Heywood, Middleton and Rochdale
Clinical Commissioning Group

NHS Heywood, Middleton and Rochdale Clinical Commissioning Group (HMR CCG) Chair's responses to public questions from Primary Care Commissioning Committee on 8th February 2019

The following questions were raised by JR on behalf of Bridging Communities 4 All.

	Question	Response
1	What area's or thematic strand are your priorities for the next 12 months?	For Primary Care, the key priorities are: • Primary Care workforce • Access/reducing variation • Introducing the changes set out in the five year framework for GP Contract Reform to implement the NHS Long Term Plan
2	What preventative work if any are you going to commission?	Public Health commissions our preventative work which includes such things as the diabetes prevention programme, sexual health screening etc. The CCG work closely with our Public Health Prevention Programme commissioners to ensure we support this area of work.
3	In 2018 a piece work was commissioned around the mental health act. What was the purpose for this?	The CCG did not commission a piece of work in 2018 re the Mental Health Act, so at this stage are unable to comment on questions 3 & 4. If further detail is provided as to what specifically is being referenced we can look into this further
4	The Mental Health Act - especially sectioning - only affects a small amount of the population in the HMR boundaries. What was your rationale and what outcome did you want from this?	As above
5.	What do you intend to commission for the BAME community which accounts for just over 24% and over which have many long term illnesses?	The commissioning for such long term illnesses is not specific to the BAME community as the way in which such conditions are managed are the same for all. However, we are aware that there can be access issues, therefore the CCG ensures that communications are targeted; examples being slots on Crescent Radio, holding events to try to encourage uptake of screening within certain communities, working with local Imams to ensure messages are shared etc. It should also be noted that for each new service commissioned, we complete an Equality Impact Assessment to ensure that our services, policies and practices do not directly, indirectly, intentionally or unintentionally discriminate against the users of our services or the staff.
5i	***15/3/19 - Supplementary question to response: This is not targeted enough.***	The commissioning of services will be the same for all communities, however the delivery will be different for long term conditions and access to services maybe different in different areas. As a CCG we are encouraging providers to say how they will deliver the outcomes. A lot of work is taking place.

		The member of the public noted that somewhere communication is breaking down and more needs to be done to address this.
6.	How do you intend to keep them informed to worsening of their conditions and preventative measures which will save the NHS considerably a large amount of money?	Again, other than access/communication, this is not dealt with differently to any other patients with long term conditions. There are processes in place to manage the different conditions in a primary care setting to reduce the cases of exacerbations requiring inappropriate secondary care input etc and ensuring that appropriate clinical advice is provided to achieve the best possible outcome for our patients.
6i	***15/3/19 - Supplementary question to response: There is not enough preventative work taking place.***	The CCG confirmed a lot of prevention work is taking place, campaigns in relation to healthy diet, regular exercise, daily mile, cervical screening awareness etc.. Advice is the same to all populations this is delivered differently to be sensitive to cultural views. A Clinical Board member confirmed the work taking place locally via the prevention access board. It is hoped to hold an engagement event to improve awareness locally in the near future. The members of the public commented that the ways in which the messages are being delivered does not always work. The CCG acknowledged it was important to get the right message to the right people and this is a discussion that is taking place with care navigators as part of the awareness event to empower individuals so they can take on that message and share with their communities.
7.	Why are commissioners not consulting with grass root organisations?	The CCG has a well established Patient and Public Engagement Committee (PPEC) that meets on a quarterly basis. The Committee has been set up to provide assurance on the delivery of the CCG's patient and public involvement duty. Ensuring the CCG's commissioning activities meets its statutory duties, adheres to national guidance and best practice. This also has task and finish groups that are convened as required and report into the PPEC. The committee's core membership has Third Sector and voluntary organisations representing those groups with protected characteristics, the Chair of the Locality Patient Participation Group (PPG) is also a member of the committee representing the wider patient population and the committee is chaired by a lay member whose portfolio includes patient and public engagement. The CCGs primary care sub-committees have patient representatives as co-opted members who are invited as dictated by the agenda. The CCG is a member of the locality patient participation group who meet every two months. This group is made up of members of individual practice patient participation

		groups who meet to discuss best practice, share information and receive updates on healthcare transformation. The CCG engages many service users and local organisations on a regular basis to ensure they are kept up to date with current issues and can input into the CCG's business. This can range from informal meeting sessions, formal presentations to full co-design/co-production (e.g. #Thrive Service) The CCG attempts to ensure that events are arranged in all areas of the borough to enable participation from as many local people as possible. When the CCG is commissioning a service through a formal tender procurement service users are supported to participate in a panel to sense check the specification, score tenders and make the final decision jointly as part of the tender panel.
7i	***15/3/19 - Supplementary question to response: Why does PPEC not have any patient representative?***	Members of the public do not attend PPEC, organisations attend on behalf of their members, as a single member of the public does not necessarily represent all of the population. The CCG Engagement lead meets with individuals outside of PPEC and the PPEC also has task and finish groups that report in when appropriate. The PPEC has representation from the Patient Participation Group and as part of Governing Body membership Healthwatch Rochdale represent patients within the borough. Patients,Carers and Service Users are involved in the commissioning of services and link with the relevant work that is taking place. PPEC is a networking committee linking with third sector and voluntary organisations to ensure that communication links are made and ensure that information is shared with individual members of those organisations. Additonally data obtained form individual patient,carer and service user experiences is utilised to performance and quality monitor commissioned services. Health watch Rochdale is establishing a patient group which patients and members of the public are welcome to join, this will link in with PPEC via Healthwatch Rochale representation.
8.	There seems to be a lack of evidence that your commissioning models and tendering covering equality & diversity impact model. What is your response to this?	There are a several support mechanism in place to support the integrated commissioning team take account of equality and diversity in commissioning. This includes access to capacity building via the Equality Analysis (EA) and Equality Impact Assessment (EIA) Masterclasses delivered by our Equality Diversity & Inclusion Strategic Lead and quality assurances of EAs undertaken. We recognise more needs to be done to ensure this becomes systematic across

		teams. We do have Equality Diversity and Human Rights (EDHR) Schedule that is embedded within our NHS Standard contracts with our providers and we recognise more need to be done to improve monitoring of this schedule. Equality questions are embedded within the NHS procurement process and some further work is required to ensure consistency across the wider health and social care landscape. Further work is required to ensure service specifications have a link to the EDHR schedule. We will be have a development session to ensure the members of the Integrated Committee and Health and Well being Board understand the role of EA/EIA in decision making . This is a priority area for 2019-20.
8i	***15/3/19 - Supplementary question to response: Is it possible to see a time line of the priority area for 2019-20?***	As a result of issues and gaps that we are aware of, which include the issues you have raised. A paper will go to the Integrated Commissioning Board after the Purdah period (3 May 2019). the date has yet to be confirmed. The paper will look at strengthening the current commissioning cycle and will also ensure the EIA is embedded throughout the cycle for Health and Social Care. The process that will be followed includes, the endorsement at Integrated Commissioning Board and an implementation phase to make the improvements.
9.	You have legal duty to provide services and take into consideration of the BAME community, under the equalities Act 2010, Ten year forward plan etc. How do you intend to address this?	Yes you are right, currently we have a lot of data of people in the borough, which informs our Joint Strategic Needs Assessment (JSNA) including for BAME communities. We recognise more needs to be done to use this data which an EA/EIA framework to inform our plans. For example our recent dementia workshop highlighted considerations that impact BAME communities; this will be fed into our forthcoming strategy to inform commissioning and service delivery. When feeding back to our communities about the transformation of local healthcare services we have commissioned 7 minute briefs to explain the key themes of transformation in three languages; English, Urdu and Bangla. As part of the engagement plan, we conducted engagement sessions with 3 groups attended by local Asian ladies who did not have English as their first language and had difficulty reading. To support their engagement the 7 minute briefs were transcribed to spoken word audio CDs to enable the ladies to listen to the messages contained in the briefs.

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The following questions were submitted by JR on behalf of Bridging Communities 4 All on 11 February 2019 in relation to Papers presented and verbal updates provided to the Primary Care Commissioning Committee on 8 February 2019.

	Questions	Response
1	From the Paperwork I did not see any patient representatives or experts by experience in the various committees that have been set up. I am aware that Healthwatch Rochdale attends to represent the patients voice but this is limited and does not fully give you focused answer of individuals using the services. Where at the Greater Manchester level patients do sit on the various committees. Can the format change in Rochdale to make it more inclusive?	At HMR CCG we have a well established Patient and Public Engagement Committee that meets on a quarterly basis. The Committee has been set up to provide assurance on the delivery of the CCG's patient and public involvement duty. Ensuring the CCG's commissioning activities meets its statutory duties, adheres to national guidance and best practice. This also has task and finish groups reporting into it. This committee has Third Sector and voluntary organisations representing those groups with protected characteristics, the Chair of the Locality Patient Participation Group (PPG) is also a member of the committee representing the wider patient population and the committee is chaired by a lay member whose portfolio includes patient and public engagement The CCGs primary care sub-committees have patient representatives as co-opted members who are invited as dictated by the agenda. The CCG is a member of the locality patient participation group who meet every two months. This group is made up of members of individual practice patient participation groups who meet to discuss best practice, share information and receive updates on healthcare transformation. HMR CCG engages many groups on a regular basis to ensure they are kept up to date with current issues and can input into the CCG's business. This can range from informal meeting sessions to formal presentations. The CCG attempts to ensure that events are arranged in all areas of the borough to enable participation from as many local people as possible. When the CCG is commissioning a service through a formal tender procurement the Engagement Lead invites service users to participate in a panel to sense check the specification, score tenders and make the final decision jointly as part of the tender panel.
2.	The LCO forum seems to be a closed shop, patients should be able to challenge at the point of discussion not retrospectively as this will waste value time all around.	One Rochdale Health & Care (the Rochdale LCO) at present does not have a legal requirement for meetings in public but has committed to a broad programme of patient and public engagement so that they can have a meaningful influence on how services are developed. The ORHC Board is currently considering how it might hold regular meetings in public.

3.	There was a mention of a new indicators framework: What are these? What are the targets for these? Where are we currently? How do you intend to improve on these indicators and what investments and consultations will be carried out, along side status quo paperwork?	A verbal update was provided regarding the development of Core+ for 2019/20. Following a robust engagement process Core + was launched as a pilot in 2017/18 to test out a new outcomes based approach to commissioning with a focus on partnership working and commissioning a borough wide approach. Within Core + a range of outcomes are identified which are arranged under a set of core themes. Each theme contains a number of indicators which have been agreed in order to measure progress against the specified outcomes. Following the success of the pilot, Core + was further commissioned and work is ongoing now to review the themes and indicators in 18/19 to inform any proposed changes for 19/20. Engagement with range of commissioners, clinical leads and CCG consistent members forms an integral part of the review process that is currently only going.
4.	With regards to Digital transformation, have you carried out a risk assessment and accessibility assessment? As I foresee up to 30% of Rochdale population that will have no access or lack of knowledge to access these services. What steps have been taken to ensure that patients, with mental health related diagnosis, will be able to fully access and understand the changes? And also consider for neuro-diversity? Rochdale is inimically deprived population, many of which will not have access to and have no knowledge of using smart phones; computers etc. and this change will cause a lot mental distress.	As stated in the recently published “five-year framework for GP contract reform to implement the NHS Long Term Plan”: Digital primary care has the potential to improve access, quality and outcomes, including through better data, more accurate diagnosis, and support tools for patients. For many patients, digital will become their channel of choice when interacting with the NHS. This is likely to be particularly true of 16-25 year olds. Increasingly they forgo traditional GP appointments. Progress on digital delivery will be important to maintain social solidarity behind the general practice model, and contract requirements will be updated annually as part of wider contract negotiations, to reflect advances in technology and delivery of the support promised in this agreement. The advancement of such technology does not remove other methods of engagement but rather, it will enhance it, offering a wider range of ways in which to access and engage with these services. This will only be offered to patients who wish to use these new technologies and for whom this is suitable. Communication will be key to ensuring patients are aware of the options available to them and how to access these, for example, NHS England will launch a public campaign in 19/20 to raise awareness of the ability to book appointments online
5.	25% of GP appointment allocation should be online, this measure you are marginalising a huge part of the population as there will be significant access issues.	This is a national requirement rather than a local one. This is set out in the recently published “five-year framework for GP contract reform to implement The NHS Long Term Plan”
6.	Repeat prescriptions to a centralised location. Risk mitigation register - has one been done and what were the outcomes?	This work is still in the development stage and we believe that changing the location of contact will not introduce any additional risks. In developing the proposed service, we are engaging with

	Who checks the repeat prescriptions requests? Will they have a medical background? If some of the medication that fall under NICE guidelines will the call centre remove them or will a GP involved in this? There are so many issues I foresee around this proposal and at the moment it is looking like this decision has been based around economic reasons with little or lack of consideration the affects on the patients. The term used in the paper "clinically Appropriate" is extremely subjective and if was carried out in an open and transparent manner GP's will have to see all their patients with complex medical needs.	other areas who have already implemented this, to ensure that we learn from their experiences, to help share what the local service looks like. In addition, this will initially be a pilot that a small number of practices will participate in, to again ensure the system works safely and meets the expected benefits. For the practices that participate in the project, some central assessment of the medication request will be undertaken at the time of receipt of the call There will be input from staff with some specialist training in medicines management / optimisation as part of the process We will not be assessing any medication against any NICE criteria as this would be too time consuming, NICE guidance is advisory and needs to be taken in the context of the patient's clinical presentation. As stated above this project is in development and we do not envisage any impact on patients The term is indeed subjective, however there are no clear objective definitions of what is clinically appropriate, each clinician will use their knowledge and skills to give the treatment which they believe will be clinically appropriate, this may differ from other clinical opinions.
7.	Diabetes dual meters. It was discussed there was zero cost to this**.** The question is that how much will the new testing strips cost in comparison to the current ones? How will these meters be rolled out? Collection of data - is this automated or reliant on the patient?	The benefits of use of the dual meter are that the CCG will reduce costs of ketone test strips The new strips are £6 which are less costly Patients will be invited to attend their practice for a change Data will be collected through the CCGs current systems
8.	There was a mention of "Urgent Care and Paediatric Review" but there was no papers present to see what changes were being discussed and what new thematic pathways were being considered**.** Who is involved in discussion?	This relates to the Paediatric Urgent Care review. The CCG was successful in securing a bid to be part of the 2018 AQuA (advancing Quality Alliance) Patient Flow Programme. This is in its infancy and AQuA will be supporting the CCG to facilitate a programme of workshops with services across the system which will include a mapping exercise to understand the current position and identify areas of improvement. As such, further information will be taken through the appropriate governance routes as the work progresses.