from the facility
    - Patient engagement phase started – will be followed by formal consultation phase – led by Arden & GEM CSU. We are expecting results from initial patient/ community feedback imminently which will feed into the format of the main consultation.
    - FBC completion expected by January 2023
    - Estimated build start date Feb 2023
    - Estimated completion by June 2024

1.3. Estates Strategy Update:

- The two previous CCGs had separate Primary Care Estates Strategies – Shropshire (last updated 2018) and Telford (last updated 2019)

- With the move to a single organisation, work has been undertaken to produce a combined Primary Care Estates Strategy for the whole of Shropshire, Telford & Wrekin in advance of the move to becoming an ICS from April 2022 onwards

- Various key programmes of work have been undertaken, some of which are being supported via national programmes of work including the national Primary Care Data Gathering programme:
    - Mapping of all premises across STW to detail size, ownership, lease dates, rent reimbursement, rent abatement end dates and amounts, premises size, space utilisation, etc.
    - SHAPE mapping tool updated with the above as part of national programme. All PMs and PCN CDs to be given training and access to own data
    - Forecasts based on latest housing allocations, following the latest Local Plan consultations by both local authorities. The Shropshire information is due to be published by end November 2021 and the Telford information early 2022
    - Primary Care networks – all PCNs are requested, as part of their PCN contract work, to provide an estates and workforce strategy. This is an emerging area of work and we are awaiting confirmation of funding from NHSE to support PCNs with their estates and workforce plans – once completed these will be fed into the overall estates plan for the CCG/ICS

- We aim to present a first draft of the document – for consideration and feedback at PCCC at the end of Q3 2021/22

2. Contracts Update

2.3. Contract Status across Shropshire, Telford and Wrekin:

- We have 50 General Medical Service contracts and 1 Personal Medical Service contract. A meeting is scheduled in Q3 with this practice to discuss converting to GMS.
- We have 4 practices that have only one GP Partner holding the contract however all have salaried GPs employed. These are Court Street, Hodnet, Shawbury and Westbury
- There are no contract expiry issues
- There are no contract terminations
- There are no contract breaches or remedial notices

2.4. Contract variations:

- An application has been received to vary the following contracts during Q2 2021/22:
    - Teldoc partners joining Shifnal & Priorslee Medical Practice.

2.5. Mergers:

- There were no mergers in Q2 of 2021/22.

2.6. Branch Surgery Closures and changes:

- There were none in Shropshire, Telford and Wrekin in quarter 2 of 21/22

2.7. Enhanced Services:

- All of the primary care locally commissioned services from 2020/21 have continued into 2021/22 and monies continue to be paid at the minimum income protected level.
- A full review of LCS is a key priority for the newly appointed Head of Primary Care Commissioning, Emma Pyrah, who started in post at the beginning of September.

2.8. Extended Access (GPFV) and Extended Hours (PCN DES):

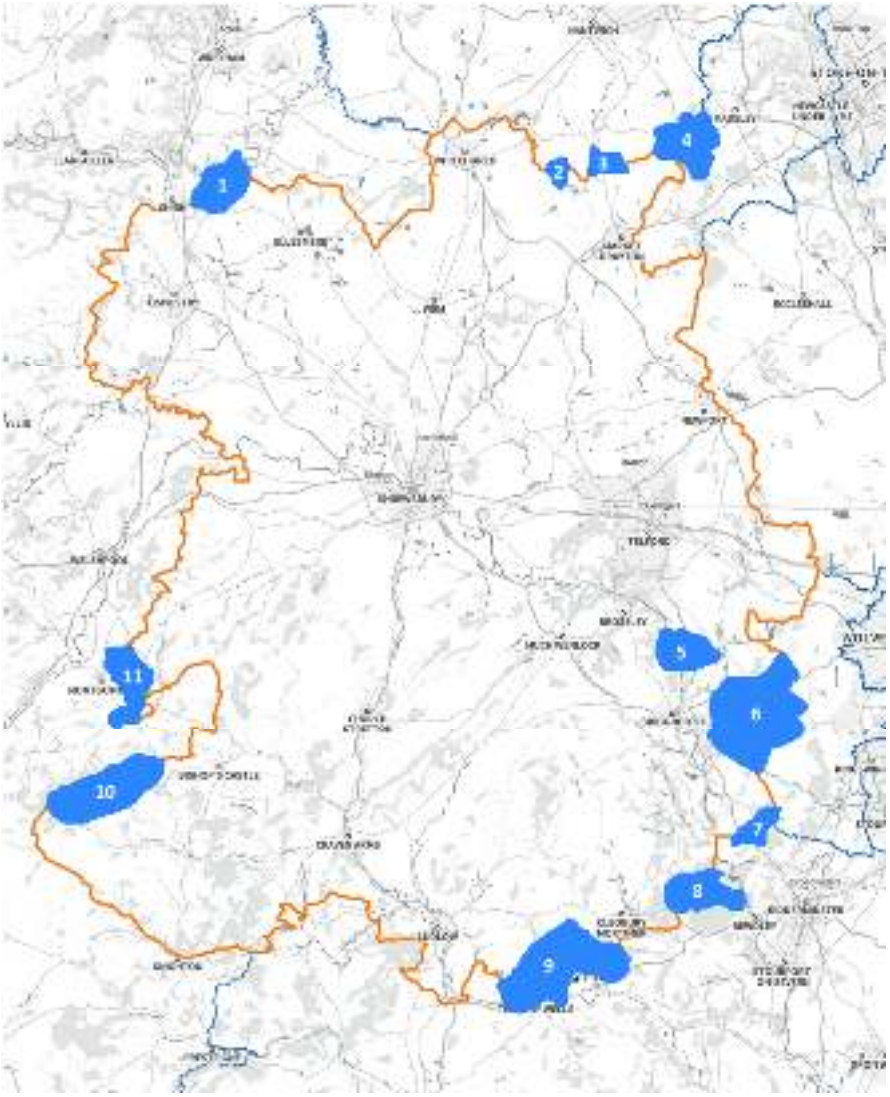
- NHS E/I had advised the new service specification would be available in September however a recent update confirmed that the specification is yet to be agreed as it is being considered against current national Winter planning.
- NHS E/I regional Access leads have set up monthly meetings to support systems during the implementation period to which a STW primary care team member/s attend.

2.9. Electronic Annual Practice Declaration (eDEC):

- Practice submissions have now been shared with the CCG. A report has been produced to appraise members on the practice responses.

2.10. Boundary changes:

- There are no applications for boundary change in Q2 of 2021/22.
- The Primary Care Team have identified that there are 11 small geographical areas in STW that currently have no practice coverage (see map below):
    - This is mainly due to these areas being very rural or close to the border of Wales or neighbouring CCGs.
    - For completeness and to offer patient choice, the Primary Care Team are currently contacting the practices whose current boundaries are closest to these areas and asking them to consider the proposal of expanding their current boundary to include these areas.
    - If a practice declines this proposal, the second nearest practice will then be approached.
    - The team does not anticipate that these boundary changes will bring an influx in patients as patients will continue to register with their closest practice. This will however give STW CCG full primary care coverage and offer patients living in those areas a STW choice going forward.
    - An update on this work will be provided to the next PCCC meeting.



2. GP IT Update

The Digital Leads/Partnership Managers within the CCG meet weekly with the MLCSU IT Project Team, to discuss on-going projects, progress reports and any risks and issues through the Digital Operational Group meeting.

2.1. Windows 10 Implementation:

- All PCs replaced/upgraded within Primary Care to Windows 10.
- Migrating from the Windows 7 Operating system that was end of life in February.

2.2. Docman 10:

- 50 out of 51 sites now live with Docman 10. Date scheduled in November for Market Drayton now to go-live. Practice constraints have meant the date has been pushed back.

2.3. Domains:

- 9 sites are now live on the Primary Care Domain (Zeus); a further 8 practices have dates scheduled in to go live
- Engagement session booked in with additional surgeries to then progress to deployment phase.
- CSU looking to scale up the project as have fallen behind where we would expect them to be. Further communications has gone out to practices advising of the importance of the domain with regards to cyber security and GP Practice Data Security and Protection (DSP) toolkit assurances
- Positive feedback collated following the most recent deployments that has been included in communications.

2.4. Electronic Prescription Service (EPS):

- Westbury have now gone live with EPS. Further work on-going with the CSU and CCIO on promoting the benefits of EPS. Plas Ffynnon have expressed an interest and asked if they can be contacted after their domain migration.

2.5. N365 : Microsoft Office 365 tailored for the NHS.

- Licensing has been applied on to the national system.
- CSU have identified pilot sites that are now on the GP domain. Delays in the deployment due to IG concerns with the data that sits in OneDrive. This is being looking into by the CSU IG team currently. N365 licensing cannot be applied until GP practices migrate to the Zeus domain, this is due to the requirement of individual login accounts on to their system.

2.6. Online Consultation /Video Consultation (OC/VC) Procurement:

- NHSE have been holding frequent Webinars on OC/VC providers. Providers meeting the required assurances are added every two weeks to the Digital First Primary Care OC/VC Framework.
- A Microsoft Teams Form has been shared with practices to collate feedback on what practices would like to see in the re-procured product. This will then devise the specification prior to procurement. An expression of interest has gone out to practices asking for a small number of colleagues to be part of the procurement panel.

2.7. Notes Digitisation:

- NHSE have un-paused the national pilot programme for Notes Digitisation only for EMIS sites at present.
- The CCG have completed all pre-requisites requested from NHSE and now await their next steps with regards to the specification and procurement.
- The Primary Care IT Lead has met with the Partnership Managers and Estates Manager to go over the questionnaire that went out to practices earlier in the year to apply scoring/weighting on the priority practices.
- NHSE have indicated the process outside of this wave of funding is also going to be amended, however the pilots are to carry on as normal.
- The process is going to move to a 'scan on demand' service whereby all notes are collected and stored centrally and scanned into the system on demand.
- This is in the very early stages at present and has raised a few concerns with the regional Digital group. We await more information on the future proposal and how particular challenges will be handled.

3. Workforce:

3.3. Main workforce focus:

- The main work by the Primary Care Team over recent months has been the management of the six NHSE/I Funding Streams:
    - GP/GPN Fellowships
    - Additional Roles Reimbursement Scheme (PCN Workforce)
    - GP Flexible Pools
    - Supporting Mentoring Scheme
    - Local GP Retention
    - Practice Resilience

3.4. GP/GPN Fellowships:

- We now have 19 newly-qualified "GP Fellows" on our programme
- A range of support schemes and projects designed and now in delivery
- Feedback from the Fellows indicates that these schemes and projects are broadly providing to be valuable and improvements are being planned based on the feedback
- Further work is being developed to roll-out the GPN side of the Fellowship programme.

3.5. Additional Roles Reimbursement Scheme (ARRS):

- Each of our 8 PCNs have submitted workforce plans indicating their current level of staffing and their plans to recruit further staff by 31st March 2022
- The indicative plans indicate around 100 ARRS-funded staff will be in post by this date, across most of the 14 staff groups
- Most popular staff groups are Clinical Pharmacists and Social Prescribing Link Workers
- Robust processes are in place to ensure appropriate management of funding reimbursement to the PCNs
- A number of bi-lateral and cross-sector conversations and meetings are taking place between local providers and the PCNs to mitigate any negative/ unintended impacts on existing provider workforce and to enable, where appropriate, partnership approaches

3.6. GP Flexible Pools:

- Following the decision of the August PCCC meeting the CCG has been in discussion with Shropdoc over the development of a local solution to the use of this funding
- A further report will be submitted to the December PCCC meeting which will include a detailed proposal to set up and deliver a digital staffing bank

3.7. Supporting Mentoring Scheme:

- Funding for this scheme has enabled us to create a single delivery process by trained GP Mentors mentoring other GPs including, but not exclusively, GP Fellows (see above)
- We have two GP Mentor Leads who have matched up 14 GP Mentors to GPs requesting mentoring support
- The funding provides payment to the Mentors and allows us to commission training for Mentors whose skills need refreshing and any other GPs who wish to become mentors
- Feedback to date on the delivery of the scheme by mentees has been positive

3.8. Local GP Retention:

- Funding for this scheme enables us to design, commission and deliver a range of projects and initiatives to support GPs to continue in their roles
- Following engagement with GPs, 8 different projects and initiatives have been identified and further work is being carried out to ensure that these are available for GPs in Q4 2021/22

3.9. Practice Resilience:

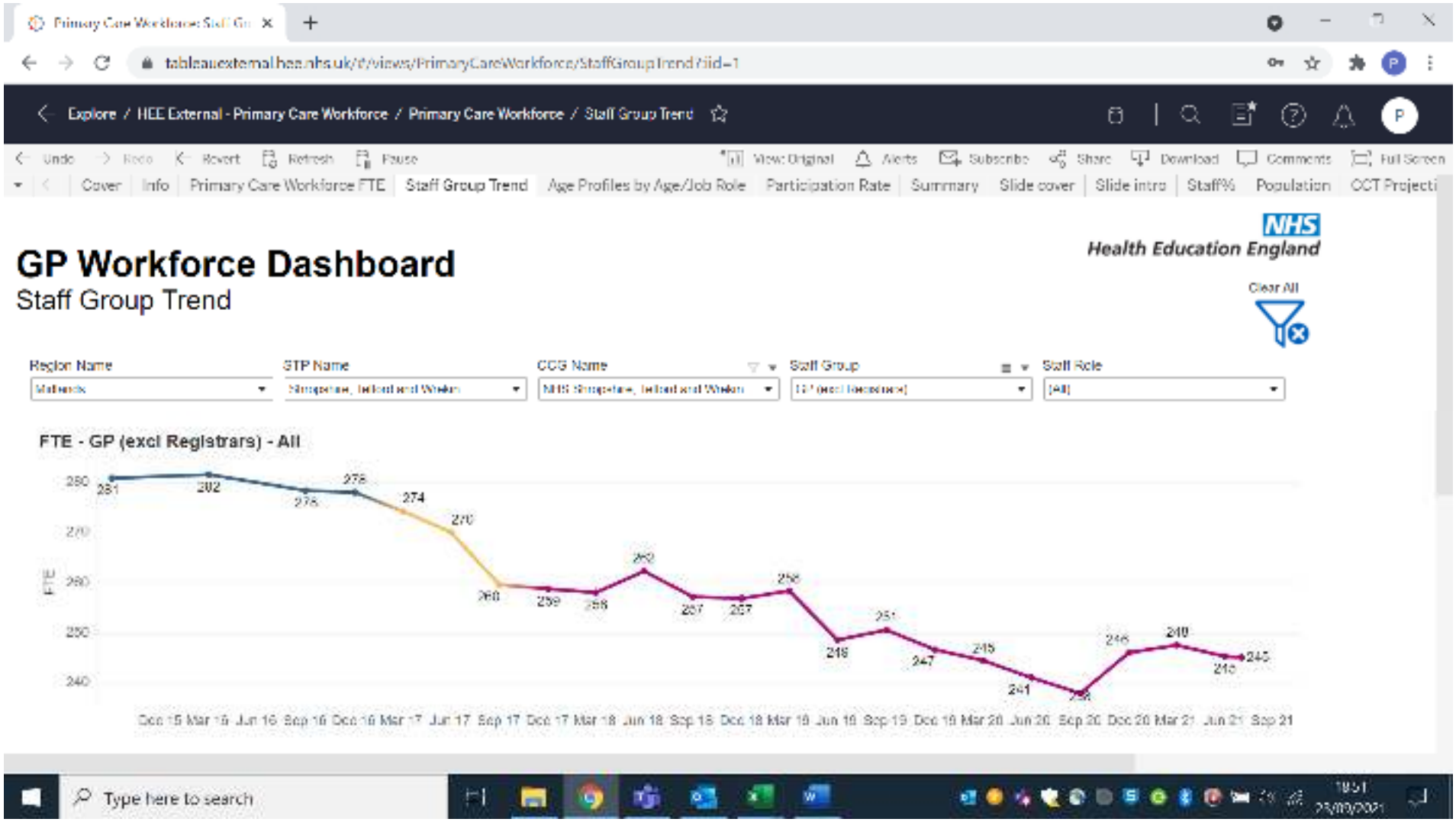
- The CCG is currently engaging with practices over the best use of the NHSE/I funding for “Practice Resilience”
- One of the key questions asked as part of the engagement exercise is whether the funding should be used centrally by the CCG to commission “all-practice” initiatives, whether it should be allocated to PCNs to coordinate projects locally, or whether individual practices should receive the funding
- The results of this engagement exercise, along with next steps, will be presented at the December PCCC

3.10. Other key initiatives (delivery by the Primary Care Team and the Training Hub):

- Continuing to commission CPD for GPNs and AHPs
- Developing and expanding all learner/student placement capacity within primary care to include new roles
- Developing a comprehensive approach to placement capacity delivery for all non-medical roles across practices and PCNs
- Monitoring of the individual SLAs with all 51 practices for use of 2020/21 GPFV funded GP Retention, Practice Resilience and Reception & Clerical Training – a report on the use of this funding will be presented at the December PCCC
- Support for the funded GP First 5s leads
- Recruitment of ambassador/leads to embed new ARRS roles
- Recruitment of two new GP Champions – one for Ethnically Diverse GPs and the other for Newly-Qualified GPs who work as Locums
- Ongoing facilitation of the Time for Care programme
- Ongoing work to increase the number of multi-disciplinary educators and assessors, including GP Training Practices
- Initiative in place to address development needs of ACPs across practices
- Working with system partners to increase the take-up of Nursing Degree Apprenticeships and Nursing Associate Apprenticeships. Promoting and supporting practices with the administrative and financial processes.
- Delivery of the GPN 10 Point Plan within the STW GPN Strategy
- Continued management of Covid Testing for practice staff (referral numbers are reducing)
- Management of the practice reimbursement scheme for costs related to practice staff working at STP-run vaccination hubs
- Continued engagement with PCNs and local providers (ShropCom, MPFT, WMAS, RJAH) re: the recruitment of new ARRS-funded roles
- Engagement with the STW STP Equalities, Diversity and Inclusion group with a view to developing a bespoke Primary Care approach
- Developing approach to Population Health needs and workforce planning
- Development of the STW Training Hub – infrastructure, website, governance and strategy, finance, communications and engagement

3.11. Latest Workforce Figures

- The latest workforce figures for Shropshire, Telford & Wrekin CCG are set out on the following pages: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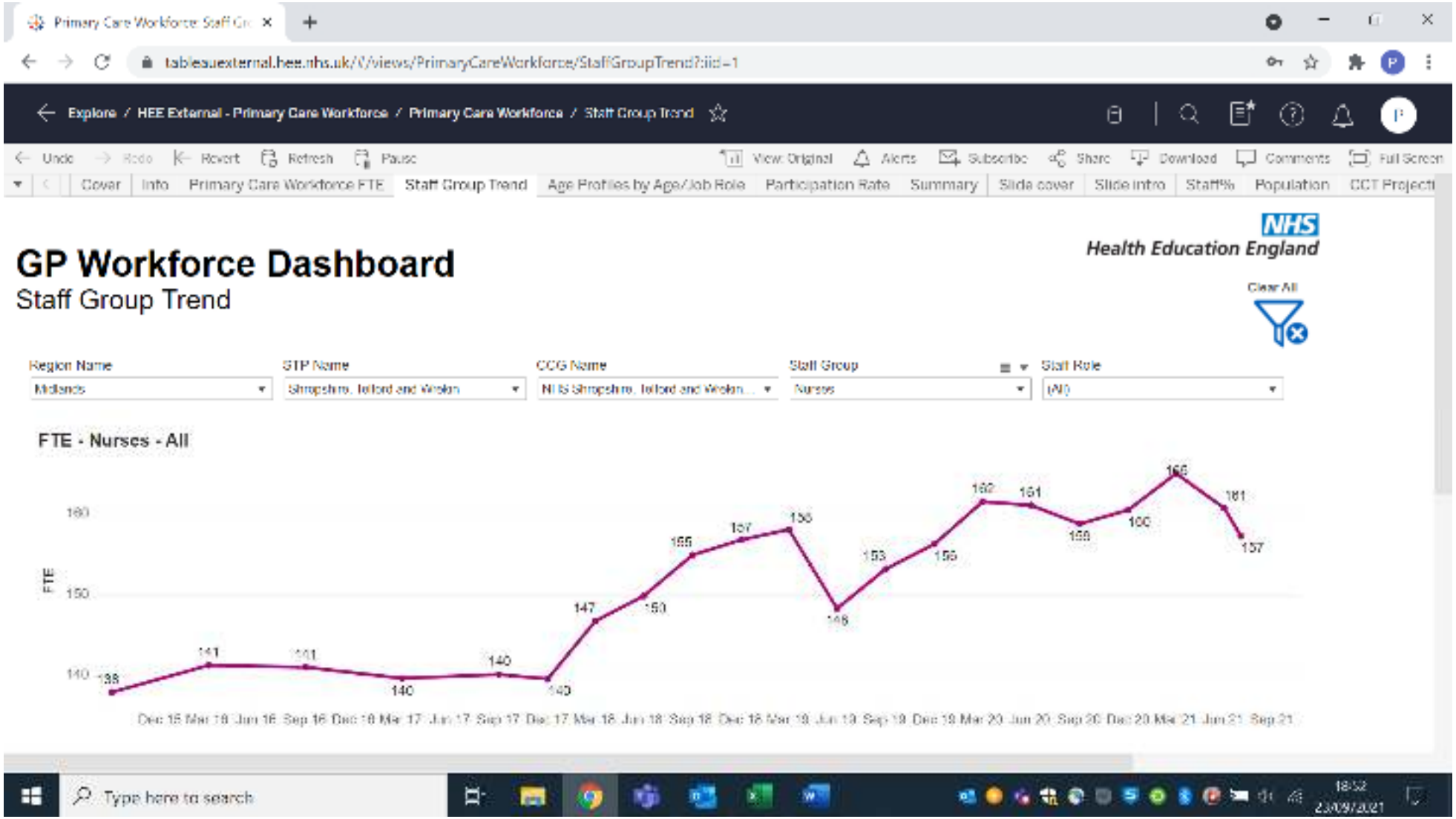
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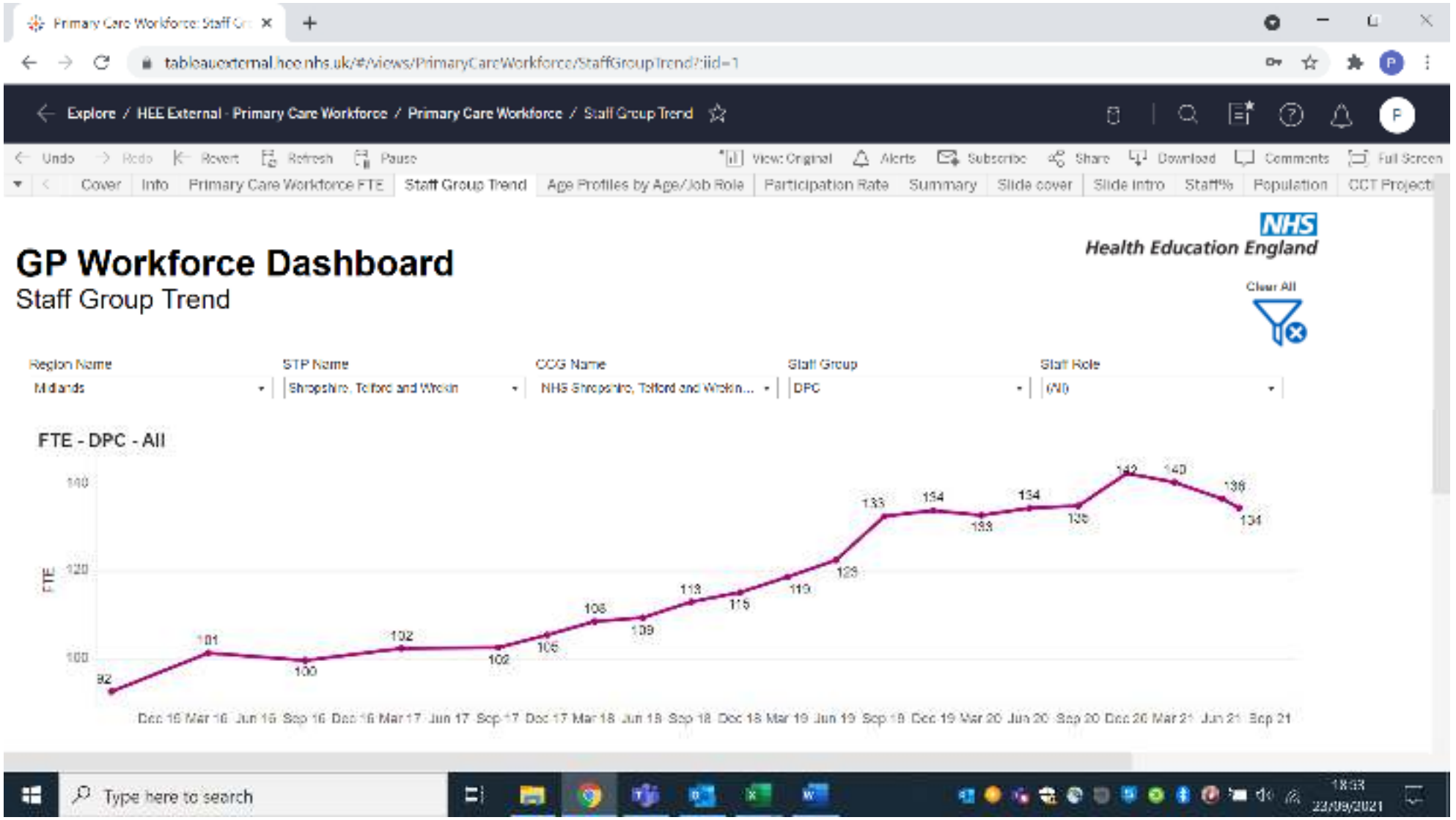
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NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Primary Care Commissioning Committee Meeting held on 6 October 2021**

Item Number:	Agenda Item:
PCCC-21-10.55	GP Practice Annual e-Declaration Report 2020-21

Executive Lead (s):	Author(s):
Claire Parker - Director of Partnerships	Bernadette Williams, Primary Care Lead - Contracting

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 during a six week period ending January 2021 however due to the exceptionally difficult and busy times for General Practice it was extended to February 2021.

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

The 2020/21 eDec was prepopulated with responses from 2019/20 practice collection. A number of questions are voluntary but all practices were encouraged to provide an answer.

There were a number of anomalies identified from submissions however these have been queried and assurances have been obtained to confirm that these were oversights.

Recommendations/Actions Required:

The Primary Care Commissioning Committee is asked to:

- Receive and note this update regarding the review and subsequent actions taken by the CCG.

Report Monitoring Form

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

Strategic Priorities – does this report address the CCG's strategic priorities, please provide details:		
1.	To reduce **health inequalities** by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities. *(If yes, please provide details of how health inequalities have been reduced).*	N/A
2.	To identify and improve **health outcomes** for our local population. *(If yes, please provide details of the improved health outcomes).*	N/A
3.	To ensure the health services we commission are **high quality**, safe, sustainable and value for money. *(If yes, please provide details of the effect on quality and safety of services).*	N/A
4.	To improve **joint working** with our local partners, leading the way as we become an Integrated Care System. *(If yes, please provide details of joint working).*	N/A
5.	To achieve **financial balance** by working more efficiently. *(If yes, please provide details of how financial balance will be achieved).*	N/A

1. Introduction and purpose

1.1 This report summarises the content of the GP Practice self-declaration completed by each practice in 2020/21. It provides assurances to the committee on a range of markers that demonstrates practice compliance to a number of contractual requirements.

2. Context

2.1 In accordance with NHS England's Primary Medical Care Policy and Guidance Handbook (PGM), commissioners of Primary Medical Care are responsible for the quality and safety and performance of services delivered by providers, within their area of responsibility. Commissioners have a statutory duty to conduct a routine annual review of every primary care medical contract it holds. This is covered through the annual GP Practice e-declaration (eDEC) collection which NHS England and NHS Improvement (NHSE/I) has established. In Shropshire, Telford and Wrekin, this have has been undertaken by the primary care team.

3. Background

3.1 The annual eDec mandatory data collection was first introduced to practices in April 2013. Information is collected in eight categories:

- Practice details
- Practice staff
- Practice premises and equipment
- Practice services
- Information about the practice and its procedures
- Governance
- Compliance with CQC
- GP IT

It captures information such as operating policies, opening times and assurance about practice procedures. This information will link with contractual requirements and may also contain responses to 'reasonable requests for information' e.g. from other government departments and bodies. The information declared can be shared within the CCG and CQC, reducing the burden of separate information returns across organisations e.g. as part of pre-inspection information requests.

4. Annual e-Declaration for 2020/21

4.1 All practices were required to submit their eDec electronically through the NHS Digital Strategic Data Collection Service (SDCS); this is usually during a six week period ending January 2021 however due to the exceptionally difficult and busy times for General Practice it was extended to February 2021. It is usually submitted by a senior member of the practice staff, usually the practice manager and/or senior partner. There was a 100% completion rate by GP Practices in the Shropshire, Telford and Wrekin area.

4.2 The 2020/21 eDec was prepopulated with responses provided from the previous year's collection. It included mandatory and voluntary questions. For questions that were marked voluntary, practices were encouraged to complete responses to these questions but could leave the questions blank if they preferred.

4.3 Following the submissions by practices, commissioners are then expected to review the practice eDec returns. It is important to note that whilst exercising of the functions passes to the CCG, the liability for the exercise of any of its functions remains with NHSE/I.

5. Outcomes of the 2020/21 submission

5.1 Individual practice declarations for 2020/21 were reviewed by the CCG lead for primary care contracting. The following questions were followed up:

Freedom to speak up guardian: One practice answered 'No' to this. **The practice has advised that their original answer was an error and has now confirmed this is in place.**

Vulnerable adults lead: One practice advised they didn't have an identified lead. **The practice has since confirmed that their original answer was not correct and that they have an identified lead in place.**

One practice answered 'No' to the question that asked if they could demonstrate reasonable grounds where it has refused an application to register and keeps a written record of refusals and the reasons for them. The same practice also answered 'No' to the question that when removing patients from its list, the practice can demonstrate that it does so in accordance with contractual requirements. **Both of these questions were checked with the practice who then confirmed that they can show due process.**

Private GP Services: A practice did not confirm that they are not advertising the provision of private GP services either by itself or through any other person: **The practice has since confirmed that this was incorrect and they do not advertise any private services.**

One practice answered 'No' to the question that asked if they 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. **The practice responded that they have completed a training analysis however they have not completed a risk analysis.** This will be followed up with the practice by primary care and quality team members.

6. Recommendations

The Primary Care Commissioning Committee is asked to:

- Receive and note this update regarding the review and subsequent actions taken by the CCG.

Appendix 1 – *guidance document.*

Annual Electronic Practice Self-Declaration (eDec) Submission Support Guidance

November 2020

Contents

Background

The annual electronic practice self-declaration (eDEC) was first introduced to practices in April 2013 and has replaced the variable arrangements (such as the submission of annual reports) which existed between former Primary Care Trusts and providers of Primary Medical Services. The eDEC is an annual mandatory data collection.
Information collected in the eDEC is covered in 8 categories, these include: 1. Practice Details, 2. Practice Staff, 3. Practice Premises and equipment, 4. Practice services, 5. Information about the practice and its procedures, 6. Governance, 7. Compliance with CQC. 8 GP I.T.

To meet the Care Quality Commission (CQC) registration requirements, all services regulated by CQC must comply with the law, but in particular, they must comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended). A number of the questions asked in this declaration therefore relate to CQC's registration requirements In addition however this version of the declaration has been amended to reflect our commitment in the General Practice Forward View to reducing workload in regulatory duplication. The CQC has reviewed the questions such that responses will form part of their pre-inspection documentation thereby reducing workload for practices.

Onward Uses of the Information

CQC inspection teams and NHS England and NHS Improvement regional local teams work closely together and share information on a regular basis. The information provided to NHS England and NHS Improvement in this declaration will be shared with CQC. Similarly, the outcome of CQC inspections will be shared with NHS England and NHS Improvement, this includes any action plans which practices may submit to CQC (where relevant).

In maintaining NHS England and NHS Improvement's commitments towards transparency and supporting patient choice, the following sections and items could be shared either with public facing NHS websites (e.g. NHS.UK/NHS Choices) and/or other information modules visible to all users of the primary care indicators website (www.primarycareindicators.nhs.uk) for instance may be used within the GPIT digital maturity index and General Practice Indicators:

Could be published in the public domain in the near future e.g. NHS Choices/ NHS.UK website	• Question 1H. Practice telephone number (for patients). • Practice Services Section (i.e. Chapter 4): all content. • Premises and Equipment Questions on wheelchair accessibility questions 3E and 3F. • The electronic practice catchment area, the practice website address, branch practice opening times, practice email address for patients, and where relevant practice Facebook page. • Question 8J: the practice is enriching the Summary Care Record of patients who have given their consent. • Question 8O: The practice makes 25% of their appointments available for booking online (this

	relates to the complete range of appointments practices offer to patients).
Will be available to anyone in the NHS and approved stakeholders with access to www.primarycareindicators.nhs.uk	• Interoperable patient records questions: 6F. • GP IT section (i.e. Chapter 8): all content. • The electronic practice catchment area.

NHS England and NHS Improvement regional local teams will receive information from the annual electronic practice self-declaration.

Clinical Commissioning Groups that commission primary care services under formal delegation from NHS England and NHS Improvement will receive information from the annual electronic practice self-declaration that is necessary in support of their delegated functions.

Legal Disclaimer

NHS England and NHS Improvement, as with all NHS organisations is required to share intelligence with other statutory bodies, both in circumstances where they have a legal right to request it e.g. National Audit Office, CQC; or where it is necessary or expedient for them to receive it in order to protect the welfare of individuals or to discharge their functions.

Practices are therefore reminded of the significance to ensure that responses provided to questions are accurate and can withstand legal scrutiny, the declaration is treated and considered to be a formal submission once declared. All information in the eDEC is subject to the requirements of the Freedom of Information Act 2000. In response to a request for information, exemptions to disclosure will be considered on a case by case basis.

Strategic Data Collection Service (SDCS)

Getting Started

The Data Collections Service grants access to SDCS for the eDec. Users will receive an automatic email from SDCS confirming which collection you have been registered to submit for and on behalf of which organisation (you can submit for multiple organisations, just outline this in your request to the Data Collections Service). The email will also include a link to SDCS: https://datacollection.sdcs.digital.nhs.uk/

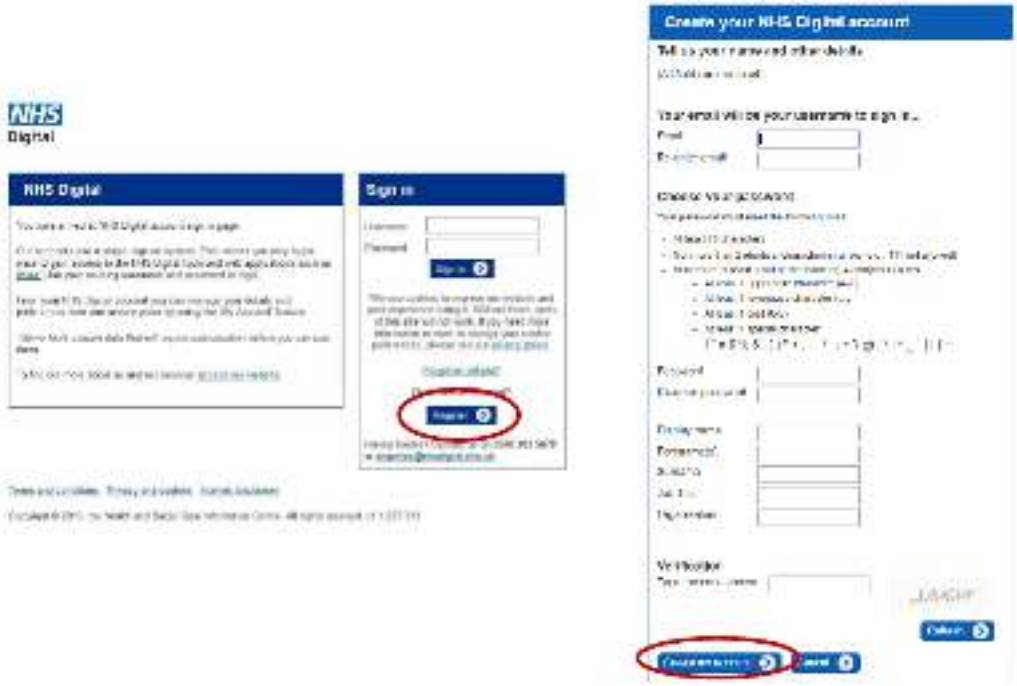
Registering your Single Sign on (SSO) Account

To access SDCS, you must have a valid SSO account. SDCS/SSO accounts can only be registered to personal, work email addresses (e.g. jane.example@nhs.net / paul.example@organisation.gov.uk). Generic, team, shared or personal private email addresses (e.g. example@hotmail.com) are not accepted.

To register your SSO account and create your password, click the link in your invitation email to navigate to the 'Sign In' screen. Click '**Sign In'**.

From the 'Sign In' page, click the **'Register'** button and Complete the registration form by filling out each of the fields in the form. 'Email' must be the email address given to the Data Collection Service/

the email that received the invitation email. Once complete, click '**Create My Account**'.



Logging in to SDCS

Once you have registered your SSO, you can log into SDCS. Click the link in your invitation email to navigate to the 'Sign In' screen. Click 'Sign In'.

Enter your username and password and click the '**Sign In'** button.
Your username will be the email address given to the Data Collections Service and the email used to register your SSO. Your password will be the password that you created when registering your SSO.

You will then be taken to the SDCS home page.

Resetting your password

You can reset your own password for your SSO account at any time. Please note that the Data Collections Service cannot action password resets. To reset your password, from the 'Sign In' page click '**Forgotten details?**' and complete and submit the subsequent form.

Accessing the eDec

Submission Page

Once logged in to SDCS you will need to select **Submissions** > **New,** this will take you to the below page.

You will need to select **GeneralPracticeAnnualSelfDeclaration-eDec** from the dropdown then click **Create.** This will take you to the eDec submission page.

This screen will show all GP surgeries you are associated with and the current progress. It also contains a link to your previous declarations.
Once you click on the relevant GP surgery, you are presented with all the questions and their status.

Completion Guidance

General Information

The eDEC is a mandatory return and remains an organisational responsibility of the practice to complete within the requested time frame. The information is submitted by a senior member of practice staff usually the practice manager and/or senior partner as similar to requirements related to completing CQRS returns. Only the person in the practice who has the permission in their user account will be able to view/edit and submit the eDEC in NHS Digital's Strategic Data Collection Service https://datacollection.sdcs.digital.nhs.uk/

The eDEC for 2020/21 includes mandatory and voluntary questions. Questions which are voluntary have been marked voluntary, practices are encouraged to complete responses to these questions but can leave the questions blank if they prefer. Responses to voluntary questions will help enable the system to better support GP practices in the future. Responding no to questions which are voluntary does not mean the practice is not compliant with their contract.

Practices who require further support to gain access to the eDEC or have any specific questions about the content or experience any technical difficulties should contact NHS Digital enquiry service quoting eDEC.

In order to account for changes which have occurred in the contract, some changes to questions have been made from last year's declaration.

For practices who submitted an electronic declaration last year, the questions and responses provided have been presented back. Practices are asked to check these responses. If no changes have occurred practices can resubmit this back.

Practices are reminded of the need to ensure that responses provided apply to any new arrangements which have since occurred from when the declaration was submitted last year, for example when a practice has merged with another and is using the same practice organisation code. With respect to branch practices, registered under the same parent organisation code (main practice) it is assumed that all responses to all questions for the main practice equally apply to the branch practices. Should any responses to questions answered in this declaration be different for a branch practice, then practices are required to explain these differences further by making use of the free text entry available in the 'supporting Information' section found at the end of the declaration.

Practice Details

This is used to confirm the basic details of your practice e.g. the name, address and contract type. This information helps to ensure the records held by the regional team are correct.
To complete this section, you should confirm that the pre-filled boxes are correct in the 'Main Practice' section. If you have any concerns about this, you should discuss this with your regional team contract manager.

Practice Details		
1D	Practice Contract Type	(GMS/PMS/APMS/other)
1E	Organisation Type[1]	(Social Enterprise/NHS body/Non NHS body)
1F	Since your practice last completed this declaration, have you changed configuration[2] 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[3]
1G	Contract start date/ end date[4] (where applicable)	DD/MM/YY

[1] This question relates to how the contractor elects to be regarded for the purposes of dispute resolution procedures, see definitions available in: http://www.england.nhs.uk/wp-content/uploads/2013/10/manag-disputes.pdf
[2] This means that there has been a change in the contractual entity of the practice.
[3] N/A applies if the practice is new and was not able to complete an electronic declaration last year.
[4] Mandatory question if responding 'Yes' to: 'new or recently changed configuration' and for APMS contracts, otherwise: optional.

1H	Practice telephone number[5] (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

For the purpose of this declaration the contractor is assumed to have sufficient staff, suitably qualified, skilled and experienced to provide a level of service sufficient to meet the reasonable needs of its patients. The practice should amend the declaration to 'NO' if it is not able to demonstrate this.

It is recognized that workforce pressures and including vacancies are increasing locum use in general practice, at a time when locum costs are rising. This section seeks to understand the extent practices are dependent on locums GP support, and how costs compare with the maximum indicative rate for locum cost.
This section relates to Regulations 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended).

Practice Staff Numbers and Suitability & Training and Support

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 (r)	*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 2020 through to 30th September 2020, where pay has exceeded the maximum indicative rate of £72.25 per hour.	
Practice Staff (Training and Support)		

[5] Response to this question could be shared with public facing NHS websites e.g. NHS Choices, NHS.UK.

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/uploads/attachment_data/file/97976/prevent-strategy-review.pdf*	Yes/No
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

This section covers the Practice premises and equipment with regards to service provision, compliance with Health and Safety regulations and infection control, as defined in the contract. Regulations 12(2)(d-f) and (h) and15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended) and the Health & Safety at Work Act 1974

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	Yes/No

	defined in Schedule 1 of the Premises Costs Directions (2013)	
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?[6]	Yes/No
	If answering No to question 3E, what arrangements are in place to meet the reasonab needs of patients who are wheelchair users?[7]	Select all which apply: 1. Home visit 2. Other (free text)

Practice Services

This section primarily relates to the core hours of 0800 – 1830 every day except weekends and bank holidays. We assume that the practice is providing general medical services to meet the reasonable needs of its patients. When entering opening times outside this window, we assume that this relates to extended hours. This section covers the provision of services, including routine and emergency/out-of-hours medical care.

All responses to questions in this chapter will also be used to allow the general public to learn more about the practices which provide particular services. This may include the sharing of responses from questions 4A through to 4X with public facing NHS websites e.g. NHS Choices.

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		

[6] Response to this question could be shared with public facing NHS websites e.g. NHS Choices.

[7] Ibid

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?	Yes / No

(Guidance Note: Provision of out of area registration by practices is optional).	

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**[8]
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 of out of hours care, please provide the name of the accredited provider.	Enter name of OOH provider[9]
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	Yes/No

[8] Declaring "not able to confirm", means that you are not able to provide evidence from patient sources, this does not necessarily mean you are not meeting the reasonable needs of your patients.

[9] If your provider is not on the list provided then enter the name by selecting 'OTHER' and enter in free text.

	its provider through non-compliance or complaints.	
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
4X (n)	The practice is currently open to all patients for both virtual and face to face appointments as clinically appropriate? Yes/No	Yes/No

Information about the Practice and its procedures

This section covers the Practice procedures and includes how the practice communicates with patients, how it stores and records information regarding medication and compliance with regulations regarding children. This relates to Regulations 9, 10, 11, 12, 13 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended).

Communicating with Patients

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	Yes/No

	months. (GMS Regulations Part 10, Regulation 78,PMS Regulations Part 11 Regulation 71).	
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? (r)	Selection all options that apply: 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)
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	Yes/No

	services either by itself or through any other person (via the practice leaflet, practice website or any other written or electronic means)?	

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 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.	Yes/ No/ N/A

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	Yes/No

	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	

Information and Clinical Governance

This section covers information and clinical Governance, and includes questions about storage of data, transmission of data, allowing patients appropriate access to the data held about them and general practice information technology. This section in part relates to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended).

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		
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,	Yes/No

	except in exceptional circumstances where the number cannot be ascertained.[10] (GMS Regulations Part 10, Regulation 70, PMS Regulations Part 11, Regulation 63).	
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

In a context of patients living longer with greater and more complex comorbid conditions the health needs of practice populations are changing. These questions have been asked to support understanding, strategy development, develop systems and processes to manage vulnerable patients and are not related to contractual compliance.
CQC Regulation 17: Good governance, includes requirements to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment (provided, this includes complying with the Data Protection Act)
This section contains 3 mandatory questions and 1 voluntary.

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 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'	Yes/No[11]
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	Yes/No

[10] Ibid
[11] Declaring "no" does not mean the practice is not compliant with their contract.

	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	
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 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?	Yes/No[12]
6O (n)	The practice has agreed and implemented a plan for QOF population stratification which prioritises highest risk patients for proactive review as described in the revised QOF guidance for 20/21. (n)	Yes/No
6P (n)	The practice has a procedure in place to ensure that all DNAR decisions made in respect of patients with a learning disability are made in line with good clinical practice and are reviewed and updated regularly? (n)	Yes/No
6Q (n)	The practice has a procedure in place to offer a maternal postnatal check at 6-8 weeks, as an additional appointment to that for the baby? (n)	Yes/No
6R (n)	The practice has a procedure in place to record the ethnicity of all their registered patients (e.g. upon registration, regular reviews)? (n)	Yes/No

Registering with CQC

CQC Regulation 15, CQC (Registration) Regulations 2009 require that CQC is notified of specific changes in the running of the service so that CQC can be assured that the provider has taken appropriate action.

[12] Ibid

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 regulations[13], put in an application if required and are in in receipt of an up to date registration certificate?	Yes[14]/No[15]/N/A[16]

General Practice IT

NHS England and NHS Improvement has a responsibility to ensure general practices are provided with core GP IT services and this responsibility has been delegated to CCGs. This section, will be analysed with other relevant sections of eDEC and together with data collected from CCGs and central NHS sources (NHS Digital) to support assurance and provide insight to support investment in digital services in General Practice. As part of the Digital Primary Care Maturity Assurance Model, the objective is to:

• Support General Practice in improving service and organisational efficiency and effectiveness by utilising digital technology enablers. This aligns with the ambitions outlined in the GPFV.

• Support local commissioners (CCGs) and NHS England in ensuring local GP IT services support GMS contractual requirements, meet NHS commitments and mandates, are safe and secure and appropriately utilise delegated GP IT funds.

• Support emerging ICS/STPs and new models of care based on integrated care by contributing General Practice digital datasets to wider "place based" digital maturity models.

The questions asked in this section are based on published guidance or NHS policies (in which case links to relevant documentation is given) or on good practice and known transformational enablers not all of which will be relevant to all general practices and localities.
Declaring No in this section does not mean the practice is non-compliant with their contract.
Responses to questions in this section will be shared within other modules of the primary care indicators website GPIT section www.primarycareindicators.nhs.uk and will be visible to all other users.

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	None or N/A

[13] Regulations here refers Regulation 15 of the CQC (Registration) Regulations 2009
[14] Declaring Yes means a change has occurred and the practice has informed CQC.
[15] Declaring No means a change has occurred but the practice has not yet notified CQC.
[16] Declaring N/A means no changes have occurred

			Homes	
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
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:	Yes / No: 1. Other local health providers can access practice records 2. Local social care providers can access practice

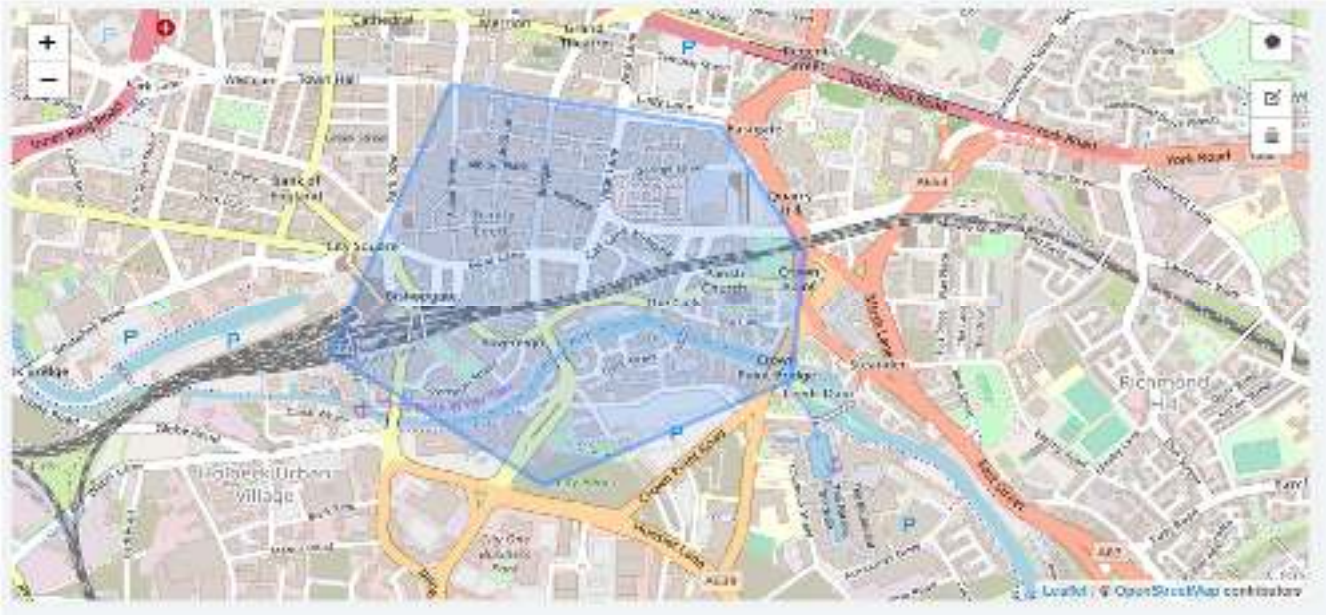
	(Ref: NIB framework)	records 3. Practice can access records from other local health providers 4. Practice can access records from local social care providers 5. None or N/A
8M (r)	The practice has completely digitised all of its paper records (Lloyd George), and with the exception of the empty Lloyd George Envelope, paper records are no longer kept on site or in storage.	Yes/No
8N	If NO, the practice uses off-site storage for its paper patient records?	Yes/No
8O (r)	The practice makes at least 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
8Q (n)	The practice no longer uses a facsimile machine to send/receive patient information?	Yes/No
8R (n)	The practice has facilities in place to enable remote working from home or settings outside the practice as part its business continuity plans and in response to Covid-19	Select all options that apply: NHS Provided laptops Personal computer (non-NHS) using virtual desktop (VDI) service Personal computer (non-NHS) with connection to the NHS network Personal Computer (non-NHS) using remote desktop protocol (a device in the surgery is kept switched on as a host) Other (not covered above) None of the above
8S (n)	The practice has a telephony system that:	Tick all that apply Is based externally in the Cloud Integrates with the clinical system to make outgoing calls Can be accessed outside practice premises to make

		outgoing calls
		Has features which manage peak demands
		Currently it meets our practice needs

Catchment Area

The Electronic Declaration requires the Practice to submit their inner contract area catchment area boundary. The aim is to use these catchment areas to allow practices and the public to determine whether services can be provided.
We expect the majority of practices to be able to enter their catchment area using the Tool provided. Proceed to the 'Catchment Area' section.

Inner catchment area (contract boundary)



To draw a catchment area

1. You can draw the shape of the inner catchment area (contract boundary) using **polygon** tool
2. Select the **polygon tool** to start
3. Click on the map to create the first point
4. then click on the map to start drawing the shape to form the inner catchment area (contract boundary), to complete the shape, the last data entry point needs to finish on the first entry point
5. The inner catchment area (contract boundary), is then presented on screen with the content coloured in
6. Select save and continue button found at the bottom of the web page to ensure your entry is saved.

Supporting Information

This information will be viewed by the regional local teams when considering the Declaration submission.
You do not have to submit anything in the supporting information section - if you have answered all the mandatory questions, then no further information is required.
Practices are reminded that no personal information should be included in this section which would identify any patient, member of staff or third parties.
This section should not be used as a substitute for drawing a catchment area form from the previous section.
Practices experiencing any difficulty using the catchment area editor should contact the NHS Digital customer contact centre.
A separate free text section has been created for:

Supporting Information		
10a GP practice links to online presence is provided via the following routes (r)[17]		
Link to practice website		
Link to practice Facebook page		
Link to alternative online presence page:		
Practice does not have an online presence:		
10C	Opening and closing times of branch practices (if different to main practice).[18]	
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.	Free Text
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?[19]	Enter time in minutes

The information is collected to support commissioners manage the contract, subsets of the data are shared with NHS.UK for use in the public domain, the entire content is shared with CQC, so practices do not have to share the same information twice prior to inspection, the content is also used for ministerial briefings and responding to FOIs.

A 'cut' of specific data relating to opening times, catchment areas and practice services section is given to NHS.UK for onward uses in the public domain.

A 'cut' of specific data relating to opening times, catchment areas and practice services section is given to NHS.UK for onward uses in the public domain.

- **NHS England**
- **CQC**
- **CCGs**
- **Local Regional Offices**

Maps data is published online and shared with the NHS.UK team

[17] Responses could be shared with public facing NHS websites e.g. NHS Choices, NHS.UK.
[18] Ibid
[19] Response will be shared with NHS Digital Burden Advise Assessment Service.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Primary Care Commissioning Committee Meeting held on 6 October 2021**

Item Number:	Agenda Item:
PCCC-21-10.56	Re-branding of Stirchley Medical Practice

Executive Lead (s):	Author(s):
	Michael Innes, Tracie Craddock

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):

Stirchley Medical Practice requests approval to change the operating name of the practice to 'Silkin Health', whilst maintaining the registered name as Stirchley Medical Practice.

Stirchley Medical Practice merged with Sutton Hill Medical Practice on 01.02.2019 following a request from the CCG in late 2018. Given this was effectively a take-over, as the Sutton Hill partners all resigned, the merged practice retained the registered name of the persisting practice – Stirchley Medical Practice.

Since the merge, the combined practice has operated out of both original practice buildings, offering the same care to all of its 24,000 patients.

However, the maintenance of one original name whilst the other is dropped has the potential to cause problems. In particular:

- the current name does not reflect the new practice boundaries,
- it potentially presents the practice as being more focussed on one sub population than the whole,

A change of the operating name will resolve these issues, whilst maintenance of the registered name will minimise the administrative impact. We understand that rebranding will require a contract variation.

The Practice has undertaken a simple risk analysis of the name change and has consulted with its PPG and CQC as well as members of staff. There have been no objections raised and opinion about the change unanimously has been positive.

Recommendations/Actions Required:

The Committee is asked to approve a change of the operating name of Stirchley Medical Practice to 'Silkin Health'.

Report Monitoring Form

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? *(If yes, please provide details of the effect upon these requirements).*	Yes/**No**
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).* The Practice has consulted with its PPG and CQC about the name change. Both have given a positive response.	**Yes**/No

Strategic Priorities – does this report address the CCG's strategic priorities, please provide details:		
1.	To reduce **health inequalities** by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities. *(If yes, please provide details of how health inequalities have been reduced).* Different estates will feel more included in the new name, encouraging better access.	**Yes**/No
2.	To identify and improve **health outcomes** for our local population. *(If yes, please provide details of the improved health outcomes).* The Merger has secured the care for the population of Sutton Hill and the environs and has put the merged practice in a very strong and sustainable position for the future. A name change will consolidate that.	**Yes**/No
3.	To ensure the health services we commission are **high quality**, safe, sustainable and value for money. *(If yes, please provide details of the effect on quality and safety of services).* The Merger has secured the care for the population of Sutton Hill and the environs and has put the merged practice in a very strong and sustainable position for the future. A name change will consolidate that.	**Yes**/No
4.	To improve **joint working** with our local partners, leading the way as we become an Integrated Care System. *(If yes, please provide details of joint working).* A rebrand of the operating name affords the opportunity for stronger links with local partners, including the local authority.	**Yes**/No
5.	To achieve **financial balance** by working more efficiently. *(If yes, please provide details of how financial balance will be achieved).*	Yes/**No**

Proposal for change of the registered name of Stirchley Medical Practice to 'Silkin Health'

For submission to the Primary Care Committee, Shropshire, Telford and Wrekin CCG

1. Background

In April 2019, following an approach from Telford and Wrekin CCG, Stirchley Medical Practice merged with Sutton Hill Practice. Sutton Hill Practice had indicated that it was unable to continue as a viable general medical practice in November 2018 and had approached the CCG for help. The CCG's position was that a merge would be the most effective solution and broached the subject with Stirchley Medical Practice. After five months of negotiation and due diligence, the two practices were approved and merged on the 1st April 2019.

Sutton Hill Practice was one of the oldest practices in the area, existing, on a different site, before the development of Telford as a new town. At its dissolution Sutton Hill practice served just under 10,000 patients.

Stirchley Medical Practice was founded at the start of the new town to serve the new estates built around Stirchley village, Aqueduct, Randlay and Brookside. At the time of the merger, it served just over 14,000 patients.

Both practices served populations with mixed degrees of deprivation, tending strongly to the lower end of the scale. Both the demographic of the populations served, and the approach to clinical care were very similar in the two practices and over the years, the practices cross covered each other for matters such as business continuity.

For the sake of CQC, NHSE/I and other organisations, the merged practice took on the name of the partnership that remained in the practice, namely Stirchley Medical Practice.

2. The area we cover

The merged practice combined now covers a population of just over 24,000 patients, having grown a little over the years. The practice boundaries were combined so that now the practice covers, some patients in Sutton Hill, parts of Madeley and Woodside, Brookside, Parts of Dawley, Aqueduct, Stirchley, Randlay, parts of Hollinswood and Shifnal, Norton and the surrounding countryside. The map below describes it pictorially. About half of the Silkin way runs through the practice area from Coalport to the Town Centre.

3. Why we want to change

It is clear, and has been from the start of our discussions about the merger, that the name of the practice no longer represents the population we cover. It has been necessary to maintain it for business purposes as much as anything else. However, we have long had a desire to make it more representative of the modern practice.

3.1 The advantages to changing for patients

For patients, it will facilitate a better understanding of the practice. For example, it will help to remove concerns about barriers to access, closure of surgeries and unequal care. Although it is later than we would have wished, because of Covid, it will allow us to re-launch the merged practice clearly for our population and for Telford and Wrekin.

3.2 The advantages for staff

For staff, it will give a single clear identity for them to own. It will help the combined staff to move on from separate past histories to a unified future, giving them something make together for themselves. It will also be much easier to say on the phone and elsewhere.

4. The risks of changing our name

We have considered the disadvantages of changing the name.

To change as a legal entity would require re-registration with CQC and all other stakeholder organisations, which entails considerable time and cost. However, we can still change the registered name, whilst maintaining the legal entity as Stirchley Medical Practice. This does not require as much bureaucracy, but would have the same effect of changing the public facing name of the practice.

There is a risk for patients who had infrequent contact that they would think that they had lost their practice leading to them not seeking help appropriately. We could mitigate this with a concerted public communication campaign, as well as with website redirects as we have already been doing for the Sutton Hill Practice website.

Patients will also feel attached to the old names and to lose that may cause distress, especially in the older population. We would hope to mitigate that with the communication campaign as well as with personal conversations during day to day interactions.

There may be a delay in notification being promoted throughout the system, leading to possible loss of orders, supplies, or information. We would mitigate this by the dual running of names in the initial stages of the changeover.

5. Consultation

In considering a change of name, we have held discussions with our staff, our patients in the form of the Patient Participation Group, and our commissioners in informal discussions. The partners selected the name initially and presented it to these groups. It has received unanimous approval so far.

6. The plan and organisations we need to involve

If approved, we would need to effect a formal change of name with the following main stakeholders:

NHSE/I, CQC, NHSBSA, Secondary Care Providers, Community Care Providers, Mental Health Providers, Out of hours provider, Local Authority

We would also inform all our business stakeholders.

We would like to plan a communication campaign, with the help of the Communications team from MLCSU, to include an offer to local radio and local papers. We have a new Logo (see below) to facilitate the recognition of the new name, which we generated as part of our staff engagement.

We would like this process to be complete by Christmas 2021.

New Practice operating name logo

M Innes & T Craddock 22/9/21

Primary care risk register - Shropshire , Telford and Wrekin 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
Active Risks 1.04.21												
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 Shropshire.	1. GPFV monies enables practices to create new creative roles 2. The Training Hub is providing a pivotal training service to primary care medical and other health professionals 3. ARRS funding is enabling additional roles to support PCN's	1. Primary care workforce plan is in place. 2. Delivery board and operational groups in place to support delivery in line with practice priorities. 3. Workforce and training hub are reported to system People Board to give system oversight and to ensure that primary care is looped into the workforce issues	1. PCN assurance meetings 2. PCN workforce plans aligned to priorities 3. Recruitment in line with ARRS financial envelope 4. Training hub board and group reporting to People Board fro system	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 workforce groups to share learning. 4. Report to people board and ensure understanding of primary care workforce issues	3x3=9 Moderate	Exec: C.Parker Owner: C Parker	26/11/2020 C.Ralph Reviewed 1 04 21 T Jones Amended C Parker june 2021
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. This iuncludes ability to manage the backlog and manage staff shortages either throu positive test or self isolation	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. information through newsletters and locality meetings, contact with partnership managers 2. refresh of weekly calls to be undertaken to get information to practice managers 3. Support for the national guidance on the return to work processes	1.Limited formal SITREP reporting 2. Demand and activity modelling needs to be done to show system pressure 3. electronic locum support service including all professions	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 5. ensure access to IPC and public health support 6. ensure IMT under new national return to work guidelines are in place	3x3=9 Moderate	Exec: C.Parker Owner: C Parker	26/11/2020 C.Ralph Reviewed 1.04.21 TJones Amended C Parker June 21
STW - 04		Jane Sullivan 04	Due to covid 19 pandemic scheduled Practice Quality Visits have been paused since March 2020. Although remote monitoring has continued a Practice Quality Visit allows for further exploration subjects and conversations between CCG and Practice to gain assurance and understanding.	1. Potential to share good practice across the system. 2. Potential to save process improvements and reduce hand-offs/inefficiencies in practices	1. Primary care and Quality Lead continue to meet quarterly with CQC to share intelligence. 2. Continue to monitor Practice performance using exisiting sources of assurance and speak to Practices individually if concerns identified.	1. CQC intelligence 2. Significant event reporting to CCG by Practices 3. Monitoring of Patient experience PALs/Healthwatch/MP letters/ complaints shared with CCG by NHSE/GP Patient Survey/FFT/N2 4. Quarterly Quality report submitted to Quality and Performa committee 5. EDEC	1. Missed opportunities during visits to explore specific areas with Practices in further depth. 2. Missed opportunties to share good practice and learning with CCG which discussions during a visit can generate.	3x2= 6 Low	1. Proposal to establish a Task and Finish Group to reestablish Practice Quality Visits from Autumn 2021 with identified agenda and terms of reference to provide a unified approach across the CCG. 2. Data and intelligence will be reviewed prior to visit to ensure that they are individual to each Practice and target areas for assurance.	3 x 2 = 6 Low	Claire Parker Zena Young	Newly added 1 4 21 T Jones Amended C Parker June 21
STW 05 Previous 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	1. To ensure the financial stability practices by ensuring rent reviews and completed on time 2. to ensure that opportunities for pilots such as the 'Cavell' project is used to the benfit of the population in the CCG	1. Premises Cost Directions 2. Scheduled programmes of rent reviews 3. Clear approvals process for new business cases 4. Project boards with risk management and mitigation for each of the projects held at least monthly	1. Accurate record keeping 2. Regular contact/liaison with NHSE (GMAS team) 3. Project board oversight for each of the new builds	1. Changes in the primary care team at NHSE 2. Triple lock process for CCG 3. Links to One Public estate	3x4=12 High	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 budgets.	3x4=12 High	Exec: C. Skidmore Owner: C Parker	1 04 21 Risk reviewed TJones Ameded C Parker June 21
STW 07		PCCC 06/21 C Parker	Allocation of practice covid expansion fund was incorrectly calculted in the national guidance and left a shortfall of 1.2m for the allocation received which was absorbed into the CCG baseline		1. Funding not utilised as part of the pulseoximetry service was put back into the baseline circa £200k		1. In ability to take any funding from primary care to ensure services are funded appropriately	3x3=9 Moderate		3x3=9 Moderate	Exec: C Parker & C Skidmore	New risk added June 2021
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 quality 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. Infequent 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 Request for this to be closed with new risk identified for Practice visits which incorporates work across STW CCG.
STW-01	T+W 4+5 Shrop	C/F Telford 24/06/19 C.Ralph	**Primary Care Networks (PCN)** 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 patients.	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 4. 8 PCNs now exist within STW CCG - only one practice remains as an orphan practice but patients are allocated	Notes of PCN meetings/assurance meetings - PCN Development meetings re-established, PCN delivering vaccination programme through existing Enhanced services, PCN development feeding into refreshed single CCG governance. Regular formal and informal meetings in place to engage, collaborate and deliver shared working arrangements. PCN's engaged at place	None	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	Reviewed 1 4 21 Tjones Covid has impacted upon planned development work however risk remians low as new ways of working togetehr arising form covid opportunities Agreed CLOSE at PCCC June 2021
STW 06 Previously S-04		PCCC 12/20	Primary Care Services in Whitchurch are under increased pressures due to difficulty in recruiting staff and managing services across several unsuitable small sites. There is a risk that Churchmere Medical Group hand back their contract if the situation continues. The planned closure of Dodington Surgery at end March 2021 adds to	To secure the future of Primary Care services in Whitchurch by building a purpose built health care facility - The Pauls Moss Development proposal..	1. GMS Contract in place. 2. Pauls Moss programme proposals in place, although currently awaiting judicial review decision. 3. CCG agreed a transformational funding package to support Churchmere Medical Group to merge with Dodington Surgery and to manage services across 3 sites	1. Regular contact with Churchmere senior partners. 2. NHSE support with merger and ETTF monies for expansion space costs. 3. Flexible use of new ARRS roles to increase clinical capacity. 4. Judicial review against Pauls Moss development was not uphed therefore the build will now go ahead		2x1=2 Very low	1. Ensure regular contact with CMG to identify issues early. 2. Ensure close liason with Pauls Moss Development partners to be alerted to judicial review decision and any further appeals. 3. Explore CCG options should a new contract holder be needed	2x1=2 Moderate	Exec: C.Parker Owner: C Parker	Reviewed 1 4 21 Tjones Amended C Parker June 21 Recommend for closure as further risks incorporated into financial risks

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.

Committee Evaluation

Name of Committee:

Date:

	Poor	Average	Good	Excellent
Clear focus on key functions of the committee				
Benefits for patients/public from this meeting				
Purpose of papers clear and contained correct information				
Appropriate Layout and presentation of information				
Opportunity for all members to participate				
Time used for relevant discussion				
Clearly identified actions/outcomes/leads/timeframes clearly identified				
Risks clearly identified & managed				
Was enough time programmed into the agenda for the items under discussion				

Comments: