PRIMARY CARE COMMISSIONING COMMITTEE

HELD IN PUBLIC SESSION ON FRIDAY 16 JUNE 2017 1:00pm – 3:00pm
THE BOARD ROOM, 3RD FLOOR, BRIERLEY HILL HEALTH AND SOCIAL CARE CENTRE, VENTURE WAY, BRIERLEY HILL, DY5 1RU

QUORACY
A meeting of the Committee will be quorate provided that at least 4 members are present of which:

- one must be either the Chair or Vice-Chair of the Committee
- one must be the Chief Finance Officer/Deputy Chief Finance Officer or Chief Nursing Officer

AGENDA

Time	Item		Attachment	Presented by
1.00 pm	1	**Apologies**		Mr S Wellings
1.00 pm	2	**Declarations of Interest** 2.1 To request members to disclose any interest they have, direct or indirect, in any items to be considered during the course of the meeting and to note that those members declaring an interest will not be allowed to take part in the consideration or discussion or vote on any questions relating to that item. 2.2 This meeting is being held in public and is being recorded purely to assist in the accurate production of minutes, decisions and actions. Once the minutes have been approved the recording will be destroyed. All care is taken to maintain your privacy; however, as a visitor in the public gallery, your presence may be recorded. Should you contribute to the meeting during questions from the public, you agree to being recorded.		Mr S Wellings
1.00 pm	3	**Questions from the Public**		Mr S Wellings
1.05 pm	4	**Minutes of last meeting held on Friday 26 May 2017**	**Enclosed**	Mr S Wellings
1.05 pm	5	**Matters Arising/Action Log**	**Enclosed**	Mr S Wellings
1.15 pm	6	**Contractual** 6.1 Report from the Primary Care Operational Group	**Enclosed**	Mrs J Robinson
1.25 pm	7	**Quality** 7.1 Report from the Quality and Safety Team	**Enclosed**	Mrs C Brunt
1.35 pm	8	**Finance** 8.1 Finance Report	**Enclosed**	Mr P Cowley
1.50 pm	9	Dementia Local Improvement Scheme	**Enclosed**	Mr A Hindle
2.10 pm	10	Primary Care Commissioning Committee Annual Report	**Enclosed**	Mrs J Taylor
2.30 pm	11	Risk Register	**Enclosed**	Mrs C Brunt
	12	**Date and Time of Next Meeting** Friday 21 July 2017 1pm – 3pm The Board Room, Third Floor, Brierley Hill Health and Social Care Centre		

PRIMARY CARE COMMISSIONING COMMITTEE

MINUTES OF THE MEETING HELD IN PUBLIC ON FRIDAY 26 MAY 2017
THE BOARD ROOM, 3RD FLOOR, BRIERLEY HILL HEALTH AND SOCIAL CARE CENTRE, VENTURE WAY, BRIERLEY HILL, DY5 1RU

Quorum:
A meeting of the Committee will be quorate provided that at least four members are present of which one must be either the Chair or Vice Chair of the Committee and one must be the Chief Finance Officer/Deputy Chief Finance or Chief Nursing Officer.

ATTENDEES:

Members

Mr S Wellings	Non-Executive Director for Governance, Dudley CCG (Chair)
Ms S Johnson	Deputy Chief Finance Officer, Dudley CCG
Dr D Pitches	Consultant in Public Health, Dudley MBC
Dr C Handy	Non-Executive Director for Quality & Safety
Mr J Young	Head of Quality Assurance, Dudley CCG

In Attendance

Mrs J Robinson	Primary Care Contracts Manager, Dudley CCG
Ms J Emery	Chief Executive, Healthwatch Dudley
Mr P Cowley	Senior Finance Manager, Dudley CCG
Mr D Stenson	Patient Opportunity Panel Representative
Mr B Dhami	Senior Contract Manager, NHS England (West Midlands)
Mr M Kolia	Dudley LPC Representative
Mr R Franklin	BI Developer and Analyst, Dudley CCG

Minute Taker:

Mrs R Gretton	Personal Assistant, Dudley CCG

1. APOLOGIES FOR ABSENCE

Apologies were received from:

Mr M Hartland, Chief Operating and Finance Officer, Dudley CCG
Mrs E Smith, Governance Support Manager, Dudley CCG
Mr D King, Director of Membership Development and Primary Care, Dudley CCG
Mrs L Broster, Director of Communications and Public Insight, Dudley CCG
Mrs A Nicholls, Interim Deputy Head of Commissioning (Primary Care) NHS England (West Midlands)
Dr V K Mittal, GP Representative
Miss T Jeavons, Primary Care Contracts Support Officer, Dudley CCG
Mrs C Brunt, Chief Nurse, Dudley CCG
Dr T Horsburgh, Clinical Executive for Primary Care, Dudley CCG
Mrs J Taylor, Commissioning Manager for Primary Care, Dudley CCG
Mrs J Jasper, Lay Member for Patient and Public Involvement, Dudley CCG
Mr T Thomik, Dudley LPC Representative

2. DECLARATIONS OF INTEREST

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

Mr Stenson declared his standing interest as Non-Executive Director for Black Country Partnership Foundation Trust.

3. QUESTIONS FROM THE PUBLIC

Mr Wellings had received no questions from the public.

4. MINUTES FROM THE PREVIOUS MEETING HELD ON 21 APRIL 2017

The minutes of the Committee held on 21 April 2017 were accepted as a true and accurate record.

5. MATTERS ARISING/ACTION LOG

MATTER ARISING

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

PCCC/JAN/2017/9.1	Part a and b of this action would be discussed on the agenda and part c was agreed to be deferred until June 2017
PCCC/MAR/2017/7.1(b)	It was reported that a meeting is to be arranged for a local flu plan, but also to look at immunisation uptake and how improvements can be made. This item was agreed to be deferred until July 2017
PCCC/MAR/2017/11.0	The Committee was informed that an evaluation had been requested, though was still outstanding and it was agreed that this item be deferred until September 2017
PCCC/APR/2017/12.0	The Committee was informed that this item was in progress and it was agreed to be deferred until June 2017
PCCC/APR/2017/13.0	This item was agreed to be deferred until June 2017

6. CONTRACTUAL

6.1 REPORT FROM THE PRIMARY CARE OPERATIONAL GROUP

Mrs Robinson spoke to this item to update the Committee on the issues discussed at the Primary Care Operational Group (PCOG) held on 3 May 2017.

The Committee was informed that one request had been received for consideration of variation to the contract, in regard to a 24 hour retirement of one partner at Lower Gornal Medical Practice. Plans were noted to be in place for service delivery during the reduced period of working.

It was reported that the majority of the PCOG meeting was devoted to discussion around the Bilston Street Surgery closure. Key points were outlined within the report, though subsequent to circulation of the papers further actions had been taken by the practice.

It was noted that 887 patients now remain registered at the practice as opposed to that contained within the report. All patients had received further written communication along with MJOG messages, social media messages, posters and a countdown to closure within the practice.

It had been agreed with the practice that they would maintain the clinical system until 6 June 2017 following the closure on 31 May 2017, in order to allow for GP2GP transfer of electronic records to continue. The Committee was informed that a temporary worker and ex-member of staff were aiding in the printing of clinical records from the system, with assurance that this task would be completed on target. The majority of the records would then be collected by NHS England on 7 June 2017.

Verbal assurance had been received from the practice that remaining vulnerable patients had been contacted and as of the morning of 26 May 2017, four pregnant ladies and fifteen under 16 year olds remained registered at Bilston Street Surgery and would be contacted individually by telephone once more. It was reported that on 30 May 2017 the list of remaining vulnerable patients would be considered for allocation by NHS England to a practice.

Weekly conference calls were reported to be taking place with the Practice Manager, along with internal CCG communications and visits to the practice by representatives from both the CCG and NHS England twice weekly.

The Committee was informed that a mechanism was in place in regard to screening programmes which would allocate patients who had not re-registered with a new GP to a dummy code until such time that a decision had to be made for further continuation of that provision.

It was reported that a lessons learnt exercise would be undertaken around this process to inform any similar future situations should they arise.

Thanks were given to Mrs Robinson and all involved in the work undertaken and support of NHS England during and for the closure process.

The Committee was informed that PCOG received the Quality and Safety report, with no contractual actions needing to be taken.

It was reported that the Terms of Reference for the PCOG are being reviewed and would be presented to the Committee in due course.

Resolved:

1) **The Committee noted the actions of the Primary Care Operational Group for assurance**
2) **The Committee approved the 24 hour retirement request**

7. QUALITY

7.1 REPORT FROM THE QUALITY AND SAFETY TEAM

Mr Young spoke to this item to highlight key points within the report.

CQC Inspections

The Committee was informed that those practices requiring follow up inspections had seen a pattern of improvement in their ratings.

A CQC inspection report had been published for Stourside Medical Practice, who had received an inadequate rating. It was reported that a meeting had taken place between CCG representatives and the practice, with active engagement and positive initial assurance around an action plan to improve on re-inspection. Regular updates had been requested from the practice and a mock inspection will take place in due course.

Concern was noted by the Committee in regard to the 'red' area listed within the report of the 'well led' domain, which was explained to come from the practices lack of systems and processes in place and could be linked to the absence of a Practice Manager. It was reported that a new Practice Manager was now in place and with the support of Dr Hearn these issues should now be easily addressed by the practice.

No issues were raised by CQC around direct clinical care and the managing safety alerts issue was clarified not to mean that the practice was not managing safety alerts, but that they had not demonstrated this to the fullest degree.

The Committee was informed that the practice is taking part in the GP Resilience Programme, as part of the GP Forward View and also the RCGP Support Programme due to them entering special measures.

It was reported that several conversations are taking place currently around the future of CQC inspections and the CCG are actively engaging with CQC locality and nationally on the shape of this for the future, with particular reference to new models of care. It was noted that Healthwatch are also involved in this process from a patient perspective.

In response to question around inspection ratings related to QoF and the Dudley Quality Outcomes for Health Framework (DQOFH) and if this had affected practice ratings, it was reported that some confusion was apparent early on for practices using the DQOFH and articulation from practices around how achievement was evidenced to CQC. Conversations had taken place around this with CQC and feedback from practices in regard to the template is being received on a continuing basis.

Infection Prevention & Control (IPC)
It was reported that the first inspection in the new schedule had taken place and would be fed through at the next Committee.

Datix
The Committee was informed that one practice was keen to sign up to using Datix, with three or four practices also requesting to engage in conversations to potentially trial the system.

Primary Care Assurance Tool (PCAT)
Assurance was given to the Committee that there was a consciousness that the Quality and Safety report was somewhat disjointed from the PCAT information and so work had taken place to bring the two together with the emergence of a set of consistent information that would be reported over the coming months.

Resolved:

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

8. FINANCE

8.1 FINANCE REPORT

Mr Cowley spoke to this item to present baseline budgets for the financial year 2017/18.

The Committee was informed that the financial figures reported last month had since been finalised without changes and had been assured by audit again without amendment.

It was noted that the report shows budgets that have been delegated to the Committee for the financial year 2017/8 totalling £41.4m, with £40.6m delegated to Co-Commissioning Primary Care and £800k delegated to Primary Care Development.

Key areas for spenditure and associated risks are set out within the paper. It was noted as was the case last year, due to the expenditure being fixed and non-discretionary, the overall level of risk associated with the budgets remains low.

The Committee was updated on figures within the report, noting that uncommitted reserves following allocation of budgets to cover commitments made is actually £203k, not the £253k stated within the report and further work will need to be undertaken to decide priorities for spending those uncommitted reserves.

The paper details non-recurrent investment reserves and contingency reserves to cover any significant overspend, though budgets had been set aside for those areas where increases are expected.

There is an expectation that further allocations will be received in respect of the GP Forward View priorities, which are all noted within the report. No cost pressures were associated with those budgets.

Questions were raised around the extended access in regard to DNA of appointments, with a spend of £1.9m being used to offer additional appointments when large numbers are not attended and whether funds should be spent on reducing DNA appointments. It was noted that DNA rates over the term of the scheme were encouragingly low.

Resolved:

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

9. PERFORMANCE

9.1 PERFORMANCE REPORT

Mr Franklin entered the meeting

Mr Franklin spoke to this item to update the Committee on the Primary Care Assurance Tool (PCAT) and further development of the tool.

Around twelve months ago the initial version of the PCAT Tool was presented to the Committee. Since that time it had been shared across the organisation as a format to jointly report across multiple committees.

The performance for Primary Care for the latest quarter is shown within the report and the key points were highlighted.

It was noted that IT issues had been previously experienced in regard of the product being available to membership practices. An agreement was now in place with Dudley IT, to roll out the tool in the week commencing 5 June 2017 and will allow practices to see their performance across various domains.

The prescribed element of the tool was reported not yet to be available but would be included in the next quarter.

West Midlands Standardised Admission Ratio (WMSAR)
The Committee was informed that Dudley CCG is 23% above the expected rate of emergency admissions. Work was noted to be taking place outside the primary care remit in addition, with the commission of an audit to review emergency admissions at DGNHSFT on the basis that previous analysis had highlighted that certain types of admissions should not be coded as an admission.

The Friends and Family Test Q3 16/17
It was reported that there are still some practices that are not reporting this information. The primary care contracting team had been liaising with practices around this and some issues had been highlighted to be experienced during the data submission process. No concerns were noted of practices not completing the required information and action is taking place to look at any submission problem.

The Committee was informed that performance is above the national average that is nationally recommended, with more responses seen in Q3 than previously and Q4 looking positive.

NHS Choices Q416/17
Conversations are taking place around this and those practices that have low scores, with further action taken as necessary.

GP Practice Standardised Admission Ration (SAR)
The Committee was informed that this is a rate that shows emergency admissions by practice, standardised by age, gender and deprivation. Some practices are noted to have higher rates, specifically Summerhill Surgery, which could be arguably expected purely due to care home demographics.

The Committee requested a triangulated report of the top twelve concern practices, so that focus can be

made by the Committee

ACTION: MR FRANKLIN

It was noted that the Quality and Safety report will also feature as part of the report going forward.

From a Healthwatch perspective, it was highlighted that soft intelligence could also inform indicators and further discussion would need to continue as to how this could be fed into the tool and how that would happen.

Resolved:

1) **The Committee received the report for assurance**
2) **The Committee requested a triangulated data report**

Mr Franklin left the meeting

10.0 RISK REGISTER

Mr Young spoke to this item to note that the risk register is currently under review to produce a more generic streamlined register that accurately reflects the key risks.

External review will also being requested.

Resolved:

1) **The Committee noted the risk register on the review which is in progress**

11.0 DATE AND TIME OF NEXT MEETING

Friday 16 June 2017
1 – 3pm
The Board Room, Third Floor, Brierley Hill Health & Social Care Centre

MINUTES ACCEPTED AS A TRUE AND CORRECT RECORD

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

PRIMARY CARE COMMISSIONING COMMITTEE

OUTSTANDING ACTION LIST – 16 JUNE 2017

MEETING REFERENCE	ACTION	LEAD	STATUS	DEADLINE DATE	DATE COMPLETED
PCCC/JAN/2017/9.1	<u>Performance report</u> a. The Committee requested an exception report of the top 10 and bottom 10 practices b. The Committee requested a report of those practices who do not submit FFT data c. The Committee requests an update on work/actions taking place around PAU	Mr Franklin Mr Franklin Dr Horsburgh	In Progress In Progress In Progress	May 2017 May 2017 June 2017	
PCCC/JAN/2017/10.0	<u>Primary Care Corporate Objectives</u> a. The Committee requested further clarification in the alignment of the objectives to the categories b. The Committee agreed that the report be reported to Audit Committee for governance assurance and consideration c. The Committee agreed that reflections in terms of clinical leadership support arrangements be raised with the Clinical Executive Team	Mr King Mr King Dr Horsburgh	In Progress	August 2017	
PCCC/MAR/2017/7.1(b)	<u>Quality & Safety Report</u> The Committee requested a report from Public Health for further details on the immunisation landscape	Mrs Brunt	In Progress	July 2017	

MEETING REFERENCE	ACTION	LEAD	STATUS	DEADLINE DATE	DATE COMPLETED
PCCC/MAR/2017/11	DPMA Training Budget Business Plan The Committee requested evaluation of the proposal to see the success of training and also that columns included to see alignment to the MCP	Mrs Taylor	In Progress	September 2017	
PCCC/APR/2017/8.2	Health Infrastructure Strategy Implications for Primary Care In view of the potential implications to practices, a further consultation of the framework was recommended to be taken to fully enlighten of the specifics with the membership prior to approval by the Committee. A further report was requested following consultation in June 2017.	Mr Cowley	In Progress	June 2017	
PCCC/APR/2017/12.0	Primary Care Organisational Structure The Committee agreed the proposed structure subject to presentation of the ToR for the PCDG and PCSG for Committee approval	Mrs Taylor	In Progress	June 2017	
PCCC/APR/2017/13.0	Supporting Professional Decisions The Committee requested further detail around the membership of the panel and who that would work	Dr Horsburgh	In Progress	June 2017	
PCCC/APR/2017/14.0	Patient Participation Group Update It was requested that in two months' time, a list of practices where there is concern in regard to their PPG is presented to the Committee	Ms Hodgson	In Progress	June 2017	
PCCC/MAY/2017/9.1	Performance Report The Committee requested a triangulated data report of the top 12 practices of most concern in relation to the indicators	Mr Franklin	In Progress	August 2017	

PRIMARY CARE COMMISSIONING COMMITTEE

Date of Committee: 16 June 2017
Report: Update from the Primary Care Operational Group
Agenda Item: 6.1

TITLE OF REPORT:	Update from the Primary Care Operational Group
PURPOSE OF REPORT:	To update the Committee following the Primary Care Operational Group meeting held on 7 June 2017
AUTHOR OF REPORT:	Mrs J Robinson, Primary Care Contracts Manager
MANAGEMENT LEAD:	Mrs C Brunt, Chief Nurse
CLINICAL LEAD:	Dr T Horsburgh, Clinical Executive for Primary Care
KEY POINTS:	• The group considered and recommends the contractual changes set out below in the recommendations • The group considered the quality and safety issues that are set out in the quality and safety report • The group received an update in respect of the Bilston Street Surgery Closure • Update provided in respect of GP Resilience Programme 2016/17 • The Group received the GMS contract compliance report and provides assurance that there are no contractual breaches to be issued for any Dudley practice • The Group reviewed the Primary Care Operational Group Terms of Reference

RECOMMENDATION:	The Committee is asked to:
	
	• Note the actions of the primary care operational group for assurance
	• Approve the contractual changes recommended by the group as follows:
	  • The addition of Dr Pervaiz at St James Medical Practice (Jalota)
	  • A change to the practice name from Dudley Partnerships for Health to Dudley Wood Surgery

FINANCIAL IMPLICATIONS:	Not applicable
WHAT ENGAGEMENT HAS TAKEN PLACE:	Not applicable
ACTION REQUIRED:	**Decision** ✓ **Approval** ✓**Assurance**

DUDLEY CLINICAL COMMISSIONING GROUP – PRIMARY CARE COMMISSIONING COMMITTEE UPDATE FROM THE PRIMARY CARE OPERATIONAL GROUP

1.0 INTRODUCTION

1.1 This report provides an update from the Primary Care Operational Group (the 'Group') following its meeting held on 16 June 2017.

2.0 CONTRACTING ISSUES

2.1 PRIMARY CARE CONTRACTUAL CHANGES

2.2 The group considered and supported the following contractual changes for approval by the Committee:

St James Medical Practice (Jalota)	Addition of Dr S Pervaiz to the GMS contract	Effective date: 1 July 2017
Dudley Partnerships for Health	Practice name change to Dudley Wood Surgery	Effective date: As soon as approved

The group was assured that the addition of a second partner at St James Medical Practice (Jalota) would deliver the full range of services and reduce the potential risk associated with a single handed practice.
In addition the group was assured that Dudley Partnerships for Health had undertaken sufficient consultation with their patients regarding the change to the practice name and it was fully supported by their Patient Participation Group.

2.3 **Closure of Bilston Street Surgery, Sedgley, DY3 1JA**

2.4 Bilston Street Surgery Closed on 31 May 2017

2.5 The group received the final exit plan and risk register and were assured by the dispersal process. The patients who did not register before the closing date are now held in abeyance by NHS England, Primary Care Support Services. In 3 – 6 months' time the next steps will need to be determined.

2.6 The outcome of a lessons learned exercise will be presented to the Group in September

2.7 **Contract Monitoring**

2.8 Under fully delegated co-commissioning arrangements the CCG has to discharge its responsibility of seeking and confirming contractual compliance of all primary medical contracts that fall under its governance.

2.9 In order to fulfil this responsibility a contract review process was developed using a template and process adopted from NHS England. This was also developed in conjunction with the Local Medical Committee and the Dudley Practice Managers Association.

2.10 The group received the GMS contract monitoring report and was assured that there are no contractual breaches to be issued for any Dudley practice.

2.11 The group will be designing a quality assurance framework from which the contractual monitoring process for 2017/18 will be developed. The Contractual responsibilities to be monitored during 2017/18 will be determined by the Group and will be presented to the Committee for approval.

3.0 QUALITY AND SAFETY

3.1 The group considered the quality and safety issues that are set out in detail in the Quality and Safety report to the Primary Care Commissioning Committee.

3.2 There are no issues in the quality and safety report that require contractual actions to be taken against any practice.

4.0 TERMS OF REFERENCE

4.1 The Primary Care Operational Group Terms of Reference was discussed and amended by the Group and will be presented for approval at the next Committee.

5.0 RECOMMENDATION

The Committee is asked to:

- Note the actions of the primary Care Operational Group for assurance
- Approve the contractual changes recommended by the group as follows:
    - The addition of Dr Pervaiz at St James Medical Practice (Jalota)
    - A change to the practice name from Dudley Partnerships for Health to Dudley Wood Surgery

NHS
Dudley
Clinical Commissioning Group

DUDLEY CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE

Date of Meeting: 16 June 2017
Report: Quality & Safety Report
Agenda Item No: 7.1

TITLE OF REPORT:	Quality and Safety Report
PURPOSE OF REPORT:	To provide on-going assurance to the Primary Care Commissioning Committee (PCCC) regarding quality and safety in accordance with the CCG's statutory duties
AUTHOR(s) OF REPORT:	Mr J Young, Quality and Patient Safety Manager
MANAGEMENT LEAD:	Mrs C Brunt, Chief Nurse
CLINICAL LEAD:	Dr R Edwards, Clinical Lead, Quality & Safety
KEY POINTS:	• One CQC report has been published since the last report • A framework has been developed to support the reduction of Healthcare-Associated Infections (HCAI) • Work is underway to agree plans for flu immunisations for this winter
RECOMMENDATION:	The Primary Care Commissioning Committee is asked to: • **Note** this report for assurance
FINANCIAL IMPLICATIONS:	None to report
WHAT ENGAGEMENT HAS TAKEN PLACE:	N/A
ACTION REQUIRED:	✓ **Assurance**

1 Introduction

1.1 A primary care quality and safety report is provided to the CCG Quality and Safety Committee (QSC) and CCG Primary Care Operational Group (PCOG) monthly. This report is a material summation of the report submitted to the latest QSC plus any additional information identified after the QSC report was finalised.

1.2 The PCCC will be briefed on any contemporaneous matters of consequence arising after submission of this report.

2 CQC Inspections

2.1 Appendix A shows the latest status of CQC inspections across Dudley.

2.2 **Clement Road Surgery** has been rated as good overall and for all domains following their previous requires improvement rating for the safe domain.

2.3 Dudley CCG attended a CQC workshop on 06/06/17 to discuss how CQC, CCGs and NHSE could work better together, Work is ongoing to develop the right frameworks to support this.

3 Serious Incidents (SIs)

3.1 Currently, there is one open SI. Support is continuing to be provided by the Q&S team to ensure a robust RCA is carried out and documented.

4 Infection Prevention & Control (IPC)

4.1 The first IPC audit on the 2017/18 schedule was carried out on 24/05/17, with the practice being rated as green overall.

4.2 An HCAI Reduction Assurance Framework has been developed with the local Office of Public Health team, and clearly sets out the expectations that the CCG has around the prevention of infection in its provider organisations – including primary care - as well as the key responsibilities of the CCG.
The framework does not describe any new or different responsibilities but simply reflects the current requirements in line with national guidance and legislation.
This framework was discussed at PCOG on 07/06/17 and will be made available to all practices; compliance with the framework will be reported by exception through PCOG and PCCC.

4.3 A meeting has been arranged for 28/06/17 to discuss local flu planning and a wider discussion regarding how we could improve all immunisation uptake rates in Dudley. Indications suggest the 2016/17 Q4 uptake figures will show a slight improvement for Dudley.

4.4 National guidance regarding flu has been circulated – key changes this year are:

- Vaccination of the morbidly obese will attract a payment under the DES
- Reception year children (aged 4 – 5 years) will now be offered flu vaccination in reception class rather than through general practice as in previous years
- School year 4 children (aged 8 – 9) will now also be offered the vaccination

4.5 Locally, NHSE are also planning to fund CHIS sending out letters to parents of all 2 & 3 year olds reminding them to contact their GP to arrange a flu vaccination for their children. This follows a pilot last year which resulted an increase in uptake.

5 Service Developments

5.1 **Datix** – Datix is now being used within the CCG Quality & Safety team to manage all incidents and patient safety concerns. A follow-up meeting with one practice has resulted in agreement to use the live system from 1st July. Meetings are now being arranged with other practices to discuss trialling and to gain further feedback on improving the system. Some IT connectivity issues that had been experienced by some sites have now been resolved.

5.2 **Primary Care Assurance Tool (PCAT)** – further meetings have been scheduled for w/b 12/06/17 to finalise the content and format. It is anticipated that future PCOG, PCCC and QSC reports will be generated using PCAT.

APPENDIX A: Overview of CQC Inspections (as of 08/06/17)

Practice Name	Visit Date	Report Published	Overall rating	Safe	Effective	Caring	Responsive	Well Led
Pedmore Road Surgery	22/10/2015	14/01/2016			Good	Good	Good	Good
Steppingstones Surgery	28/10/2015	17/12/2015	Good	Good	Good	Good	Good	Good
Rangeways Road Surgery	12/11/2015	07/01/2015	Good	Good	Good	Good	Good	Good
Bath Street Surgery	24/11/2015	28/01/2016				Good		
Woodsetton Medical Practice	08/12/2015	04/02/2016	Good		Good	Good	Good	Good
Bilston Street Surgery – **follow up**	09/12/2015	14/03/2016	Good		Good	Good	Good	Good
Lapal Medical Centre	15/12/2015	11/02/2016	Good	Good	Good	Good	Good	Good
The Waterfront Surgery	17/12/2015	03/03/2016						
The Limes Medical Centre	13/01/2016	11/02/2016	Good		Good	Good	Good	Good
Moss Grove Surgery	19/01/2016	10/03/2016						✪
Central Clinic - **follow up**	02/02/2016	03/03/2016	Good	Good	Good	Good	Good	Good
Dudley Partnerships for Health	10/02/2016	14/04/2016						
Stourside Medical Practice	16/02/2016	04/04/2016			Good		Good	Good
Lower Gornal Medical Practice	01/03/2016	06/04/2016	Good		Good	Good	Good	Good
Quincy Rise Surgery	09/03/2016	02/06/2016						
AW Surgeries	14/03/2016	11/05/2016					✪	
Eve Hill Medical Practice	15/03/2016	17/05/2016	✪		✪	✪		✪
Northway Medical Centre	14/04/2016	09/06/2016						
Cross Street Health Centre	25/05/2016	24/06/2016						
Feldon Lane Surgery	04/05/2016	30/06/2016						
Ridgeway Surgery	17/05/2016	06/06/2016						
Quincy Rise – **follow up 1**	18/07/2016	02/09/2016	No change to ratings from this inspection					
Bath Street – **follow up**	26/07/2016	22/09/2016						
St. James Medical Practice (Porter)	02/08/2016	13/09/2016						
Bilston Street - **follow up (2)**	10/08/2016	No report	No change to ratings from this inspection					
Wychbury Medical Group	16/08/2016	03/10/2016						
Clement Road Surgery	25/08/2016	12/10/2016						
Norton Medical Practice – **follow up**	01/09/2016	03/10/2016						
Bilston Street – **follow up (3)**	06/09/2016	09/11/2016						
The Waterfront Surgery – **follow up**	06/09/2016	01/12/2016						
High Oak Surgery – **follow up**	14/09/2016	19/10/2016						

Practice Name	Visit Date	Report Published	Overall rating	Safe	Effective	Caring	Responsive	Well Led
Links Medical Practice (Netherton)	20/09/2016	31/10/2016						
Castle Meadows Surgery	04/10/2016	01/11/2016						
Coseley Medical Centre	06/10/2016	29/12/2016						
Dudley P'ships for Health – **follow up**	12/10/2016	12/01/2017						
Thorns Road Surgery – **follow up**	21/10/2016	14/12/2016						
The Limes Medical Centre – **follow up**	27/10/2016	16/12/2016						
The Greens Health Centre	10/11/2016	09/01/2017						
Summerhill Surgery – **follow up**	17/11/2016	16/12/2016						
Quincy Rise Surgery – **follow up (2)**	23/11/2016	26/01/2017						
Pedmore Medical Practice – **follow up**	30/11/2016	23/02/2017						
Quarry Bank Medical Practice	06/12/2016	09/01/2017						
Woodsetton Medical Practice - **follow up**	19/12/2016	18/01/2017						
Lower Gornal Medical Practice - **follow up**	21/12/2016	18/01/2017						
Wordsley Green Health Centre	10/01/2017	08/02/2017						
Kingswinford Medical Practice	12/01/2017	07/02/2017						
Three Villages Surgery	18/01/2017	21/04/2017						
Halesowen Medical Practice	20/01/2017	20/03/2017						
Stourside Medical Practice – **follow up**	01/02/2017	18/05/2017						
Northway Medical Centre	09/03/2017	11/05/2017						
Feldon Lane Surgery – **follow up**	16/03/2017	21/04/2017						
Clement Road Surgery – **follow up**	12/04/2017	22/05/2017						

Key:

	Good		Inadequate		Requires Improvement	✪	Outstanding

NHS
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DUDLEY CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE

Date of Report: 16 June 2017
Report: Finance Report
Agenda item No: 8.1

TITLE OF REPORT:	Primary Care Commissioning Finance Report
PURPOSE OF REPORT:	The report provides an overview of financial performance against budgets delegated to Committee.
AUTHOR OF REPORT:	Mr P Cowley, Senior Finance Manager
MANAGEMENT LEAD:	Mr M Hartland, Chief Operating and Finance Officer
CLINICAL LEAD:	Dr T Horsburgh, Clinical Lead
KEY POINTS:	• Baseline budgets reported to Committee in May have been loaded onto the ledger • At this early point in the year a break-even position is forecast against all budgets.
RECOMMENDATION:	Committee is requested to note the reported financial position for assurance.
FINANCIAL IMPLICATIONS:	As above.
WHAT ENGAGEMENT HAS TAKEN PLACE:	None
ACTION REQUIRED:	Decision Approval **Assurance** √

Finance Report (May 2017)

This report submitted to Dudley CCG Primary Care Commissioning Committee provides a provisional breakdown of financial performance for Co-commissioned Primary Care and other budgets within the remit of the committee during the month of May.

NHS
Dudley
Clinical Commissioning Group

Contents

Appendices

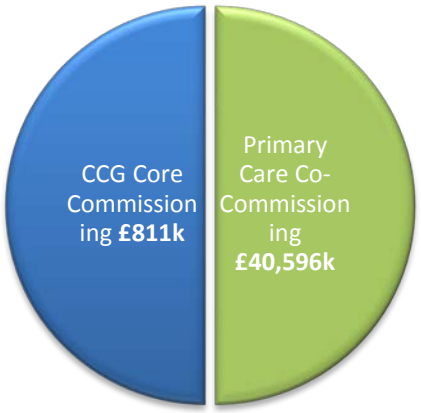
Financial Overview

Budget Allocations

Budgets reported to the committee have an annual value at May 2017 of £41,407,000, including both the delegated co-commissioning allocation and core CCG budgets.

There have been no allocation changes since baseline budgets were reported .

Allocation Breakdown



Performance against Budget

At this early stage in the financial year there is insufficient data to indicate variance in forecast expenditure from the Baseline Budgets report presented to Committee in May. As such, a break-even position is reported against all service lines.

Co-commissioned Primary Care

Area	Budget (WTE)	Annual Budget (£'000)	Forecast Variance (£'000)
GP Contract		27,333	-
QOF and Enhanced Services		6,360	-
Premises Costs		4,431	-
Dispensing/Prescribing Drs		273	-
Other GP Services		1,827	-
Reserves		372	-
Total	**-**	**40,596**	**-**

CCG Core Commissioning

Area	Budget (WTE)	Annual Budget (£'000)	Forecast Variance (£'000)
Primary Care Training		71	-
Nurse Mentors and EVTS	0.84	174	-
Practice Engagement LIS		566	-
Primary Care Investments		-	-
Total	**0.84**	**811**	**-**

Thinking Differently

NHS
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PRIMARY CARE COMMISSIONING COMMITTEE

Date of Committee: 16 June 2017
Report: Dementia Local Improvement Scheme
Agenda Item: 9.0

TITLE OF REPORT:	Dementia Local Improvement Scheme (Enabling Primary Care Diagnosis and Holism)
PURPOSE OF REPORT:	To inform the Committee of a Local Improvement Scheme to improve dementia diagnosis in primary care.
AUTHOR OF REPORT:	Mr A Hindle - Commissioning Manager for Integration
MANAGEMENT LEAD:	Mr N Bucktin – Director of Commissioning
CLINICAL LEAD:	Dr R Bramble – Clinical Lead for Older People
KEY POINTS:	• Dudley practices have an unusually low rate of dementia diagnosis and this is one of the measures that the CCG is rated on • A dementia Local Improvement Scheme (LIS) ran from January 11th March 31st 2017. This was successful in that the diagnosis rate increased from 57.8% to 60.54% • This paper proposes to repeat the LIS to continue to assist with increasing dementia diagnosis rates and achieving the CCG target of 67% the national England benchmark (current Dudley CCG rate is 61.3%) • The LIS also aims to improve dementia awareness and confidence in diagnosing in primary care • DCCG executives were requested by NHSE West Midlands to attend an escalation confirm and challenge session on June 1st. Actions to improve the diagnosis rate were agreed and monthly reporting to NHSE will continue to ensure the 67% target is achieved
RECOMMENDATION:	That the proposals for the Dementia LIS (outlined in appendix 1-6) be approved.
FINANCIAL IMPLICATIONS:	• Cost of scheme at same diagnosis rate achieved as in 16/17 scheme - £77,500
WHAT ENGAGEMENT HAS TAKEN PLACE:	• There was initial engagement to all practices via a GP Education event on Dementia and via the Members News. • The LIS has been discussed and supported by Dudley Clinical Executive
ACTION REQUIRED:	Approval

1. PURPOSE OF THE REPORT

To inform the Committee of a Local Improvement Scheme to improve dementia diagnosis in primary care.

2. BACKGROUND

2.1 Although there has been a concerted focus on dementia diagnosis and support services over the last few years Dudley practices has a low rate of dementia diagnosis and this is one of the measures that the CCG is rated on.

2.2 The suggested prevalence for Dudley in December 2016 was 4,110 and the number of people diagnosed was 2,376. That means that nearly two thousand patients in Dudley have an undiagnosed Long Term Condition that could benefit from pharmacological and non-pharmacological management. Also earlier diagnosis of dementia is now widely accepted as being in the long term interest and delivers better health outcomes for patients.

2.3 A Local Improvement Scheme to improve dementia diagnosis in primary care (see appendices) was funded via NHS England non-recurrent primary care programmes from January 11th to March 31st.

2.4 The purpose was to:-

- assist with increasing dementia diagnosis rates and achieving the CCG target of 67% the national England benchmark as the Dudley CCG rate was 57.8 %
- to improve dementia awareness and confidence in diagnosing in primary care
- to reduce waiting times for people who do not need a comprehensive assessment

2.5 Practices were encouraged to screen for dementia and make a diagnosis within Primary Care (£150 for each diagnosis). Practices that do not wish to diagnose dementia in-house could still benefit by referring to other practices that do.

2.6 The LIS was launched via a GP dementia education programme on January 11th 2017. This included a presentation from a leading Older Adult Psychiatrist who informed on how GPs can safely diagnose, treat and refer most patients with dementia.

3. INFORMATION

3.1 The Dudley CCG dementia diagnosis rates increased from 57.8% in December 2016 to 60.54% by the end of March 2017 (2,376-2,488). This increase of 112 does not reflect the total number of people diagnosed as each month there are a proportion of people on the dementia register that are removed due to a death.

3.2 The number of practices that participated was 28. Claims are still being submitted but 14 practices diagnosed 132 people.

3.3 As the target was not achieved the CCG received a letter from the Director of Commissioning Operations NHS England (West Midlands) requesting the CEO, Chair and GP lead for Dementia to attend an escalation confirm and challenge session.

3.4 The above meeting took place on June 1st (attended by the DCCG Chair, Director of Commissioning on behalf of the CEO and the GP lead for dementia) and resulted in a number of agreed actions including reinstating the Dementia LIS and a programme of training events aimed at ensuring clinicians feel confident to diagnose dementia in Primary Care.

3.5 The recommendations were discussed at clinical executive on June 5th and the continuation of the Dementia LIS was supported.

3.6 The CCG will be reporting back every month to NHSE and the West Midland Network Clinical Director for Dementia on the progress to reach the national benchmark target.

4 FINANCIAL IMPLICATIONS

4.1 As a payment-per item scheme, the maximum potential commitment against this scheme is the cost of diagnosing every undiagnosed patient in Dudley, which at £150 for 1,600 undiagnosed patients would represent a cost of £251,410. This is however an extremely unlikely scenario. In order to hit the CCG's target to diagnose 67% of patients being diagnosed, the number of diagnosed patients would need to increase by 266, the cost of which would be £41,230.

4.2 The table below shows the potential cost of the scheme, and achieved diagnosis rates, for a range of levels of additional diagnoses achieved during the life of the scheme. The cost of £155 per diagnosis assumes that 10% of patients would be diagnosed following referral to another practice.

Base Diagnoses	Additional Diagnoses	Number of Diagnoses	Diagnosis Rate	Cost at £155 per diangosis
2488	0	2488	60.5%	£0
2488	266	2754	67.0%	£41,230
2488	500	2988	72.7%	£77,500
2488	750	3238	78.8%	£116,250
2488	1000	3488	84.9%	£155,000
2488	1250	3738	90.9%	£193,750
2488	1500	3988	97.0%	£232,500
2488	1622	4110	100.0%	£251,410

4.3 During the scheme which ran from January to March 132 people were diagnosed, and if practices diagnosed patients at the same rate throughout the period to the end of March 500 people would be diagnosed at a cost to the CCG under the scheme of £77,500.

4.4 Should Committee wish to pursue this scheme, it would be funded from the 1% Non-recurrent reserve that the CCG holds for Primary Care, of which £326,000 currently remains uncommitted.

5. RECOMMENDATION

That the proposals for the Dementia LIS (outlined in appendix 1-6) be approved.

Appendix 1

Dudley CCG Primary Care

Enabling Primary Care Diagnosis and Holism

2017

Sign Up Sheet

This document constitutes an agreement between the NHS Dudley Clinical Commissioning Group (**the commissioner**) and a GMS or APMS contractor (**the contractor**) in respect of participating in the CCG Primary Care Dementia Identification Scheme

The details and requirements of the scheme are set out in Appendix 1.

Description	Practice Opt In
Participate in collaborative working by the implementation of EMIS remote consultation	**Yes/No**

By entering into this agreement the contractor enters into an arrangement to deliver the requirements of specification that they are opting into provide, as set out in Appendix 1 for the period

Duration of agreement: TBC

The commissioner reserves the right to terminate this agreement should the contractors GMS contract be terminated or be subject to such conditions that in the reasonable opinion of the commissioner warrant early termination.

Signed on behalf of **the commissioner**: Date:

…… ……

Signed on behalf of **the contractor**: Date:

…… ……

Please note for GMS practices, one partner may sign, for APMS contractors, all signatories to the APMS agreement must sign.

Practice stamp:

Please return this page signed to: primarycare@dudleyccg.nhs.uk and cc andrew.hindle@dudleyccg.nhs.uk

Appendix 2: Scheme details

1. Introduction

1.1 This enhanced service is designed to reward GP practices for undertaking a proactive approach to identify patients with dementia and refer on to services for additional support.

1.2 Dementia is a very prevalent and very serious long-term condition: "Dementia and Alzheimer disease has replaced ischaemic heart diseases as the leading cause of death in England and Wales, accounting for 11.6% of all deaths registered in 2015" (Office for National Statistics) (see appendix 2 for dementia narrative)

1.3 The signs and symptoms of dementia are relatively straight-forward and are amenable to targeted screening: memory loss, affecting activities of daily living in the absence of a reversible cause.

1.4 NHS England estimates that approximately 4400 patients in Dudley suffer from dementia – however, to date GPs in Dudley have only diagnosed around 2600 patients. That means that around 1800 patients in Dudley are suffering from an undiagnosed long-term condition and are not yet benefitting from the non-pharmacological and pharmacological treatments available.

1.5 Local research shows that carers' main area of frustration is delayed diagnosis: once diagnosed they are more able to access services and typically regret that loved ones were not diagnosed sooner.

1.6 Pharmacological treatment works, especially if we act quickly: "…pooled meta-analysis of ten trials showed that donepezil led to a significant improvement in global function compared with placebo in both mild and moderate AD. This analysis also showed a greater benefit from donepezil treatment may be observed in mild rather than moderate disease and that earlier treatment may be associated with greater preservation of function." (NICE Aricept Technology Appraisal)

1.7 Pharmacological treatment saves money, especially if we act quickly: "…total cost savings (£3,300 [mild AD] vs £1,900 [moderate AD]) estimated for donepezil are greater in the mild patient group as compared to the moderate patient group *(ibid).*

1.8 Non-pharmacological therapies for all patients with dementia are widely available in Dudley and are often undersubscribed. These include:

- Dementia Gateways (day centres for patients and carers),
- Dementia Advisors (personal navigators who assist patients and carers to access services optimally)
- Respite care via DMBC
- Carer education and support via Alzheimers UK
- Social prescribing via Age UK
- Domiciliary care
- Macmillan

1.9 Lasting Power of Attorney can usually be established quickly, cheaply and easily soon after diagnosis of dementia when a patient may still have capacity to assign LPA. If LPA is not established prior to a

1.10 patient losing capacity families are often exposed to the very high cost and distress of needing to establish 'deputy' status via the Court of Protection to manage a patients financial and care needs.

For all of the above reasons Dudley CCG wishes to enable GP's in Dudley to:-

- screen for, detect and diagnose dementia as early as possible,
- initiate donepezil where appropriate,
- refer patients to dementia advisors who will offer access to social and care services.

2 Aims

2.1 Improve dementia detection amongst registered patients and improve recording of dementia

2.2 Ensure that all patients diagnosed with dementia have their primary care patient record updated.

3 Specification

To take part in this Dementia Diagnosis Service practices must:

3.1 Nominate a GP as Dementia Lead

3.2 The GP Dementia Lead must attend a GP Education Event on Dementia Diagnosis (or provide evidence of equivalent training in the diagnosis of dementia).

3.3 Run an EMIS search of "patients at risk of dementia" (see appendix 4) that have not previously had a memory assessment. This will include, for example, patients over 60 with cardiovascular risk, patients over 40 with Learning Disability, etc.

3.4 Attempt to contact these patients to determine if they have any concerns about their memory. This would usually be done once only, by a non-clinician, by telephone.

3.5 Patients that have concerns about their memory should be offered appropriate further assessment by a clinician.

a. 6-CIT memory test
b. If memory is impaired, an assessment of the effect on Activities of Daily Living
c. If dementia is suspected, blood tests (within 6 months) to rule out common reversible causes (FBC, B12, folate, TSH, U&E, LFT, Ca, Glucose or HbA1c)
d. If dementia is suspected a PHQ9 should also be performed to rule out significant depression.

3.6 All patients with an abnormal 6-CIT score should be reviewed by a GP trained in dementia diagnosis (which includes attendance at a GP Education Event).

3.7 In patients aged 75 and older:

a. If memory is impaired and it is impacting ADL's and there is no reversible cause the practice must code dementia.
b. If dementia is mild or moderate a CT brain scan should be ordered to rule out significant vascular dementia.
c. Patients with advanced dementia should not routinely be offered brain imaging: the practical difficulties of investigation (inconvenience, distress, movement artefact, risks from sedation) outweigh the benefit of differentiating vascular dementia from Alzheimer Disease bearing in mind that there is no pharmacological treatment for advanced AD.
d. Patients with probable Alzheimer Disease (mild or moderate) should be started on donepezil as per BNF guidance. Advice may be sought from practice based pharmacists, consultant geriatricians or psychogeriatricians if needed. Advice requests should be used rather than referral.

3.8 In patients aged 74 and younger:

a. If memory is severely impaired and has been worsening progressively for a long period of time and this is having a large impact on ADL's and there is no reversible cause, then you may feel confident to diagnose and code dementia.
b. Mild and moderate memory impairment, rapidly progressive impairment, significant changes in personality and behaviour or any uncertainty about diagnosis should be referred to the Memory Assessment Service.

3.9 All patients diagnosed with dementia by the practice should be offered an information pack about dementia and dementia services in Dudley. The CCG will provide these resources.

3.10 All patients diagnosed with dementia by the practice should be offered a referral to a Dudley MBC Dementia Advisor (or equivalent in neighbouring authorities).

3.11 The practice will use the EMIS searches, resources and template provided by the CCG to support the above actions.

3.12 Practices will be paid £150 for each patient successfully diagnosed and coded with dementia.

3.13 Practices that prefer not to diagnose dementia themselves are encouraged to partner with practices that offer this service using EMIS Remote Consultation. Practices that refer patients aged 75 and over to another Dudley GP, who are subsequently diagnosed with dementia, will be paid £50 (as well as the diagnosing practice being paid £150). (Patients aged 74 and younger should continue to be referred to the Memory Assessment Service.)

3.14 The CCG reserves the right to audit the use of searches and templates and to visit practices to check that assessment protocols are being followed and are well documented.

4 Monitoring

4.1 All participating practices will be able to demonstrate achievement as per the monitoring requirements set out in the LIS document in **Appendix 5**.

5. Payment

Component One: Participate in collaborative working by the implementation of EMIS remote consultation

The practice will be paid **£150** for completing all tasks outlined within this component.

Practices that prefer not to diagnose dementia themselves are encouraged to partner with practices that offer this service using EMIS Remote Consultation. Practices that refer patients aged 75 and over to another Dudley GP, who are subsequently diagnosed with dementia, will be paid £50 (as well as the diagnosing practice being paid £150).

The CCG reserves the right to retrieve payments for non-achievement and under achievement of the requirements defined within the scheme.

Name: _____ Signature: _____

Date: _____

Appendix 3

Diagnosing dementia: any appropriately skilled clinician can make the diagnosis and brain scanning not always needed

Dementia is a clinical syndrome and at one level simply implies brain failure (analogous to heart failure or liver failure). The diagnosis is a two stage process. First, to make a diagnosis of dementia you need to differentiate it from: depression; delirium; the effect of drugs and; the changes in memory expected as part of normal ageing. Two key features for a diagnosis of dementia are that the patient's symptoms should affect daily living activities and be progressive. Second is to determine the cause of condition – the commoner causes are Alzheimer's disease, vascular dementia and Lewy body dementia.

Both stages are based on a comprehensive assessment including a history, including one from someone who knows the patient well, a physical and mental state examination, including a specific assessment of cognitive function and selected ancillary investigations (Dementia: NICE Clinical Guideline 42, www.NICE.org).

Any clinician who has the appropriate skills can recognise and make a diagnosis of dementia, once it is established. Specialist advice may be needed in the very early stages and in particular clinical situations such as when the presentation or course is atypical, where significant risks are identified and in groups such as people with learning disabilities.

Specialist advice may also be needed to establish the exact cause of the dementia. This may have clinical implications for the prescription of medication such as drugs for Alzheimer's disease, treatment of vascular risk factors in vascular dementia or avoidance of antipsychotics in Lewy body dementia.

In terms of brain scanning, the NICE Dementia Guideline states "Imaging may not always be needed in those presenting with moderate to severe dementia, if the diagnosis is already clear." This may particularly apply to older and frailer patients with established dementia.

Post diagnostic support which should be person centred goes hand in hand with the diagnosis (which does not necessarily have to result in the prescription of medication) and is largely independent of the cause of the dementia.

Alistair Burns, National Clinical Director for dementia, NHS England, October

2014

Appendix 4

EMIS search for patients at risk of dementia

1. Go to Population Reporting
2. Select NHS Dudley CCG Enterprise Search and Reports
3. Select Dudley CCG – Live
4. Select Data Quality Searches
5. Select Dementia
6. The search is named “At risk of dementia and not received a memory assessment”

Appendix 5

Monitoring

1. Name of GP lead for dementia in the practice =

2. Confirmation of attending a GP education event on dementia or representative =

3. Confirmation of running the EMIS search in appendix 3 =

4. Submit all patients diagnosed each month using EMIS numbers (as these are not patient identifiable) to primarycare@dudleyccg.nhs.uk

5. Confirmation that all patients diagnosed have been provided with an information pack (see appendix 5)

Appendix 6

Dementia Information Leaflet for Newly Diagnosed Patients

What is dementia?

Dementia is a physical illness that causes problems with memory, thinking, speaking and daily living. Physical changes in the structure of the brain cause dementia. These changes can be seen on brain scans, which can help in diagnosing dementia. You are not mentally ill, and you are not going mad.

Several different conditions can cause dementia such as Alzheimer's disease or poor blood flow in the brain. Tests may be needed to find out the cause of dementia. Different causes have different treatments.

How will dementia affect you?

The various forms of dementia affect people differently, and your experience of dementia will be unique to you. Your physical make up, your emotional resilience and the support you have will all have an effect. You are also likely to feel different at different times. Don't worry if sometimes it all seems to be overwhelming. The bad times do pass.

Shock, disbelief, denial

Shock, leading to disbelief or denial is a very common reaction. Sometimes denial can be a good thing, and can help you cope with the reality of your disease at your own pace.

How to cope with the feelings

Talking with other people can help. You may find that you only want to talk to your husband or wife, or close family. Or it may be difficult talking to those closest to you. Think about joining a support group.

Many people with dementia find it helpful to talk to other people in the same situation.

Stay active: exercise will make you feel better. Carry on seeing your friends and doing the things you enjoy doing.

Sometimes writing down your feelings can help. It can help to have a record of the bad times as well as the good. The bad times will pass.

What happens next?

You will be referred to one of our specialist dementia nurses or older adult psychiatrist for further assessment and to determine the type of dementia and whether anti-dementia medication is suitable.

What support can I access?

Dudley has two" **Dementia Gateways"** which provide

- Access to **Dementia Advisors** for support for the person affected by dementia and their families
- Carers' assessment and carer support programmes,
- assessment of social needs,
- telecare (such as necklace alarms to call for urgent help when needed),
- day care
- referral to Alzheimer's Society

Dudley Dementia Gateways

Brett Young Centre (South) 01384 813600

Crystal Centre (Central) 01384 813315

… you can also contact the Dudley Dementia Advisors directly on 01384 816039

Dudley Alzheimer's Society: 0121 521 3020 **Email:** blackcountryoffice@alzheimers.org.uk **http://www.alzheimers.org.uk**

Living with dementia booklet: **http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=728**

Admiral Nurses: www.britishlegion.org.uk.

Dudley Carers Support: 01384 818723.

http://www.dudley.gov.uk/resident/care-health/dudley-social-services/do-you-need-support-now/social-care-services/carers/

Dudley MBC Adult Social Care Telephone: 0300 555 0055

Community information directory: **http://www.dudley.gov.uk/community/initiatives/dudley-community-information-directory/**

Association of Dementia: **http://www.worcester.ac.uk/discover/association-for-dementia-studies.html**

When to see the GP?

As with anyone else, a person with dementia should see their GP when they feel unwell or have concerns about their health. They should also see their GP if they suddenly become more confused or agitated, or if there are any worrying changes in their behaviour, as this could be a sign that they are ill. Many physical conditions, including chest and urinary tract infections, infected leg ulcers, and constipation, can cause additional confusion and distress. These conditions usually respond to treatment.

The person should also see the GP if they feel unhappy, anxious or restless, if there have been marked changes in their sleeping or eating patterns, or if they become very withdrawn. Any of these can be a sign of depression, which is common during the early stages of dementia

Conclusion

There are ways of living with dementia. It can be painful to think about it, and it isn't always easy to ask for help. It needs courage, and the way can be hard, but there are people who will be with you on your journey.

Thinking Differently

NHS Dudley Clinical Commissioning Group

DUDLEY CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE

Date of Report: 16 June 2017
Report: Primary Care Commissioning Committee Annual Report
Agenda item: 10.0

TITLE OF REPORT:	**Primary Care Commissioning Committee Annual Report**
PURPOSE OF REPORT:	To present the Draft Annual Report 2016/17 for the approval of the Committee To provide assurance that the Committee has discharged its responsibilities and met its Terms of Reference
AUTHOR OF REPORT:	Mrs J Taylor, Primary Care Commissioning Manager
MANAGEMENT LEAD:	Mrs C Brunt, Chief Nurse
CLINICAL LEAD:	Dr T Horsburgh, Clinical Executive for Primary Care
KEY POINTS:	The report summarises the Committee's work during the year and confirms that: • The Committee has fulfilled its statutory functions in relation to its delegated functions from NHS England relating to the commissioning of primary medical services • The Committee has fulfilled its delegated functions in accordance with scheme of delegation as set out in the CCG constitution • The Committee has made significant progress in developing and improving the quality of primary medical services in Dudley – as set out in the report • The Committee has provided a fully assured plan to NHSE in response to the GP Forward View
RECOMMENDATION:	• The Committee is asked to confirm that it is assured that the Committee has discharged its responsibilities. • The Committee is asked to approve this Annual Report.
FINANCIAL IMPLICATIONS:	• The Committee has achieved its financial targets, remaining within the resource limit delegated to it by the CCG Board.
WHAT ENGAGEMENT HAS TAKEN PLACE:	• All members of the Membership Development and Primary Care team • Sue Johnson, Deputy Chief Finance Officer
ACTION REQUIRED:	**Decision** ✓ **Approval** ✓ **Assurance** ✓

DUDLEY CLINCAL COMMISSIONING GROUP

PRIMARY CARE COMMISSIONING COMMITTEE – 16 June 2017
ANNUAL REPORT

1.0 BACKGROUND

1.1 Dudley CCG has been fully delegated to commission primary medical services from 1st April 2015. In line with statutory guidance, the CCG established a Primary Care Commissioning Committee (the Committee) as a corporate decision making body to make collective decisions on the review, planning and procurement of primary medical services in the Dudley borough.

1.2 The Committee was established in accordance with paragraph 6.9.3(h) of NHS Dudley Clinical Commissioning Group's (CCG) constitution. The terms of reference in appendix 1 set out the membership, remit, responsibilities and reporting arrangements of the Committee.

1.3 The Committee was established to fulfill the functions that NHS England has delegated to the CCG to exercise its statutory duties in the commissioning of primary care.

1.4 The Committee meets in public on a monthly basis, and all papers are published on the CCG web-site in advance of the meetings. Over the last year the Committee has held meetings in those areas affected by changes to the local GP services to ensure that the decisions are debated locally, and that the Committee has been able to make decisions informed by patient opinion.

2.0 PURPOSE

2.1 The Committee will recall that its stated purpose and application to NHS England to take on full delegated authority for the commissioning of primary medical services was predicated on three areas set out in the table below.

2.2 **Table: Application to NHS England to take on delegated functions for commissioning primary medical services**

Area	Outcome	Comment
To effectively review and pilot new ways of commissioning outside of the core requirements of GMS – setting one set of outcome measures that will apply to all those services commissioned and working as part of an integrated population based health and wellbeing service with primary care at the heart of the model.	Achieved	New contractual framework (Dudley Quality Outcomes for Health) developed and offered to practices in 2016/17 to replace QOF, DES and LISs.
To commission for shared outcomes across the whole system of integrated care to ensure that all the organisations working in Dudley are working to the same outcome objectives for our population.	Achieved	Outcome measures within Dudley Quality Outcomes for Health being used as part in the MCP contract service specifications for the

		management of LTC
To lead and manage the process for review and revising all GP contracted activity outside of GMS (so including QOF, enhanced services and PMS resource allocations), and retain any surplus within Dudley to reinvest within Dudley to improve the quality of primary care services and support the delivery of our service integration model.	Achieved	PMS premium fully re-invested in General Practice through the new Dudley Quality Outcomes for Health contract.

2.3 **Table: Functions delegated to the Primary Care Commissioning Committee as set out within the CCG Constitution**

Policy Area	Decision	Status	Comments
COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	1. Determination of arrangements for the review, planning and procurement of primary care medical services (under delegated authority from NHS England). To include • GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action, such as issuing breach/remedial notices, and removing a contract); • Newly designed enhanced services ("Local Enhanced Services (LES)" and "Directed Enhanced Services (DES)"); • Design of local incentive schemes as an alternative to the Quality and Outcomes Framework (QOF); • The ability to establish new GP practices in an area; • Approving practice	Achieved	• All DESs and LISs reviewed and relevant schemes have been incorporated into 'Dudley Quality for Outcomes Health' contract. • Full range of contractual issues (mergers, branch surgery closure applications) considered in full compliance with statutory duties and in accordance with the relevant policies and procedures of NHS England. • GMS contractual review process developed and implemented in full compliance with statutory duties and in accordance with the relevant policies and procedures of NHS England. • Extended weekend access during winter scheme developed and commissioned to increase primary care capacity during winter pressures which includes routine GP appointments. • Primary Care Development programme commissioned and positively evaluated in 2016-17. • Excluded patients scheme and out of area

Policy Area	Decision	Status	Comments
	mergers; and • Making decisions on 'discretionary' payments (e.g., returner/retainer schemes).		registrations (in hours urgent medical care) commissioned

3.0 GOVERNANCE

3.1 The Primary Care Commissioning meetings continue to be held in public session during 2016/17.

3.2 The membership of the Committee has continued to be constituted to make sure that the majority is lay and executive members. No GP members are members of the Committee. The clinical input into the Committee is obtained through a secondary care clinician, the secretary of the LMC (who has no voting rights) and a local GP who represents GP members (the GP has no voting rights and is not a member of the CCG Board).

3.3 The commissioning and governance arrangements for Primary Care have been audited internally during our 2nd year of delegation, which received positive feedback and did not highlight any areas which would impact on the achievement of the systems key objectives.

3.7 The statutory guidance reinforces the obligation to comply with section 14O of the National Health Service Act 2006 which sets out the minimum requirements in terms of what CCGs must do in terms of managing conflicts of interest as set out in the table below

3.8 Table: Summary of minimum statutory requirements for managing conflict of interests

Area	Status	Notes
Maintain appropriate registers of interest	Compliant	• The CCG maintains a Register of Interests which is published on the CCG website/made available for public access. • The CCG maintains a Register of Procurement Decisions detailing the decision made, who was involved in making the decision, a summary of any conflicts of interest in relation to the decision and how this was managed by the CCG.
Publish and make arrangements for the	Compliant	• As above

public to access those registers		
Make arrangements requiring the prompt declaration of interests by members and employees and ensure that these interests are entered into the relevant register	Compliant	• The CCG has produced its conflict of interest's policy which details the processes to follow to manage conflicts of interest. • The policy is publically available on the CCG website. • The CCG has arrangements in place for continuing to manage any conflicts of interest post-decisions being made i.e. contract management processes. • CCG members and officers have received appropriate training on conflicts of interest. • All declarations of interest are noted at every meeting and documented in the public papers.
Have regard to guidance published by NHS England and Monitor on conflicts of interest	Compliant	• As above – all policies and processes are reviewed annually and are updated when required • The CCG produces a quarterly self-assessment and assurance statement for NHS England with the approval of the Committee

4.0 COMMISSIONING

Improving outcomes for patients of Dudley

4.1 As part of our vision for transforming primary care, Dudley CCG has developed a new contractual framework for primary medical services – 'Dudley Quality Outcomes for Health' (DQOFH). The outcomes in this framework form the foundations of our new model of care which will be commissioned from the Multi-speciality Community Provider (MCP).

4.2 The DQOFH framework is designed to develop a local evidence based outcomes contract. This will drive up standards, address unwarranted variation, fit around patients and be focussed on outcomes that make a difference to their lives. Patients will be supported to manage their own condition to set personalised goals of what they would like to achieve for their health.

4.3 The commissioning and introduction of the DQOFH framework is being evaluated on behalf of the CCG by ICF (an independent research company), the Health Services Management Centre, Birmingham University and the Strategy Unit of the Midlands and Lancashire Commissioning Support Unit.

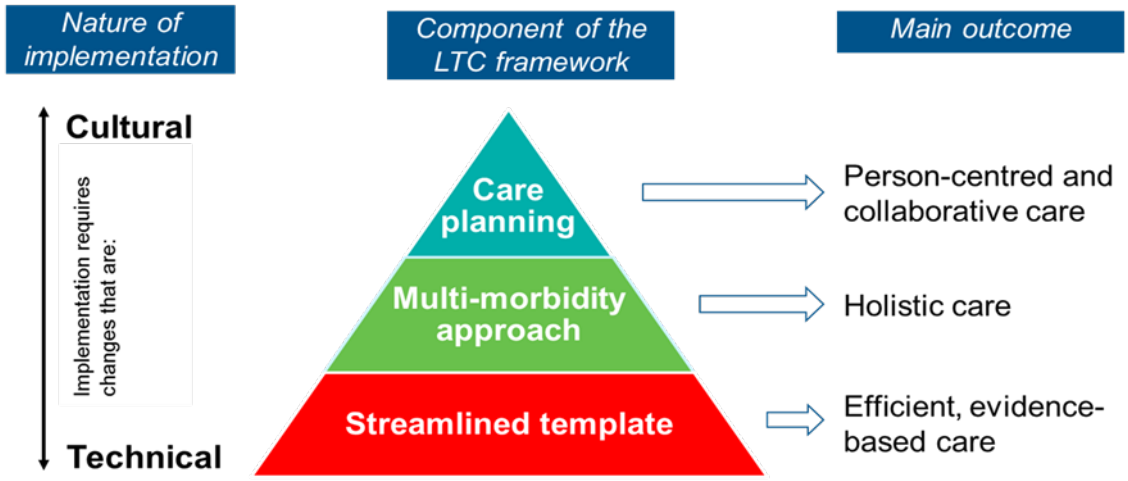
4.4 The focus on goal setting and holistic management of patients requires a significant change in the way that our practices, and our patients, engage with

this new way of working. While implementation of the framework is still at a relatively early stage, we have already identified some important early impacts. These include:

- upskilling of practice staff
- a stronger focus on care planning and supporting self-management
- a move towards a more holistic model of care
- open up the opportunity for primary and secondary care clinicians to deliver care to the population working together

4.5 The DQOFH framework has three distinct, but interlinked, components

- A new template of incentivised and evidence-based indicators, intended to simplify and rationalise previous reporting arrangements.
- A multi-morbidity approach to long term conditions (LTC) care, with practices integrating routine appointments into a single review addressing all their health needs
- The mainstreaming of collaborative care planning, with professionals taking on a more facilitative role which is focused on supporting self-management.



Improving access for patients of Dudley

4.6 As part of our plan to provide additional primary care capacity during our winter months when demand is higher due to seasonal illnesses, we commissioned an extended weekend access scheme which ran from 1st November 2016 to 31st March 2017.

4.7 13 of our practices opted to provide weekend access to their own patients (population coverage of 96718, 31% of total population) with a further 10 practices opted to provide weekend access to their own and other practices patients. This was facilitated by our practices agreeing to work collaboratively (using remote consultation) by securely sharing access to the medical record

(following patient consent,) to another practice so that the consultation can be made.

4.8 Through this scheme we were able to offer an additional 135 hrs of clinical consultation and an additional 476 appointments time per week, and proved popular with the public with a 92% uptake for Saturday appointments and 87% on a Sunday.

4.9 During 2017/18 we will continue to work with our public to fully understand their needs in terms of access to primary medical services, so that we commission sufficient access to meet the needs of our local population.

5.0 THE GENERAL PRACTICE FORWARD VIEW

5.1 In 2016, NHS England published the General Practice Forward View (GPFV). It sets out a National 5 year plan to make changes and improvements across general practice and primary care so that it delivers care in the right way for the people who need it.

5.2 Working with our patients and our practices we have produced a plan that described how we will implement the GPFW in Dudley, which includes:

- Increasing our levels of investment in primary care to drive innovation and improvement to support our model of care with primary care at its heart;
- Expanding roles in primary care to support an improved experience of care for our patients, which increases accessibility and offers continuity and coordination;
- Investing in multidisciplinary learning and development to develop skills, knowledge and confidence in collaborative working and service improvement;
- Using technology as an enabler to reduce workload within practices;
- Developing innovative solutions to help manage demand within Dudley;
- Developing new relationships with our local communities to help build community resilience and promote healthy behaviours;
- Designing and delivering an MCP for Dudley which better meets the needs of and improves the health outcomes for our local communities;
- Investing in the infrastructure to support the central role of general practice in the MCP model of care;
- Investing in technological solutions to empower patients and staff;

- Commissioning and enabling practices to use the 10 High Impact Actions' to release capacity. The 10 high impact actions are described in more detail here **(https://www.england.nhs.uk/gp/gpfv/redesign/gpdp/** and in Dudley our GPFW plan describes how we are making improvement in each of these areas to support service improvements across all practices and implement new ways of working.

6.0 CONTRACTING

6.1 Under fully delegated co-commissioning arrangements the CCG has to discharge its responsibility of seeking and confirming contractual compliance of all primary medical contracts that fall under its governance. In order to fulfil this responsibility we have developed a contract review process based on high trust, fairness and equitability. We involved the Local Medical Committee and Dudley Practice Managers Association in its development.

6.2 All Dudley practices have now had a contract compliance review. We will be evaluating the findings and developing a new framework for next year. In addition to providing assurance that Primary Medical Services are being delivered in accordance with the General Medical Services Contract, practices tell us that they have found the process useful to support preparation for Care Quality Commission visits, and that they have also benefited from sharing good practice.

6.3 The Primary Care Commissioning Committee has considered a wide range of contracting issues. Committee has approved 32 contract variations in full compliance with statutory duties and in accordance with the relevant policies and procedures of NHS England. During the year Committee had to consider a significant contractual issue following the sudden closure of a branch surgery as a result of repossession by a landlord. Throughout the period of closure we sought to facilitate a resolution, taking legal advice and consulting with NHS England at each stage. All actions and decisions were discussed in public. Patients were invited to a listening event held locally in conjunction with Healthwatch Dudley so that concerns about the quality of medical services could be heard. We commissioned an independent consultant to review of the actions taken and to provide us with lessons learned.

7.0 QUALITY

7.1 By the end of 2016/17, all practices in Dudley had been visited by the Care Quality Commission (CQC).

This has resulted in:

- 36 practices being rated as good overall
- 8 rated as requires improvement; this includes 1 practice who have also been re-inspected but the report has not yet been published
- 1 practice rated as outstanding
- 1 practice as yet unrated as the report has yet to be published

This represents just over 80% of practice being rated as good or outstanding at the end of the year.

7.2 During the year we had four practices that were rated as inadequate following their first inspection. The CCG provided support and advice to each of these practices in order to help them address the issues identified, included a number of funded sessions of dedicated practice manager, nurse and GP mentorship. Together with the hard work that all four practices put in to improving the systems and processes, this resulted in all four practices improving their ratings on re-inspection, including one practice which actually achieved a good rating.

7.3 In addition, we continue to identify specific training needs and provide relevant education wherever possible. This year we have funded a series of half-day bespoke courses providing training in managing conflict in the workplace *xxxxxxx* recognising the fact that front-line staff in primary care are often placed in difficult and sometimes potentially dangerous situations. These courses have been designed to equip staff with the tools and knowledge they need to help diffuse these situations whilst keeping themselves and their patients safe.

8.0 PRIMARY CARE DEVELOPMENT

Primary Care Development

8.1 Primary Care has been, and will remain, at the heart of the CCG's model of care and our vision for the future. In 2016/17, we made significant investments as part of our ongoing programme to further strengthen and improve primary care. A separate, but complementary, piece of work was also launched to ensure that Primary Care plays a leading role in developing and delivering the MCP.

Improving Primary Care

8.2 Our dedicated primary care development team includes GPs, nurses and practice managers who play a key role in delivering the training, development and mentorship which drives service improvement.

8.3 A development programme called EPIC (Enabling Practices to Improve and Change) has also helped to accelerate improvements across practices in quality, efficiency, communication between staff and with patients, engagement with patient groups and collaboration between practices.

8.4 As well as delivering a better experience for large numbers of patients, the EPIC initiative has also helped to free up more GP time to see patients, improved practice productivity and supported enhanced training and career development

for clinical and non-clinical staff.

Primary Care and the MCP

8.5 Since the CCG began its MCP project, a parallel piece of work has been preparing GPs to play their part in delivering it. This work has been managed, staffed, and resourced separately from the CCG's procurement process to avoid any conflicts of interest.

8.6 The MCP-related primary care development work is GP-led and driven by our GP Collaborative Steering Group who have focussed on:

- engaging with potential partners in the MCP
- developing the integration agreement which will set out in detail the relationship between practices and the MCP
- preparing the collective primary care response to the MCP procurement.

8.7 Originally activities undertaken by the GP Collaborative steering Group were aligned and reported to the Committee for governance and assurance processes. During 2016/17 there has been a need to demonstrate clear distinction between primary care and MCP development which has required in a change in the structure and reporting mechanisms within primary care. *See appendix 1*

9.0 PRIMARY CARE PERFORMANCE

9.1 The performance of Primary Care in Dudley is reported through the Primary Care Analysis Tool (PCAT) and the Committee has been assured over the course of 2016/17 regarding the high performance and quality of primary care in Dudley. In those cases where there are exceptions, these are reported, and the CCG has effective systems and processes in place to address performance issues through the activities of the membership engagement team.

10.0 PRIMARY CARE ENGAGEMENT

10.1 Through Committee primary care has continued the annual programme of GP Engagement visits that have informed the way in which services are commissioned by the CCG on behalf of member practices

10.2 Continued to meet with the GP membership on a monthly basis through our locality meetings, and bi-monthly with the wider membership events.

10.3 Engaged with practice managers and the Dudley Practice Management Alliance to discuss practice management development and the commissioning of primary care schemes.

11.0 FINANCE

11.1 As the table below shows, Committee has successfully achieved its financial targets, remaining within the resource limit delegated to it by the CCG Board. The position in respect of Primary Care Co-Commissioning is break-even, with a small underspend reported against recurrent core CCG budgets.

Area	Annual Budget (£'000)	Forecast Variance (£'000)
Primary Care Co-Commissioning	39,863	(1)
Primary Care Training	70	0
Nurse Mentors and EVTS	196	(10)
Practice Engagement LIS	591	(31)
Total	**40,719**	**(41)**

11.2 **Value for Money**

An assessment has been made of the cost of the operation and administration of the Committee throughout the year. This is based upon the attendance of Committee members. The cost is calculated based on the average hourly cost of each individual at an estimated 2 hours per Committee. The notional cost for 2016/17 is **£7,482** and based upon the outcomes achieved by the Committee as described above, this has been viewed as an effective use of public funds.

11.0 ATTENDANCE AND QUORACY

11.1 The Committee has met monthly in public between 1st April 2016 and 31st March 2016.

11.2 A register of attendance is set out in appendix 2.

12.0 DECISION REGISTER

12.1 In line with statutory guidance, the Committee as a corporate decision making body keeps a register of procurement decisions. The following key procurement decisions have been extended by the Committee between 1st April 2016 and 31st March 2017

- A 12 month contract for the provision of an 'out of area registrations' in hours urgent primary care (including home visits) enhanced service.

- A twelve month contract for the provision of excluded patients (violent and aggressive patients) service

- A seven month contract for the provision of extended weekend access during winter for primary medical services local improvement scheme (LIS)

13.0 RECOMMENDATION

13.1 The Committee is asked to confirm that it is assured that the Committee has discharged its responsibilities.

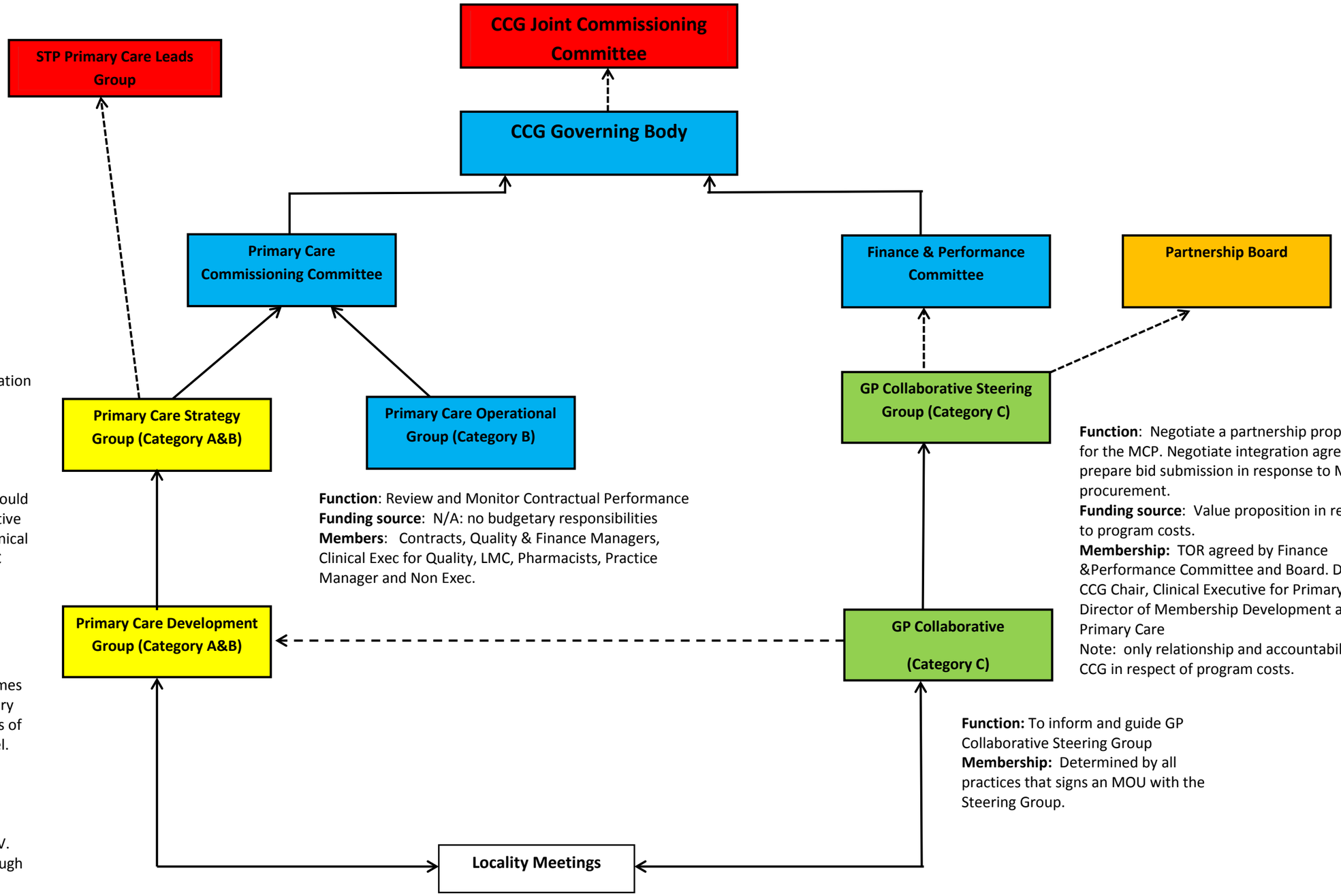
13.2 The Committee is asked to approve this Annual Report.

14.0 APPENDICES

- Appendix 1: Primary Care Governance Structure
- Appendix 2: Committee Attendance Register

Appendix 1
Category A – MCP procurement
Category B – CCG usual business
Category C – MCP development

Primary Care Commissioning & Development. Executive Lead: Caroline Brunt. Source of Funding: Delegated commissioning budget and GPFV.
Primary Care Development of MCP. Executive Lead: Daniel King. Source of Funding: Value Proposition for Program Costs.
Statutory Function – approval and assurance.
New care model implementation
STP alignment



Function: Share best practice across the STP footprint, explore opportunities for collaboration and delivery of schemes on an STP footprint where appropriate and standardise approaches across the STP in relation to delivery of GPFV.
Funding source: N/A
Members: Primary care leads across all 4 CCG's

Function: Assurance & co-ordination of the work of the development group and implementation and tracking of the GPFV.
Funding source: delegated commissioning and GPFV.
Members: TOR to be agreed should include Chief Nurse, Non-executive Director for Governance and Clinical Executive for Primary Care, LMC

Function: Review and Monitor Contractual Performance
Funding source: N/A: no budgetary responsibilities
Members: Contracts, Quality & Finance Managers, Clinical Exec for Quality, LMC, Pharmacists, Practice Manager and Non Exec.

Function: Negotiate a partnership proposition for the MCP. Negotiate integration agreement; prepare bid submission in response to MCP procurement.
Funding source: Value proposition in relation to program costs.
Membership: TOR agreed by Finance &Performance Committee and Board. Dudley CCG Chair, Clinical Executive for Primary Care, Director of Membership Development and Primary Care
Note: only relationship and accountability to CCG in respect of program costs.

Function: development of schemes to be commissioned from primary care to implement requirements of GPFV within the new care model. Includes all aspects of the GPFV relating to primary care development.
Funding source: delegated commissioning budget and GPFV.
Note: no longer resourced through Value proposition.
Members: TOR to be revised GP led, should include GP, practice

Function: To inform and guide GP Collaborative Steering Group
Membership: Determined by all practices that signs an MOU with the Steering Group.

Footnotes:

- Time limited structure transitioning into an MCP i.e. primary care development group responsibilities will sit in the MCP once established.
- The GP Collaborative Steering Group only reports to F&P on the Financial Accountability of program costs delegated to it.
- The views of the Primary Care Collaborative will be expressed at the Primary Care Development Group in an advisory capacity i.e. non- voting member on sustainability and implementation of schemes moving into MCP.
- Primary Care Commissioning and Development funded through delegated Commissioning budget, including GPFV monies.
- Primary Care Development of MCP funded through value proposition for program costs.

Appendix 2

PRIMARY CARE COMMISSIONING COMMITTEE ATTENDANCE 2016/17

* Included in the notional cost.

NAME	ROLE	15/04/2016	27/05/2016	17/06/2016	15/07/2016	19/08/2016	30/09/2016	21/10/2016	18/11/2016	16/12/2016	20/01/2017	17/02/2017	17/03/2017
VOTING MEMBERS													
Mr Steve Wellings*	Lay Member & Vice-Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Chris Handy*	Lay Member	x	✓	✓	x	✓	✓	x	x	✓	x	✓	x
Dr Mary Heber*	Secondary Care Doctor ***(Left 31/04/17)***	✓											
Dr Andrew Catto*	Secondary Care Doctor – Interim ***(Left 28/02/17)***		x	x	x	x	x	x	x	✓	x	x	
Mrs Caroline Brunt*	Chief Nurse	✓	x	x	✓	x	✓	x	✓	✓	x	✓	✓
Mr Matthew Hartland/Ms Sue Johnson*	Chief Operating & Finance Officer/Deputy Chief Finance Officer	x	x	x	x	✓	✓	✓	✓	x	✓	✓	✓
Dr David Pitches*	Public Health Representative	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	x
NON-VOTING MEMBERS													
Mr Daniel King*	Director of Membership Development & Primary Care	✓	✓	✓	✓	x	✓	x	✓	✓	x	x	X
Dr Tim Horsburgh*	LMC Representative	✓	✓	✓	✓	✓	✓	✓	x	✓	x	✓	✓
Mrs Jayne Emery	Healthwatch Dudley	✓	✓	✓	x	x	✓	✓	x	✓	✓	✓	✓
Mr David Stenson	Patient Opportunity Panel Member	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	x	✓
	HWBB Representative												
Mr D Patel / Mr T Thomik	LPC Representative	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	x
Dr V K Mittal	GP Lay Member	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	x	✓

NAME	ROLE	15/04/2016	27/05/2016	17/06/2016	15/07/2016	19/08/2016	30/09/2016	21/10/2016	18/11/2016	16/12/2016	20/01/2017	17/02/2017	17/03/2017
IN ATTENDANCE													
Mrs Anna Nicholls	NHS England Representative	x	x	✓	✓	✓	✓	x	✓	✓	x	✓	x
Mrs Julie Robinson	Primary Care Contracts Manager	✓	x	x	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Phil Cowley	Senior Finance Manager for Primary Care	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	x	✓
Mrs Julie Jasper	Lay Member for Patient & Public Engagement	✓	✓	✓	✓	x	✓	✓	✓	x	✓	x	✓
Mrs Joanne Taylor	Commissioning Manager - Primary Care	x	✓	✓	✓	x	x	✓	x	✓	x	✓	✓
Mrs Teresa Jeavons	Primary Care Contracts Support Manager	x	✓	✓	x	x	x	✓	✓	✓	✓	x	✓
Mr Anthony Nicholls	Head of Intelligence and Analytics	✓	✓	✓	✓	x	x	✓	x	✓	x	x	x

ID	Original Date	Last Review (Committee Date)	Last Update (Risk Amended)	LINK TO CORPORATE OBJECTIVE (SEE TAB 1 & 2)	Risk Description	Accountable Committee	Accountability Sponsor & Owner	Management Lead	P	I	Initial Risk Score (PxI) Score before any controls are in place.	Key Controls What controls/systems are in place to assist in securing delivery of our objective. Such as strategies, policies and procedures	Gaps in Control Where are we failing to put controls/ systems in place. / Where are we failing in making them effective. For example lack of training or no regular review of	Gaps in Assurance Where are we failing to gain evidence that our controls/ systems, on which we place reliance, are effective. Such as no assurance a strategy or policy is effective	Internal Assurances Board Reports, Minutes of meetings	External Assurances Internal and External Audit Reports, CQC Reports	Actions To improve control, ensure delivery of principal objectives, gain assurance	(R) P	(R) I	Residual Risk Score (PxI) Score following controls	Risk Trend	Timescales Date action will be completed	COMMENTS
34	22/04/2013	17/03/2017	17/02/2017	2	~~The impact of significant individual performance issues in relation to primary medical services that could result in removal of GP member from the Performers' List~~ There is a risk that a GP Member is removed or suspended from the Medical Performers List and that the CCG is not sufficenlty prepared for the potential adverse impact on Primary Medical Services and Patient Care being delivered	PCC	Steve Wellings	Caroline Brunt	4	4	16	~~CCG ensures that GP have an Appraisals~~ ~~National Performers Regulations~~ ~~Peer Review Audit~~ ~~Training and Education~~ ~~GMC Registration~~ GP under performance, failure to revalidate and non enagement is referred to the NHS England Professional & Practice Information Gathering Group (PPIGG). Safeguarding team monitoring ?? CQC reporting and intelligence sharing between CCG & CQC	CCG does not receive timely notifications of complaints from NHS England No robust mechanism for the consistent triangulation of soft intelligenceand other information available	Management of soft intelligence through CQC is not a formal process	Primary Care Operational Group (PCOG) reporting into Primary Care Commissioning Committee (PCCC) Quality & Safety Committee (Q&S) report to PCOG on any issues	Fortnightly two way communication between Q&S and the PPIGG at NHS England Safeguarding ?? CQC Visits and reports	~~GP / Nurse Mentoring~~ ~~Commissioning of Services for Primary Care~~ ~~GP Education, training and Development~~ To discuss with NHSE ways in which notifications of complaints can be shared with the CCG. Review the TOR for PCOG to provide a better mechanism for triangulating information. Development of a Primary Care Assurance Tool (PCAT) Formalise the process of obtaining soft intelligence with CQC	4	2	8	=	Jul-17	~~Recent allegations and charges against a GP has increased this residual risk score from 2 to 12. (3x4).~~ The probablity will remain high but the impact is as managed as much as possible. **THIS RISK IS NOW COVERED UNDER RISK 132**
50	04/08/2014	17/03/2017	17/02/2017	2	Failure of member practices to meet the standards of the Care Quality Commission risks continuity of service provision in member practices.	PCC	Steve Wellings	Caroline Brunt	4	4	16	Relationship with the Link Inspector at the CQC who is invited to attend the Primary Care Operational Group (PCOG). Training and Development with Practices to help them manage inspections. Blue Stream online academy. Quality Assurance Manager for Primary Care appointed and in post. PCOG and PCC following NHS England "Framework for responding to CQC inspections of GP practices". CCG has support process and package in place for all practices.	Further develop the working arrangements with NHS England Professional & Practice Information Gathering Group.	None identified	All CQC inspection reports considered in the Primary Care Operational Group and coordinated actions in place between CCG, NHS England and CQC.	CQC Reports and associated action plans from GP Practices.	Develop a quality framework and Care Quality Review Meeting (CQRM) for Primary Care	3	3	9	=	On-Going	Residual risk score decreased from 12 to 9 as a practice was classed as inadequate and in special measures but has now turned round to score Good. The report is however draft and not yet published. **THIS RISK IS NOW COVERED UNDER RISK 132**
59	29/10/2014	17/03/2017	17/02/2017	3	The ability of member practices to fulfil their contractual obligations and provide primary medical services as a result of difficulties recruiting substantive GPs	PCC	Steve Wellings	Caroline Brunt	3	4	12	Developing and implementing the new model of care - Dudley Multispecialty Community Provider (MCP). As part of the new model, developing and investing in the clinical and non clinical infrastructure and estate to deliver the model.		N/A	Engagement visits with all GP practices. Workforce data collection. Developing and investing in the clinical and non clinical infrastructure and professional development to implement the new model of care.	NHS England and Health Education England commitment to training and professional development. New models of care team supporting the Dudley Vanguard MCP model of care and development.	Successful bids to the new models of care team for additional investment and support to enable the implementation of the new model of care.	3	3	9	=	On-Going	**THIS RISK IS NOW COVERED UNDER RISK 133**
69	22/05/2015	17/03/2017	17/02/2017	2	Loss of Primary Care Medical Services as a result of increasing overheads and financial pressure on member practices beyond their control i.e. increasing cost of medical indemnity insurance, rent increases and financial sustainability of operating branch surgery sites.	PCC	Steve Wellings	Caroline Brunt	2	3	6	Developing and implementing the new model of care - Dudley Multispecialty Community Provider (MCP). As part of the new model, developing and investing in the clinical and non clinical infrastructure and estate to deliver the model.	None identified.	N/A	Engagement visits with all GP practices. Workforce data collection. Developing and investing in the clinical and non clinical infrastructure and professional development to implement the new model of care. Successful bids to the new models of care team for additional investment and support to enable the implementation of the new model of care.	New models of care team supporting the Dudley Vanguard MCP model of care and development.	Education, training and support. Providing access to specialist advice and support. Coordinating and supporting practices liaising with NHS property services regarding rent increases. Investing in systems and creating processes that enable improvements in practise efficiency i.e. practice development programmes. Implementation of the new model of care including successful bid to the new model of care team for additional investment, and the development and implementation of the estates strategy. Publication of the GP Forward View	1	3	3	=	Apr-17	Action PCOG to reconsider this risk in its entirety and advise the Committee accordingly **THIS RISK IS NOW COVERED UNDER RISK 135**
81	05/10/2015	17/03/2017	17/02/2017	1	The risk to provision of primary medical services arising from unforeseen branch surgery closures.	PCC	Steve Wellings	Caroline Brunt	4	4	16	GP Practices need to undertake statutory Consultation and apply to CCG, which has full authority to decide on an application	None	None	Application considered by PCOG decision by PCCC	NHS England Policy which CCG adopted under delegated primary care commissioning	Support GP Practices in the consultation process. Primary Care contracts manager meeting practices to take through contractual process in terms on branch closures. Finance & IT provide advice on financial advice and IT infrastructure advice.	1	3	3	=	Mar-17	Changes made to Risk Description for clarity of purpose **THIS RISK IS NOW COVERED UNDER RISK 134**
96	17/06/2016	17/03/2017	17/02/2017	4	That increases in the cost of facilities management and service charges of buildings owned by NHS Property Services (NHSPS) may destabilise the finances of General Practices, leading to loss of services.	PCC	Steve Wellings	Caroline Brunt	2	3	6	The CCG has set up a working group of affected practices to ensure visibility of issues and co-ordinate practice responses, and has offered to act on practices' behalf in dealing with NHSPS to resolve existing disputes.	Further development of CCG and practice relationships with NHS Property Services is required.				Liaise with NHS Property Services on behalf of General Practices and use tenants' forum to identify common issues and approaches to resolution	2	3	6	=	Jun-17	**THIS RISK IS NOW COVERED UNDER RISK 135**
118	08/06/2016	17/03/2017	17/02/2017	1A	Lack of clinical and managerial capacity and capability for primary care to deliver the required transformation and operate primary care at scale	PCC	Steve Wellings	Caroline Brunt	4	3	12	Primary Care Development Steering Group established and co-ordinating and developing plans to enable practices to improve and change.	None identified.	None identified	Primary Care Development Steering Group reports to the Primary Care Commissioning Committee	Primary Care Commissioning Committee reports to NHS England	None identified	3	3	9	=	Mar-17	This Risk was approved by the Committee subject the sponsor being changed to Steve Wellings **THIS RISK SHOULD BE UNDER F&P**
119	08/06/2016	17/03/2017	17/02/2017	4B	Where there is poor quality estate that compromises the ability of practices to deliver General Medical Service contracts	PCC	Steve Wellings	Caroline Brunt	4	3	12	Primary Care Estates Strategy and participation and support of CCG to enable access to National funding streams.	None identified.	None identified	The CCG agreed its Estates Strategy. Practical support available to practices to prepare and access National funding streams.	None identified	None identified	3	3	9	=	On-going	This Risk was approved by the Committee with the alterations as outlined. **THIS RISK IS NOW COVERED UNDER RISK 134**
124	18/11/2016	17/03/2017	17/02/2017	4B	The impact of contractors (single handed or partnership) not performing against their GMS/APMS contract which may result in remedial/breach notices and possible termination of contract by provider or commissioner	PCC	Steve Wellings	Caroline Brunt	3	3	9	Support provided to contract holder to remedy the breach. Support provided by NHS England, West Midlands	None	N/A	N/A	N/A	Monitored through Primary Care Commissioning Committee. Legal advice will be taken	3	3	9	=	Jan-17	Committee approved **THIS RISK IS NOW COVERED UNDER RISK 132**

GLOSSARY

ABBREVIATIONS

Abbreviation	Meaning
#NOF	Fractured Neck of Femur
£K	£1,000 equivalent
A&E	Accident and Emergency
ABC / ABCD	Above and Beyond the Call of Duty (Local surveys which include praise for nominated staff members as well as assessment of services)
ACRA	Advisory Committee on Resource Allocation
ACS	Acute Coronary Syndrome
AD	Assistant Director
AfC	Agenda for Change
AHSN	Academic Health Science Networks
ALE	Auditors Local Evaluation
ALOS	Average Length of Stay (in hospital)
AMI	Acute Myocardial Infarction
AMMC	Area Medicines Management Committee
Anti-D	An antibody occurring in pregnancy
Anti-TNF	Drugs used in the treatment of rheumatoid arthritis and Crohn's disease
ARIF	Aggressive Research Intelligence Facility
ASAP	As soon as possible
AVE	Advertising Value equivalent
BACs	Bank Automated Credit
BCC	Black Country Cluster
BCG	Bacillus Calmette-Guerin
BCPFT	Black Country Partnership NHS Foundation Trust
BCUCG	Black Country Urgent Care Group
BFT	Behavioural Family Therapy
BLCCB	Black Country Local Collaborative Commissioning Board
BME	Black Minority Ethnic
BMJ	British Medical Journal
BPAS	British Pregnancy Advisory Board
BSCCP	British Society of Colposcopy and Cervical Pathology
CAB	Citizens Advise Bureau

CABG	Coronary Artery Bypass Graft
CAO	Chief Accountable Officer
CAMHS	Children and Adolescent Mental Health Service
CASH	Contraception and Sexual Health
CAT	Change Agent Team
CBSA	Commissioning Business Support Agency
CCBT (CBT)	Computerised Cognitive Behavioural Therapy
CCF	Capable Care Forum
CCG	Clinical Commissioning Group
CCRN	Comprehensive Clinical Research Networks
CDC	Clinical Development Committee
CEO	Chief Executive Officer
CFO	Chief Finance Officer
CHADD	The Churches Housing Association of Dudley & District Ltd
CHC	Continuing Healthcare
CHD	Coronary Heart Disease
CIS	Community Investment Strategy
CMO	Chief Medical Officer
CNST	Clinical Negligence Scheme for Trusts
CNT	Community Nursing Team
CONNECT	Mental Health information website for staff
COSHH	Control of Substances Hazardous to Health Regulations 2002
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CRL	Capital Resource Limit
CRRT	Community Rapid Response Team
CSSD	Central Sterile Services Department
CT scan	Computer Topography
CQNO	Chief Quality and Nursing Officer
CQUIN	Commissioning for Quality and Innovation
CQRM	Clinical Quality Review Meeting
CVD	Cardio Vascular Disease
CWAS	Coventry and Warwickshire Audit Services
DACHS	Directorate of Adult Children and Housing Services
DCS	Dudley Community Services
DCVS	Dudley Community Voluntary Service
DES	Directed Enhanced Service
DfES	Department for Education and Skills
DGFT	Dudley Group Foundation Trust
DNA	Did not attend

DoH	Department of Health
DoLS	Deprivation of Liberty Safeguards
DoS	Directory of Service
DTC	Diagnostic and Treatment Centre
DWMHPT	Dudley and Walsall Mental Health Partnership Trust
DXA	Dual X-ray Absorptiometry (measures bone density).
E&D	Equality and Diversity
EAU	Emergency Assessment Unit
EBME	Electro Bio-Mechanical Engineer
ECA	Extra Care Area
ECM	Every Child Matters
ECT	Electroconvulsive Therapy
ED	Emergency Department
EI	Early Implementer
EI	Early Intervention
EMI	Older People with Mental Illness (Elderly Mentally Ill)
EPP	Expert Patients Programme
EPR	Electronic Patient Record
ERMA	Emergency Response & Management Arrangements
ERT	Enzyme Replacement Therapy
ESR	Electronic Staff Record
FCEs	Finished Consultant Episodes
FED	Forum for Education and Development
FHS	Family Health Services
FIP	Computerised data collection facility used by community health teams.
FMC	Facility Management Centre
FOI	Freedom of Information
FYE	Full Year Effect
GMS	General Medical Services
GOWM	Government Office for the West Midlands
GP	General Practitioner
GPAQ	General Practice Assessment of Quality
GPwSI	GPs with Special Interest
GU	Genito-urinary
GUM	Genito-urinary Medicine
HCAI	Healthcare Associated Infections
HEE	Health Education England
HENIG	Health Economy NICE Implementation Group
HF	Heart Failure
HIC	Health Improvement Centre

HIV	Human Immunodeficiency Virus
HPA	Health Protection Agency
HPS/S	Health Promoting Schools / Service
HPU	Health Protection Unit
HR	Human Resources
HSC	Health and Safety Commission
HSCQC	Health and Social Care Quality Centre
HSE	Health and Safety Executive
HT	Home Treatment
HV	Health Visitor
IAPT	Improved Access to Psychological Therapies
IC	Infection Control
ICAS	Independent Complaints Advocacy Service
ICNA	Infection Control Nurses Association
ICP	Integrated Care Pathway
ICSM	Interim Customer Services Manager
IFR	Individual Funding Request
IG	Information Governance
IOSH	Institute of Occupational Safety and Health
IT	Information Technology
IUCD	Intrauterine Contraceptive Device
JCAB	Joint Clinical Advisory Board
JCC	Joint Consultative Committee
JD	Job Description
JE	Job Evaluators
JM	Job Matching
KLOE	Key lines of enquiry
KSF	Knowledge and Skills Framework
KPI	Key Performance Indicators
LAA	Local Area Agreement
LAC	Looked After Children
LAT	Local Area Team
LBC	Liquid Based Cytology
LD	Learning Disability
LDP	Local Delivery Plan
LEA	Local Education Authority
LIFT	Local Improvement Finance Trust
LIG	Local Implementation Group
LIT	Local Implementation Team
LMC	Local Medical Committee

LNG	Local Negotiating Committee
LPS	Local Pharmaceutical Scheme
LRF	Local Resilience Forum
LTC	Long Term Conditions
LVD	Left Ventricular Dysfunction
LVSD	Left Ventricular Systolic Dysfunction
MAPA	Management of Actual and Potential Aggression
MAU	Medical Assessment Unit
MBC	Metropolitan Borough Council
MDT	Multi Disciplinary Team
MIMT	Major Incident Management Team
MIRE	Major Incident Response Executive
MLSOs	Medical Laboratory Scientific Officers
MRSA	Methicillin Resistant Staphylococcus Aureus
MSS	Medium Secure Service
NCA	Non contract activity
NCB	National Commissioning Board
NCRS	National Care Record System
NELHI	National Electronic Library for Health Information
NICE	National Institute for Clinical Excellence
NGMS	New General Medical Services
NHS	National Health Service
NHSCPT	NHS Community Practice Teacher
NHSCSP	NHS Cancer Screening Programme
NHSE	NHS England
NHSLA	NHS Litigation Authority
NHSP	National Healthy Schools Programme
NICE	National Institute for Clinical Excellence
NOF	New Opportunities Fund
NPfIT	National Programme for IT
NPSA	National Patient Safety Agency
NRF	Neighbourhood Renewal Fund
NRLS	National Reporting and Learning System
NRT	Nicotine Replacement Products
NSF	National Service Framework
OAT	Out of Area Treatment
OBD	Occupied Bed Day
OD	Organisational Development
ODM	Oesophageal Doppler Monitoring
OOH	Out of Hours

OSC	Overview and Scrutiny Committee
OT	Occupational Therapist
PALS	Patient Advice and Liaison Service
PAF	Positive Assurance Framework
PAS	Patient Administration System
PAU	Paediatric Assessment Unit
PbR	Payment by Results
PC	Personal Computer
PCDB	Primary Care Delivery Board
PCCC	Primary Care Commissioning Committee
PCDC	Primary Care Development Committee
PCOG	Primary Care Operational Group
PCT	Primary Care Trust
PDF	Portable Document Format
PDP	Personal Development Plan
PDS	Personal Dental Services
PDSA	Plan, Do, Study, Act
PDU	Professional Development Unit
PE	Pulmonary Embolism
PEAK	Database holding the main registered details of patients and associated referral, contact, caseload, outpatient, inpatient, MH Act and clinic information.
PEAT	Patient Environment Action Team
PEC	Professional Executive Committee
PEPP	Pooled Budget External Placement Panel
PFI	Private Finance Initiative
PGD	Patient Group Directives
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PIN	Personal Identification Number
PMLD	Profound and Multiple Learning Difficulties
PMS	Primary Medical Services
PPA	Prescription Pricing Authority
PPG	Patient Participation Group
PPIF	Patient and Public Involvement Forum
PSA	Public Service Agreement
PSHE	Personal and Social Health Education
PTCA	Percutaneous Transluminary Coronary Angioplasty
Q&A	Questions and Answers
Q&S	Quality & Safety
QA	Quality Assurance

QIPP	Quality, Innovation, Productivity and Prevention
QMAS	Quality Management and Analysis System
QOF	Quality and Outcome Framework
QPDT	Quality and Practice Development Teams
RACPC	Rapid Access Chest Pain Clinic
RAS	Respiratory Assessment Service
RCA	Root Cause Analysis
RES	Race Equality Scheme
RHH	Russells Hall Hospital
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
RMO	Responsible Medical Officer
RRL	Revenue Resource Limit
RSL	Register Social Landlords
RTT	Referral to Treatment Target
SAP	Single Assessment Process
SEPIA	Mental health computer system
SFBH	Standards for Better Health
SFI	Standing Financial Instructions
SIC	Statement of Internal Control
SLA	Service Level Agreement
SRE	Sex and Relationship Education
SSD	Social Services Department
SSDP	Strategic Services Development Plan
STI	Sexually Transmitted Disease
STRW	Support, Time & Recovery Worker
TB	Tuberculosis
TIA	Transient Ischaemic Attack
TP	Teenage Pregnancy
TPT	Teenage Pregnancy Team
TTO	To Take Out
UCC	Urgent Care Centre
UHBT	University Hospital Birmingham Trust
Vaccs & Imms	Vaccinations and Immunisations
WAN	Wide Area Network
WCC	World Class Commissioning
WIC	Walk in Centre
WMAS	West Midlands Ambulance Service
WMCSU	West Midlands Commissioning Support Unit
WMHTAC	West Midlands Health Technology Advisory Committee
WMSCG	West Midlands Strategic Commissioning Group

WMSSA	West Midlands Specialised Services Agency
WTE	Whole Time Equivalent