NHS
Gloucestershire
Clinical Commissioning Group

Primary Care Commissioning Committee (PCCC)

Meeting to be held at 11:00 on Thursday 28th July 2016 in the Board Room, Sanger House, Brockworth, Gloucester GL3 4FE

No.	Item	Lead	Recommendation
1.	Apologies for Absence	Chair	
2.	Declarations of Interest	Chair	
3.	Minutes of the Meeting held on 26th May 2016	Chair	Approval
4.	Matters Arising	Chair	
5.	Primary Care Strategy	HG	For further comment
6.	Delegated Primary Care Commissioning Financial Report	CL	Information
7.	Learning/Physical Disability Community Enhanced Service	HG	Approval
8.	Sevenposts: Bishops Cleeve premises development	AH	Approval
9.	Primary Care Quality Report	MAE	For information
10.	General Practice Forward View Investment Plan	HG	Information
11.	Any Other Business (AOB)	Chair	
Date and time of next meeting: Thursday 29 September 2016 at 11:00am in the Board Room at Sanger House			

A recording will be made of this meeting to assist with the preparation of the minutes. This recording will be made on an encrypted device owned by the CCG and will be held securely for a maximum of one week before being deleted

MINDFUL EMPLOYER

NHS
Gloucestershire
Clinical Commissioning Group

Primary Care Commissioning Committee

Minutes of the Meeting held on Thursday 26th May 2016 in the Board Room, Sanger House, Gloucester GL3 4FE

Present:		
Alan Elkin	AE	Chair
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Julie Clatworthy	JC	Registered Nurse
Colin Greaves	CG	Lay Member - Governance
Mary Hutton *(part meeting)*	MH	Accountable Officer
Cath Leech	CL	Chief Finance Officer
Dr Andy Seymour *(part meeting)*	AS	Clinical Chair
Mark Walkingshaw	MW	Deputy Accountable Officer
In attendance:		
Helen Goodey	HG	Director of Primary Care and Locality Development
Becky Parish	BP	Associate Director, Engagement and Experience
Anthony Dallimore	AD	Associate Director of Communications
Stephen Rudd	SR	Head of Locality and Primary Care Development
Claire Feehily	BPi	Chair of Healthwatch Gloucestershire
Alan Potter	AP	Associate Director of Corporate Governance
Fazila Tagari	FT	Corporate Governance Support Officer
There was 1 member of the public present.		

1 Apologies for Absence

1.1 Apologies were received from Cllr Dorcas Binns.

2 Declarations of Interest

2.1 AS declared a general interest as a GP member.

3 Minutes of the Meeting held on Thursday 31st March 2016

3.1 The minutes were approved subject to the amendments below:

- JC to be included in the list of attendees.
- Section 8.1.2 to be amended to read *'**AH** advised that the practice was working with a third party..'*
- Section 9.1.1 to be amended to read *'JG provided an update regarding **Springbank** surgery'.*

3.2 CG highlighted section 8.1.7 relating to the Stow Surgery new premises development and enquired if the Value for Money Report from the District Valuer had been received. HG agreed that she would confirm this with Andrew Hughes. HG

4 Matters Arising

4.1 24.09.2015 AI 5.8 – Springbank Procurement Update – AP agreed that he would follow up the NHS England action in relation to forwarding the nurse led paediatric model from Swindon.

4.2 28.01.2016 AI 7.2.2 – 2016/17 Budget Proposals – The update regarding the budget proposal was covered under Agenda Item 6.2. **Item Closed.**

5 Primary Care Strategy

5.1 Draft Primary Care Strategy

5.1.1 HG introduced the draft Primary Care Strategy which was taken as read and provided the background context to developing the strategy and invited feedback.

5.1.2 HG advised that Strategy identified the current national and local challenges and brings together the feedback from the primary care workforce with the latest national policy and evidence and was a key element of the Sustainability and Transformation Plan

5.1.3 It was noted that full stakeholder engagement would be undertaken on the Strategy which would subsequently inform the final version.

5.1.4 BP provided an update on the engagement process and members noted that a consultation exercise on the draft Primary Care Strategy would commence following the feedback received at the meeting today. This would include:

- Primary Care Operational Group (PCOG);
- Governing Body;
- GP Members;
- Locality Executives;
- Local Medical Committee (LMC);
- Practice Participation Groups;
- STP Oversight Board;
- Health and Wellbeing Board; and
- Other voluntary and community groups.

5.1.5 CF questioned the model of participation which would be used for the Strategy and at what point participation would occur prior to the final version.

5.1.6 CF stated that patients' outcomes were not prominent within the document and suggested that further emphasis on improving patient outcomes was included.

5.1.7 CF considered that the primary care patient feedback was not strong and highlighted that there had been three years of Patient Advice and Liaison Service (PALS) data available and suggested that this was utilised to support the Strategy further. CF also stated that health outcomes were not implicit and felt that this should be driving the strategy forward.

5.1.8 CF informed members that a Healthwatch Board meeting was being held later that day and proposed that the Strategy was discussed at the meeting. CF suggested that any feedback could be reported to BP. CF

5.1.9 CG felt that the focus of the Strategy was misplaced and drew attention to page 7 of the document which stated *'Our vision for primary medical care, as a membership organisation, is from our members' provider perspective'.* CG felt that the patient perspective should be encapsulated and that the primary care

vision was weak and should link with improving health outcomes for patients.

5.1.10 CG also noted that the financial allocations were incorrect whilst acknowledging that this was a draft document.

5.1.11 JC suggested that the document should be targeted as a commissioning strategy as it was a provider driven document and laid out a position for providers to respond to. JC stated that Gloucestershire had a good standard of primary care and felt that this was underestimated within the document.

5.1.12 JC also felt that the Strategy was focused on national issues and recommended that local data was utilised to further strengthen the Strategy.

5.1.13 AE felt that GP services had been perceived in a historical context and felt that potential models of future delivery of primary care should also be taken into account.

5.1.14 HG accepted the comments and recognised that further work was required in order that patient focus was key and acknowledged that this would be a dynamic document during the consultation process.

5.1.15 The Committee expressed thanks to SR for his hard work in drafting the Strategy.

5.1.14 <u>RESOLUTION:</u> The Committee reviewed the draft Primary Care Strategy and provided feedback and noted that further feedback from wider stakeholders would be incorporated as the strategy develops.

5.2 General Practice in Gloucestershire BMJ campaign

5.2.1 AD presented a video regarding the BMJ GP recruitment campaign and noted that this formed part of the overall workforce strategy.

5.2.2 It was noted that as well as high visibility Gloucestershire branding in the print and online publication, the local BMJ recruitment campaign also had a microsite which included the campaign film, the current vacancies feed and also linked to Twitter.

5.2.3 Members were advised that the video could be accessed on the link below:

http://www.beagpingloucestershire.co.uk

5.2.4 HG provided a brief context underpinning this campaign and advised that a survey had been undertaken with all GP practices in order to understand the workforce and recruitment issues that were being faced by them. It was noted that 41% of the responses received indicated that they had GP vacancies and 57% had planned GP retirements.

5.2.5 HG confirmed that the campaign was one component of the workforce plan. HG also confirmed that the CCG had been engaging with ST3s in collaboration with the Deanery to develop fellowship contracts in order to retain the GPs that had trained in Gloucestershire.

5.2.6 AE enquired regarding the success rate following the campaign and was advised that positive feedback had been received from the GPs who were advertising vacancies and had advised that there had been considerable interest. HG also advised that the campaign had created considerable interest nationally and from other CCGs who were considering this approach.

5.2.7 CF queried the channel of communication for sharing the video. AD advised that the BMJ video would be referred to on the first page of the BMJ which would provide a link to the website and social media.

5.2.8 CF also queried what would be the top three negative reasons if a potential GP were to contact an established Gloucestershire GP. AS considered that there should be no negative message being portrayed as the aim would be for GPs to promote their vacancy. HG added that the national challenges could be raised as an issue. CG stated that premises could be highlighted as a potential issue although acknowledging that there was an investment strategy to address these issues.

5.2.12 <u>RESOLUTION:</u> The Committee noted the BMJ video.

5.3 General Practice Five Year Forward View

5.3.1 HG provided a brief summary of the contents of the report and advised that the General Practice Forward View was published in April 2016 by NHS England.

5.3.2 HG advised that there was a focus on increased investment, workforce, workload, practice infrastructure and care redesign for primary medical care over the next five years.

5.3.3 HG informed members that she had presented the report at the full LMC meeting who were generally supportive of the proposals although prudent regarding the implementation process.

5.3.4 HG advised that the report also identified an increase in investment of £2.4bn a year by 2020/21 into general practice services supported with an extra £508m five year Sustainability and Transformation package nationally. This included a requirement for CCGs to provide £171m of practice transformational support. HG advised that these were being worked through at a local level.

5.3.5 Members noted that the report also discussed an investment for physician associates, mental health workers and clinical pharmacists to support practices.

5.3.6 HG advised that workload pressures had also been acknowledged and that a simplified system for CQC would be introduced which will include a reduction in inspections from CQC for those practices rated as ‘good’ and ‘outstanding’ and include the move to five yearly CQC inspections for most practices.

5.3.7 The report also identified the initiative to develop and support new workplace incentives to promote employee health. Members noted that Gloucestershire already had Occupational Health services available to employees.

5.3.8 Members were informed that the report also mentioned the introduction of a new voluntary Multispecialty Community Provider contract from April 2017 to integrate general practice services with

community services and wider healthcare services.

5.3.9 AE requested that CL provided an update regarding the financial position and was advised that it was understood that certain elements had already been allocated within the existing budget although it was noted that further clarity was required.

5.3.10 CG expressed concerns regarding the relaxation of the CQC inspection regime and felt that standards could fall. AS informed members that preparing for these inspections had major resource implications for practices as well as well as causing anxiety to the practice. It was also highlighted that all practices that had been inspected to date had been rated as 'good' or 'outstanding'. JC considered that the proposals for reduced input from CQC placed a greater emphasis on the CCG to review its quality arrangements. MAE advised that robust assurance processes would need to be developed in order to identify any practices that were at risk and to provide support mechanisms.

5.3.11 AE understood that there was a good working relationship with the GP practices. HG concurred and advised that there was a dedicated team established to provide support to the GP practices. HG also advised that getting the communication channels right was an embryonic process and highlighted the 'What's New This Week' bulletins. AS advised that GP practice visits were also being resumed within the next month.

5.3.12 CF felt that the national message would be confusing for patients and queried if the model was fundamentally being changed without the full understanding of the public. AS advised that communication plans would be developed to mitigate this issue. HG advised that the national guidance on patient communication had not been issued and noted that the feedback received to date had been invaluable.

5.3.13 AE highlighted that the Patient Participation Groups (PPGs) was a marginal representation of the population. CF felt that it was important that the working age, young adults, parents and children etc. had the opportunity to provide input within the system and that their voices were heard.

5.3.14 <u>RESOLUTION:</u> The Committee noted the presentation.

6 <u>Finance</u>

6.1 Delegated Primary Care Commissioning Financial Report 2015/2016

6.1.1 CL presented the 2015/16 report which outlined the financial position on delegated primary care co-commissioning budgets at the end of March 2016.

6.1.2 CL reported that the CCG reported an outturn underspend of £10k against delegated budgets at the end of March 2016. The recurrent impact of the 2015/16 expenditure position had been accounted for in the 2016/17 budget.

6.1.3 JC queried if there was an impact on the outcomes for the reduced spend in Enhanced Services. CL advised that this was a refinement of the forecast outturn and should not affect outcomes.

6.1.4 <u>RESOLUTION:</u> The Committee noted the report.

6.2 Finance Report 2016/2017

6.2.1 CL presented the 2016/17 financial report which outlined the changes in the assumptions used in setting the draft budgets for 2016/17 following the March PCCC meeting.

6.2.2 CL informed members that NHS England had confirmed that the 1% headroom requirement on delegated co-commissioning budgets should be used to cover any unmitigated risks across the health community, not solely within primary care.

6.2.3 Members were informed that detailed guidance for the GMS contract 2016/17 had now been published and the GMS contract payment had increased. It was also noted that the contract payments take account of the implications from changes made in the current financial year, particularly regarding Springbank and St Lukes.

6.2.4 CL noted that the primary care allocation for 16/17 now included the funding previously held by NHSE for functions including primary care information governance and smartcards. Further clarification has been requested from NHSE as this may result in a cost pressure to the CCG.

6.2.5 RESOLUTION: The Committee noted the report.

7 Primary Care Contracts

7.1 Sixways Practice – Application for a change to the practice's boundary

7.1.1 HG presented the report and advised that the practice had requested approval to move their boundary and decrease their practice area. The report was taken as read.

7.1.2 HG advised that the Primary Care Operational Group had made a recommendation that the PCCC should approve this request.

7.1.3 BP advised that she had attended a meeting with other CCGs the previous day most of whom had joint commissioning arrangements. It was noted that they were interested in the detail we required regarding boundary change requests and that a great deal of interest was expressed and that Gloucestershire was commended by that group.

7.1.4 JC questioned if the impact assessment considered the travelling time for patients or clinicians and this was advised that this was for clinicians. JC also requested that incidents and complaints were considered as part of the assessment.

7.1.5 RESOLUTION: The Committee:

- **considered the recommendation from the Primary Care Operational Group meeting of the 19th April 2016; and**
- **approved the boundary change request.**

8 Any Other Business

8.1 MH provided an update on the Quarter 4 Assurance meeting that

was held with NHS England where the performance of the CCG had been reviewed. MH informed members that NHS England had concluded that the CCG should be put forward as 'outstanding' in respect of its work around primary care although this would be subject to national moderation. This was due to the work being undertaken to develop the primary care strategy. The committee thanked the team for their hard work.

9 The meeting closed at 12:08.

10 Date and Time of next meeting: Thursday 28th July 2016 in the Board Room at Sanger House.

Minutes Approved by Gloucestershire Clinical Commissioning Group Primary Care Commissioning Committee:

Signed (Chair):_____ Date:_____

NHS
Gloucestershire
Clinical Commissioning Group

Matters arising from previous Primary Care Commissioning Committee Meetings – May 2016

Item	Description	Response	Action with
24/09/2015 Item 5.8	Springbank procurement update	JC queried the possibility of the availability of a Nurse led Paediatric service within GP Surgeries. DE advised she would forward the model from Swindon where this was in place, for information.	**DE**
28/01/2016 Item 6.12	Application to close branch surgeries in Hawkesbury Upton and Wickwar from Culverhay Surgery	CG felt that it would be useful to receive feedback on the implementation and suggested that an update was provided in six months (July 2016)	**HG**
28/01/2016 Item 9.1	Any Other Business	CG suggested that a self-assessment was undertaken to reflect on the role as a Committee in order to improve on processes and identify areas for development where further training was required	**AE**
26/05/2016 Item 3.2	Minutes of the Meeting held on Thursday 31st March 2016	CG highlighted section 8.1.7 relating to the Stow Surgery new premises development and enquired if the Value for Money Report from the District Valuer had been received. HG agreed that she would confirm this with Andrew Hughes.	**HG**
26/05/2016 Item 5.1.8	Draft Primary Care Strategy	CF informed members that a Healthwatch Board meeting was being held later that day and proposed that the Strategy was discussed at the meeting. CF suggested that any feedback could be reported to BP.	**CF**

NHS
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Clinical Commissioning Group

Agenda Item 5

Primary Care Commissioning Committee

Meeting Date	**Thursday 28th July 2016**
Title	**Primary Care Strategy for Gloucestershire**
Executive Summary	Having taken on commissioning responsibility for Primary Care from NHS England in April 2015, the CCG's Primary Care and Localities Team has been working hard with partners and stakeholders since early 2016 to develop a comprehensive Primary Care Strategy for the next five years; the Team is now in a position to present the latest draft to the PCCC for comments, with a view to seeking approval as soon as possible. The timing of this work has been excellent, coinciding as it does with the production of the local Gloucestershire Sustainability and Transformation Plan (STP), and also the national NHS England General Practice Forward View. Primary Care plays a pivotal role in the health and care community delivering its STP, within the context of the Forward View, which sets out an ambitious transformation programme for primary care over the next five years, supported by £2.4 billion of funding for England as a whole. The production of this Strategy has been led by Locality and Primary Care Directorate, who have worked to initially engage with a wide range of internal CCG senior management and clinical colleagues, including members of the Primary Care Commissioning Committee (PCCC). The draft that resulted from this internal engagement was then used to discuss with a wider range of internal and 'external' partners, including:

	• CCG Locality Executive Groups; • Gloucestershire Patient Participation Group Network; • County, District and Parish Councils; • GHNHSFT, GCS, 2gether and SWAST; • West of England Academic Health Science Network (WEAHSN); • VCS Alliance; • Healthwatch Gloucestershire; • Gloucestershire Police and Crime Commissioner; and • Gloucestershire Local Medical Committee (LMC). The comments received have then been incorporated into the latest draft strategy being presented to the PCCC today. Once the PCCC has commented further today, these comments will be incorporated where appropriate into a 'final' version for presentation to the Governing Body at its September meeting. The full version of the Strategy is presented. Work is underway to summarise this into a 'Short Guide' for a wider audience, including patients, primary care teams, staff within local providers, county/district/parish council staff and the public generally. The intention is to link this process with the parallel process currently underway to produce a 'Short Guide' for the STP. The 'final' version of the Short Guide will be included in the papers for the Governing Body in September. Finally, please note that the 'final' version of the full Strategy will be converted into a published form by the CCG's Graphics Team prior to presentation to the Governing Body.
Risk Issues: **Original Risk**	The main key issue is to ensure that the Strategy sets out both a clear context in which primary

Residual Risk	care is operating and an ambitious plan for the next five years, a plan that reflects national guidance and local ideas and circumstances. It is crucial that this plan translates national guidance to meet the needs of the local population. A further key issue relates to the national £2.4bn of funding; at the time of writing the full details about what this means at a local Gloucestershire level are not available. Clearly, the ability to deliver the plans detailed in the Strategy will be strongly influenced by the money available. However, whatever funding is available, the CCG will work with its partners to progress with the plans as much as possible, as quickly as possible. It is recognised there are risks associated with each of the six components within 'Our Plan for the Future'. These will be developed and detailed as part of the programme planning process being undertaken by each of the workstream groups. An initial risk identified across all six components is the availability of key senior managers and clinicians to support not only the Primary Care Strategy work, but also the range of workstreams across the whole of the STP. For example, senior leadership is required in setting up integrated working arrangements in 'clusters' across our seven localities, as well as undertaking the transformational changes set out within our STP. In order to mitigate this, we will therefore commence early discussions with STP colleagues to ensure we are planning for a reasonable spread of senior input.
Financial Impact	The Primary Care revenue allocation is anticipated to grow by around £11.5m over the

	next five years. While a large proportion of this will be subsumed by cost inflation and the increased demand generated by our forecast population profile, we will be investing in delivery of the six components within this Strategy.
Legal Issues (including NHS Constitution)	This Strategy will support our STP footprint in ensuring ongoing delivery of the NHS Constitution requirements. Gloucestershire CCG needs to act within the terms of the Delegation Agreement with NHS England dated 26 March 2015 for undertaking the functions relating to Primary Care Medical Services and is therefore working within this remit in the development and delivery of this Strategy. There are no known legal issues.
Impact on Health Inequalities	The Strategy seeks to reduce identified health inequalities through, for example, commissioning on a place-based approach to ensure that local needs are best met.
Impact on Equality and Diversity	An Equality Impact Analysis is currently in draft format and the final version will be presented to the Governing Body in September.
Impact on Sustainable Development	In line with the STP, this strategy seeks to maximise the delivery of appropriate services in the community. In many cases then, this will reduce the amount of travelling people need to do around the county.
Patient and Public Involvement	Engagement with the public and patients has been focused through representative bodies, in particular Patient Participation Groups and Healthwatch Gloucestershire. As described above, the comments received have been incorporated into the latest draft strategy. On a quarterly basis, patient experience data (such as the GP Friends and Family Test results)

	help to inform commissioning and monitoring of primary care through the Primary Care Clinical Quality Review Group. The Strategy itself has within it a section called 'Engagement and Stakeholder Involvement Approach'.
Recommendation	The PCCC is asked to: • comment on the Primary Care Strategy, with a view to making a recommendation to the Governing Body to approve the Strategy; and • comment on the proposed approach for a 'public-friendly' short guide of the Strategy
Author	Jonathan Jeanes / Stephen Rudd
Designation	Programme Manager / Head of Locality and Primary Care Development
Sponsoring Director (if not author)	Helen Goodey Director of Locality Development and Primary Care

One Gloucestershire
Transforming Care, Transforming Communities

Gloucestershire CCG Primary Care Strategy 2016 - 2021

Joining Up Your Primary Care: General Practice

Version: 0.2.1
Last updated: 27/07/2016

Table of Contents

Executive Summary

This strategy supports the vision for a safe, sustainable and high quality primary care service, provided in modern premises that are fit for purpose. Our ambition is to support patients to stay well for longer, connect people to sources of community support and ensure people receive joined up out of hospital care.

This requires a resilient primary care service at the core of local communities, playing a leading role not only in the provision and co-ordination of high quality medical care and treatment, but also in supporting improved health and well-being.

The pages that follow set out the national and local challenges we face, such as increased demand, a growing population with more complex needs, workforce pressures and constrained funding growth. We must though use the opportunities we have to play to our strengths and wherever possible, meet these challenges with local solutions.

These strengths are highlighted by the fact that despite the very real pressures that exist, there continues to be overall high levels of patient satisfaction with the quality of primary care in Gloucestershire.

There is also resolve and common purpose amongst primary care professionals in Gloucestershire to explore new ways of working and protect and enhance the primary care service for current and future generations of patients and healthcare professionals.

The six strategic components of the strategy:

1. Access

This section of our strategy sets out our commitment to provide patients with improved access to primary care in Gloucestershire, including extended evening and weekend access, that is joined up, easy to navigate and provided locally.

Our approach will be informed by evaluation of the Choice+ pilot that has been in place across our localities and other local services and we will work with practices, patients and providers to design our long-term models of care.

We will also further develop our approach to Social Prescribing. These initiatives, in all our localities, are helping practices to manage demand and support people with broader, non-medical needs to improve their well-being and access sources of community and social support.

2. Primary Care at Scale

There is an increasing trend towards delivery of Primary Care at Scale, with the traditional small GP partnership model often recognised as being too small to respond to the demographic and financial challenges facing the NHS.

By 'Primary Care at Scale,' our strategy refers to GP practices and other professionals, such as clinical pharmacists, working together in closer partnership (or networks) to deliver more sustainable services. This could result in a number of benefits including access to a wider range of local services for patients within the local community, increased staff resilience, improved staff satisfaction, work life balance and learning opportunities, and improved financial sustainability.

This section of the Strategy describes how we could take this forward.

3. Integration

Through our localities, we will support GP practices to work as part of an integrated (joined up) team of multi-disciplinary team (including community, voluntary and hospital services) for the benefit of a defined population of around 30,000.

This is likely to involve an extended team of GPs, nurses, allied health professionals and specialists offering easy access to a wide range of health and care close to people's homes.

Our strategy also sets out plans for the creation of a working group with representatives from all localities, with responsibility for developing a joined up, seven-day urgent care system, with centres and services to meet the needs of local communities.

4. Greater use of technology

Through implementation of our IM&T strategy and local 'digital roadmap', we will work to provide secure access to patient records for clinicians and care workers, where and when they are needed and provide access for patients and their carers to their digital health records. We will also empower patients and their carers to take greater responsibility for their health through increased use of technology-based support tools and other on-line resources, including information on local services and support.

We will also look to extend the role of technology to support direct patient care, including on-line video consultations and e-consultation.

5. Estates

Our strategy describes how we will implement our five year Primary Care Infrastructure Plan. The Plan sets out where investment is anticipated to be made in either new or extended buildings to enhance the practice team and patient environment and to support modern healthcare.

The Plan is informed by evidence of future population growth and need as well as considering current provision, condition of buildings and existing schemes in various stages of development. In some cases, it may be beneficial for practices to look at shared premises to meet the needs of their local populations, but not in every case – it is very much dependent on a range of local circumstances.

Buildings will need to be developed in a flexible way to take into account future demand, new technology, and the bringing together of other community, care or leisure services.

6. Developing the workforce

This component is critical to the sustainability of primary care in Gloucestershire.

Our Strategy describes our approach to recruitment, retention and return of the GP workforce, the education and training of the Practice Nurse workforce and development of the 'skill mix' in primary care, including new roles to support current professionals in providing care.

Moving forward

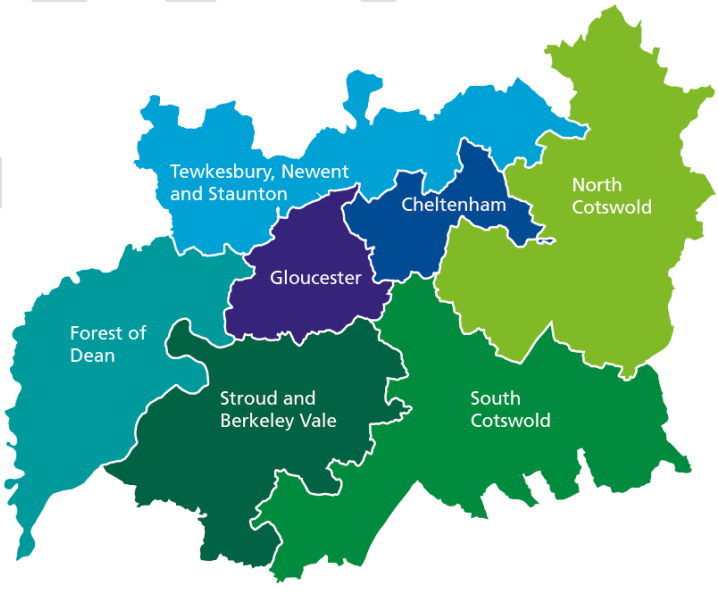
A resilient, sustainable primary care that can adapt to the current and future needs of our patients is central to our ambitions for the whole of the Gloucestershire healthcare system.

Our commitments against the six components will be resourced appropriately and we will provide clinical and managerial support to achieve them.

We will now develop detailed action plans and through this Strategy we have described our approach to engaging and working closely with patients, member practices, the Local Medical Committee, our providers and community partners to move things forward and make this strategy a reality.

Gloucestershire CCG Primary Care Strategy 2016 - 2021

Part 1: Setting the Context



Foreword by our Clinical Chair

I welcome and support the development of this Primary Care Strategy because, being both a clinical leader of our membership organisation as well as a Gloucestershire GP, I recognise the significant difficulties and challenges facing primary care in Gloucestershire, as well as the opportunities we have within our grasp. I also recognise that having recently taken over the responsibility for the commissioning of primary care from NHS England, as a CCG we need to create a clear vision for the future and a plan for how to achieve our vision.

We are serious about change, not for the sake of change itself, but in order to deliver the vibrant, sustainable, high quality primary care service that we all aspire to and that the population of Gloucestershire deserve.

From my own personal experience, and talking to my primary care colleagues, it is clear that many of us are feeling the strain that the increasing workload is placing on us all and the impact this is having on our ability to provide the highest quality care for our patients.

I recognise too that providing great care comes down to a combination of many variables, some of which are complex and out of our control. However, we do know that variation does exist and that we can take steps to reduce that. The CCG is committed to supporting our member practices to do this through the delivery of the vision included within this paper. This vision was developed from the countywide sessions where we collectively discussed the future of primary care in Gloucestershire.

There have been many national documents released over recent months and years regarding the future of primary care. The seismic shift though that has been felt since the release of the NHS England Five Year Forward View cannot be ignored. Our intention has been to read and listen to the evidence and examples from elsewhere, but in my role of clinical lead for this work, ensure our Gloucestershire primary care strategy is right for our practices and, more importantly, for our patients.

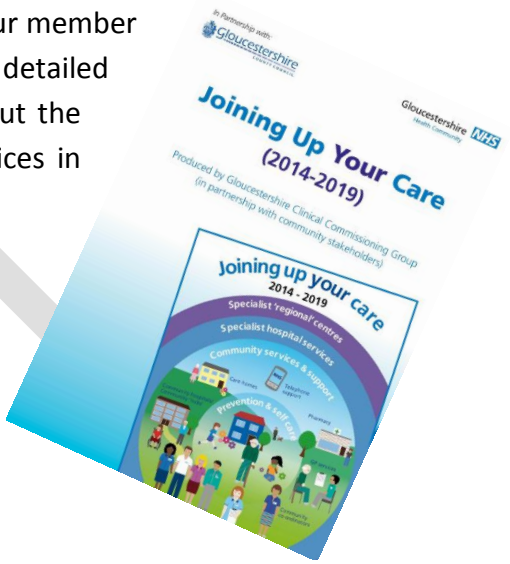
Dr Andy Seymour

Clinical Chair – Gloucestershire CCG

Introduction

This Strategy has been developed for our practices and health and care community partners to set out our vision and plans for Primary Care[1] in Gloucestershire over the coming five years. Accompanying this Strategy is a 'short guide' for our patients and the public.

Following extensive engagement with strategic partners including our member practices, the public and our staff, Gloucestershire CCG developed a detailed five-year strategic plan - Joining Up Your Care (JUYC) - that sets out the future shared vision for the development of health and care services in Gloucestershire:



"To improve health and wellbeing, we believe that by all working better together - in a more joined up way - and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to all local people".

Our analysis of the impact of demographic growth demonstrates that if the pattern of health and care provision stays the same, the demand on existing health and care services for our population will significantly increase. In order to live within our means, our approach to the delivery of healthcare in Gloucestershire will need to be transformed. Close collaborative working with our local providers, including primary care, to develop and implement new service models and pathways will be central to ensuring success.

The challenges facing Gloucestershire include:

- Rising life expectancy means that the population aged over 65 is increasing rapidly, more so in Gloucestershire than England as a whole. This growth is increasing fastest in the oldest age sub-group; those aged 85 and over;
- As life expectancy increases, so will the number of people who will live with one or more long term health condition that limits their lifestyle. In Gloucestershire it is estimated that 47,500 people over the age of 65 are living with a long term health condition. This is projected to rise to 77,000 by 2030;

[1] Primary Care is the first point of contact for many people accessing health care services, and this Strategy relates to those services provided by general practice.

- Compounding the issue of an ageing population, disparities in deprivation across the county are mirrored in health outcomes - rates of premature mortality from CVD, respiratory disease and some cancers are correlated with deprivation across districts;
- This increased demand will not be matched by the funding required to meet it, which means health and social care in Gloucestershire is facing a significant financial gap if we don't make considerable changes to the way we deliver services;
- A key part of our approach will be moving away from episodic models of care delivery to integrated care pathways focussed on 'end to end' care delivery across providers that make the best use of technology and skills to reduce inefficiency in our health systems.

Listening to and learning from patients' experiences

Our patients are at the front and centre of everything we do. We want to listen and learn from their experiences.

We have used this feedback from our patients to help shape this Strategy, ensuring we constantly strive to address the issues highlighted and continue to improve the experience of primary care for our patients.

As commissioners we have access to a range of collective patient feedback about experience of primary medical services: regular national surveys, Patient Advice and Liaison Service (PALS) contacts, Friends and Family Test (FFT) and comments collected reactively and proactively by Healthwatch Gloucestershire. Practices themselves have access to individual patients and carers experiences and gather further feedback from their patients in many ways, often now in collaboration with the Patient Participation Groups (PPG).

How do patients provide feedback and what do they tell us?

There are many ways in which patients can provide feedback on their experiences. There are several examples below:

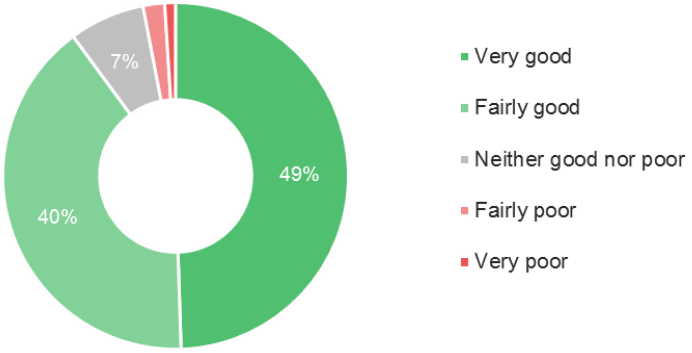
National GP Patient Survey

It is good to see that in the most recently published national GP Patient Survey results (July 2016), practices in Gloucestershire continue to perform better than, or in line with, the national CCG average. There is nevertheless practice variability hidden within that overall level achievement. The full details are included at Appendix 1.

The overall results are well summarised by the following question:

Overall, how would you describe your experience of your GP surgery?

CCG's results



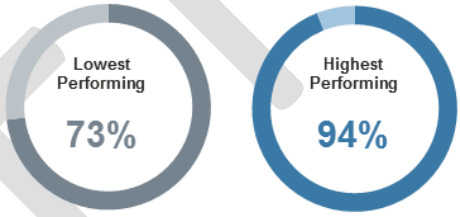
National results

85%
Very or Fairly Good

5%
Fairly or Very Poor

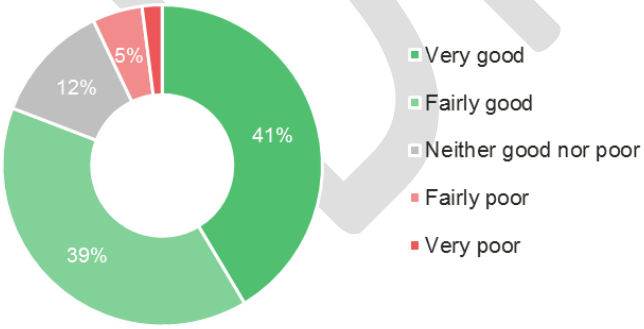
Practice range in CCG – % **Good**

Local CCG range – % **Good**



In these GP Patient Survey results, experience of making an appointment at practices in the Gloucestershire CCG area overall perform better than, or in line with, the national average, with 80% reporting a positive experience compared to a national average of 73%.

CCG's results

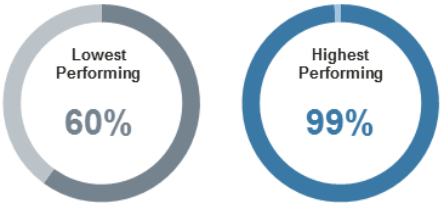


National results

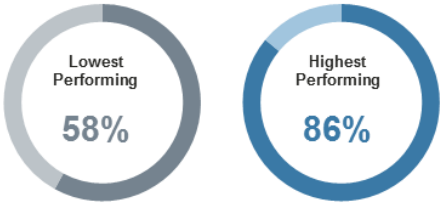
73%

12%

Practice range in CCG - % **Good**



Local CCG range - % **Good**



The CCG will continue to promote the national GP Patient Survey and encourage practices to discuss their individual practice results with their Patient Participation Groups (PPG) to identify areas for local improvement and action.

Friends and Family Test (FFT)

The Friends and Family Test (FFT) is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

Healthwatch Gloucestershire

In March 2015, Healthwatch Gloucestershire published the results of a survey they had conducted which asked the question: "Good Practice: GP Services in Gloucestershire - What do patients want?" The report provides a lot of detail and can be found on the Healthwatch Gloucestershire website at: http://www.healthwatchgloucestershire.co.uk/News/Healthwatch_Gloucestershire_publishes_report_on_GP.aspx?page=56455

Highlights include:

- *85% rated their GP surgery good or very good, 11% neither good nor poor, 3% poor or very poor, and 1% did not reply.*
- *79% were happy overall with the service they receive from the GPs at their surgery, 4% are not, 16% said it depends on the GP and 1% did not reply.*

Respondents to the survey were asked to suggest improvements and the five most common suggestions were as follows:

> *being able to get an appointment sooner; longer opening hours (e.g. Saturdays or evenings); improved waiting room (e.g. more welcoming or better lighting); better attitude from receptionists (e.g. friendlier or less intimidating); and being able to see their own GP or a GP of their choosing (e.g. within a reasonable timescale)*

Every three months, Healthwatch Gloucestershire produces a summary of feedback it has received. During 2015/16 the majority of positive feedback about GP services related to the standard of care provided by GPs. However, common concerns, which were repeated throughout the year, related to:

- Long waits to get non urgent GP appointments, especially with a named GP
- Access to surgeries when they are relocated
- Unable to make GP appointments at the desk in some surgeries
- Access to GP services by seldom heard groups e.g. homeless young people, ethnic communities, sensory impaired

- Availability of evening or weekend appointments at some GP surgeries
- Concerns over the impact of proposed housing developments on GP resources
- No evening or weekend appointments at some GP surgeries
- Receptionists asking personal questions in a public place
- Concerns over inadequate GP cover in some localities/surgeries
- Long waits holding on the telephone line

Improving access to services

As shown above, in all respects, improving access to services remains the top of the list in feedback from patients.

Access relates not only to timely booking GP and nurse appointments, particularly for a named GP, at convenient times for patients, but also to practice telephone response times, ability to book appointments in person, access to information, geographical and physical location of practices and concerns regarding population growth due to new homes developments.

In this Strategy we set out the commitments we are making over the coming five years to deliver our vision for primary care in Gloucestershire. We also describe how we hope our patients will feel. In response to patients' feedback a key component of this Strategy is **Access to services: evening and weekends, flexible to meet patients' needs**. If we are able to deliver this commitment, we want to hear that:

> *"they are easily able to access the right person at my doctor's surgery to care for me in a way, and at a time, that is convenient to me."*

Clearly 'access' is not the only subject patients comment upon, and other aspects of experience such as premises, use of new technology and treatments and more joined up services have for example recently been subject to debate with PPGs and others. These components, alongside access to services, are discussed in more detail within this Strategy.

Our Vision

Extending the role of primary care is vital for the successful delivery of our shared vision (see page x). As described within the 'National Context: Policy' section below, the health and care community in Gloucestershire has developed a five year Sustainability and Transformation Plan (STP), building on the existing JUYC strategic plan. This Primary Care Strategy is a key 'system enabler' for the ambitions set out within the STP.

By leading the way in being in the first tranche of CCGs to take delegated commissioning responsibilities for primary care services provided by general practices, we have already shown our commitment to commissioning across whole pathways of care and taking a joined up approach to primary care strategic development that is focused on the local context and local population needs.

Our vision for primary care, as a membership organisation, very much builds on the strong foundation of good primary care services already in place across the county – as demonstrated by our patient ratings (see above) and that all of our practices inspected by the Care Quality Commission (CQC) and reported to date have been rated either good or outstanding.

Our vision is focused on, firstly, maintaining but then improving health outcomes for patients in what is a challenging time for primary care nationally and locally. In a time when practices are closing nationally at the rate of almost one a day, we want to build a sustainable primary care in Gloucestershire that is high quality, safe and providing an extended primary care service that delivers more care locally for patients. Our vision also includes the feedback we received in our countywide sessions with practices in September and November 2015, where GPs and their staff shared their views of where they would like to see primary care in the future.

Delivery of the vision will result in a strong, resilient, primary care that, as the start of most patients' journey through health and social care, will be responsive to need and help more patients to receive care out of hospital.

Our Gloucestershire Primary Care Vision

So patients in Gloucestershire can **stay well for longer** and receive **joined-up out of hospital care** wherever possible, we need to have a **sustainable, safe and high quality** primary care service, provided in **modern premises** that are fit for the future.

To do this, we will:

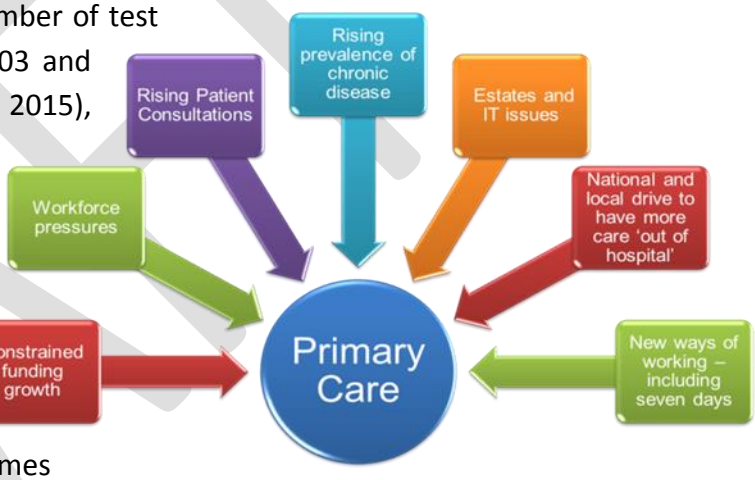
- **Attract and retain the best staff** through promoting Gloucestershire as a great place to live and work, and offering excellent training opportunities;
- Ensure **good access** to primary care **7 days a week**;
- Create a **better work-life balance** for primary care staff;
- **Maximise the use of technology**;
- **Reduce bureaucracy**;
- Support practices to explore how they can work closer together to provide a **greater range of services** for larger numbers of patients

National Context: Overview

Across the country, the NHS is facing significant challenges. Rising life expectancy has been a fantastic achievement for the NHS, but as life expectancy continues to increase, so does the number of people who will live with one or more long term health conditions that limits their lifestyle. The Department of Health estimates that by 2018, there will be 2.9 million people with three long-term conditions (from 1.8 million in 2012), and their health care will require £5 billion additional expenditure (Department of Health, 2012).

"If general practice fails, the whole NHS fails"
BMJ, 2016

With an estimated 90% of all patient contacts with the NHS occurring in general practice, these challenges are inevitably being encountered within our practices in Gloucestershire. For example, the rise in complex patients has meant that the number of test results dealt with by practices tripled between 2003 and 2013 (Primary Care Workforce Commission, 2015), consultations have increased significantly (Health and Social Care Information Centre (HSCIC), 2009), the GP workforce has decreased (HSCIC, 2014) and investment in premises has been insufficient (BMA, 2014). This is all set against a backdrop of general practice funding as a share of NHS spending reducing since 2005/06 (HSCIC, 2012) resulting in individual GP incomes experiencing a real-terms fall (Dayan et al., 2014), creating increasing sustainability and resilience issues.



Two of the most fundamental issues nationally and locally relate to workforce and funding:

Workforce pressures

During the period 2006-13, the total GP workforce rose by just 4%, while hospital and community services consultant numbers rose by 27% over the same period. In addition, the crisis is set to worsen:

- A large number of GP retirees within the next five years - 54% amongst over 50 year olds (Dayan et al., 2014)
- A lack of new medical students entering the profession with more than one in ten slots for new GP trainees unfilled (BMJ Careers, 2014);
- Health Education England reporting only 40% of medical students chose general practice (Health Education England, 2014);
- A significant proportion – 33% - of general practice nurses are

due to retire by 2020.

At the same time, there has also been a shift from a predominantly GP Partner role to working as salaried employees.

Constrained funding growth

It is well recognised that spending on primary care as a % of overall healthcare spend has been reducing year-on-year since 2005/06 (HSCIC, 2012), with the majority of growth directed towards acute hospital care. However, what is less well publicised is the relationship for GP practices between earnings, expenses and their resulting income. As GP practices are independent businesses, they require sustainable income in order to fulfil expenses, maintain staff and services, invest in their businesses and have sufficient remaining funds to pay their partners an income.

The combination of all these factors is threatening the sustainability of services and employment of staff, resulting in a crisis in general practice. Without taking mitigating actions, this crisis will inevitably impact upon patients.

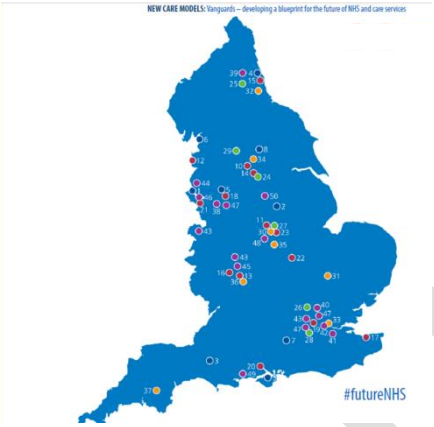
The national pressures described above are well documented and have been discussed at length by many papers, which go on to put forward potential solutions. For the purposes of creating the Gloucestershire Primary Care strategy, these papers have been reviewed and the key common strategic themes that emerge are summarised by the author of this Strategy in Annex One below.

National Context: Policy

The Five Year Forward View (FYFV), published October 2014, set out a new roadmap for the NHS. While setting out a whole range of changes, primary care is prominently placed:

> *"The foundation of NHS care will remain list based primary care"*

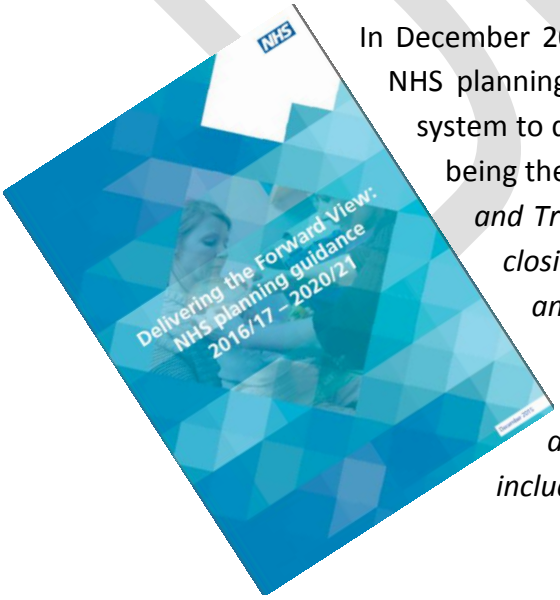
The FYFV points out that England is too diverse for one care model, instead that models such as Multispecialty Community Providers (MCP) and Primary and Acute Care Systems (PACS) should be pursued.



In early 2015, the Vanguard Programme commenced, with these new emerging models of care being tested within 50 sites across England, including:

- Nine PACS
- Fourteen MCPs
- Six enhanced health in care home pilots
- Eight urgent and emergency care schemes
- Thirteen acute care collaborations

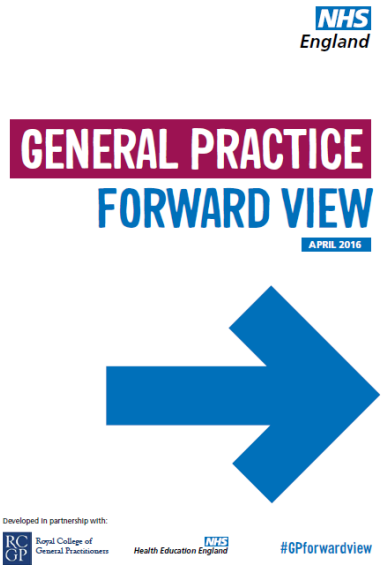
More details on the Vanguard Programme can be found at: https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/



In December 2015, NHS England published "Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21". This requires every local system to deliver nine 'must dos' for 2016/17, with the most significant being the requirements to "*Develop an agreed five year Sustainability and Transformation Plan (STP) that explains how the triple aim of closing the gaps in health and wellbeing, finance and efficiency, and care and quality will be achieved. This will be the mechanism for release of future transformational funding*": as well as to "*Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues".*

NHS England objectives that are relevant for our Strategy are summarised at Annex Two.

Even more recently, in April 2016, NHS England published the "General Practice Forward View". The document sets out a range of measures to support general practice, addressing the evidence presented by the British Medical Association, the Primary Care Foundation, the NHS Alliance and others – summarised within Table 1 on page 12 of this document. The document announcements include:



- Investing an additional £2.4 billion a year by 2020/21
- A further £0.5 billion of non-recurrent STP investment
- A practice resilience programme
- A range of workforce measures:
  - Double growth rate of workforce
  - Support for doctors suffering burnout
  - An extra 1,500 clinical pharmacists for practices
  - Practice nurse development and return to work
  - Practice manager development
  - Piloting medical assistant roles
  - 1,000 new physician assistants
  - 3,000 new mental health workers
- Supporting new models of care

Within the headline £2.4 billion increase by 2020/21 is £900 million for capital investments over the next five years and £500 million for funding additional capacity, including seven-day services. In addition, CCGs are also expected to find additional funding for primary care through shifting services – and therefore funding – from acute to primary and community settings.

The document also:

- Announces a risk-based approach to Care Quality Commission (CQC) inspections, with those practices rated as 'good' or 'outstanding' only being inspected at five year intervals, while practices where the CQC has concerns may be revisited sooner. New care models, such as federations and super-partnerships, will have a streamlined offer.
- Describes new legal requirements in the NHS standard contract for hospitals that will reduce workload on GP practices, such as preventing hospitals from re-referring patients back to their GP due to outpatient non-attendance;
- Brings a significant focus to the greater use of technology to enhance patient care and experience, and streamline practice processes. For example, more funding for practice IT systems and to stimulate uptake of online consultations, actions to support a 'paper-free' NHS by 2020, online support to patients to encourage more self-care, a focus on IT interoperability to support collaborative working and the availability of WiFi in practices;
- Previews:
  - A future announcement in 2016 on reducing the impact on general practice of rising indemnity costs;

- A set of key indicators to measure general practice quality to be published in July 2016;
- A new national programme - launching in September 2016 - to help practices support people living with long-term conditions to self-care;
- A review of the Quality and Outcomes Framework (QOF) with the General Practitioners Committee (GPC) to explore a potential alternative;
- New rules - from September 2016 - to enable NHS England to fund up to 100% of premises development costs, rather than the current 66% cap;
- A £30 million three year programme: "Releasing Time for Patients", which will support implementation of 'Ten High Impact Actions' (see below).

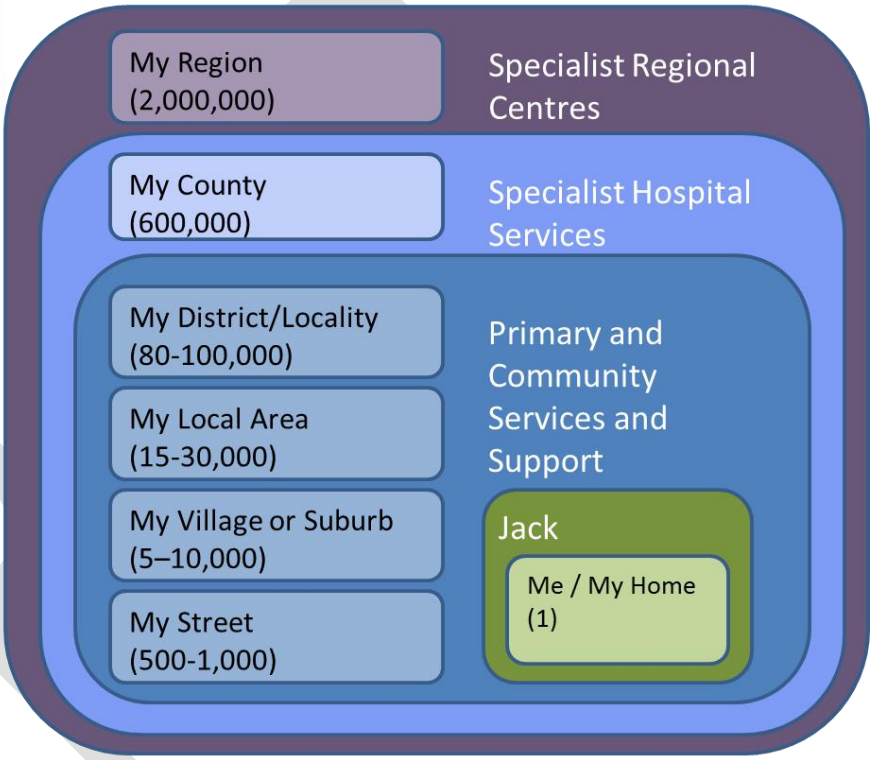
Figure 6: Ten High Impact Actions, General Practice Forward View, NHS England 2016

Local Context

Strategic

In developing the five year strategic plan – Joining Up Your Care – in 2013/14, the CCG wrote a clear narrative called 'Jack's Story' showing how we will work to join up services for patients so there are only seamless transitions of care, with a focus on supporting patients to stay at home or in their communities. We have continued to build on this approach, with the Gloucestershire community now adopting a 'People and Place' model for planning and delivering care locally, building on natural communities and geographies.

Services modelled around a place / population perspective building on Jack's Story

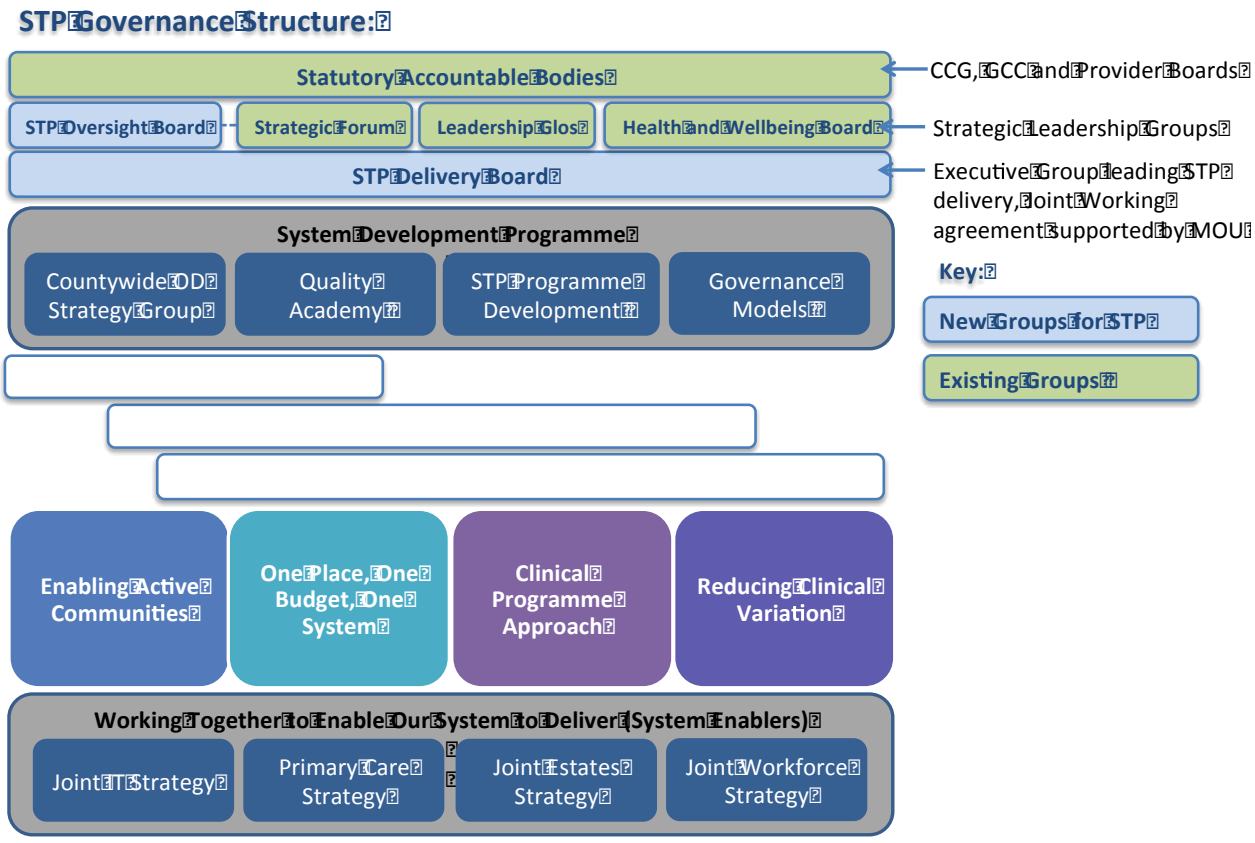


The People and Place model has been developed with, and supported by, the Gloucestershire Strategic Forum (an Chief Executive and Chair-level Group of all the commissioners and providers) and underpins the Gloucestershire devolution proposals (see www.weareglos.com), which have at their heart developing vibrant communities within which to work, invest, as well as live. Primary and community services are therefore at the core of our local service offering, demonstrating the CCG's commitment to out-of-hospital care – with Primary Care very much a core component.

As a CCG we have just finished the development of our STP for 2016 – 2020, covering the whole of Gloucestershire and led by our CCG Accountable Officer. During 2015/16 the CCG has been working with our partners through the Gloucestershire Strategic Forum to develop a system-wide

strategic transformation plan, which sets out our system response to how we will close the three gaps (Health and Wellbeing, Care and Quality, Finance and Efficiency) in Gloucestershire.

The diagram below sets out the leadership and governance we have agreed across Gloucestershire's partners for the delivery of the STP, along with the key STP work programmes:



As can be seen above, this Primary Care Strategy is a 'System Enabler' to delivery of the STP ambitions and therefore is crucially important across the whole system in delivering improved health outcomes for patients. Primary Care is a key component of the new models of care delivery under our "One Place, One Budget, One System" approach, handling 90% of all patient contacts. For this reason, Primary Care will be fundamental in the delivery of our objectives.

Local Geographic and Demographic Context: Gloucestershire

As at the end of December 2015, there are approximately 635,000 patients registered with a Gloucestershire GP. They are served by 81 GP practices across our county, creating an average registered list size of 7,716 (which compares to a national average of 7,292 (HSCIC, 2015)). However there is a wide variation in practice list sizes, ranging from 2,700 patients up to almost 24,000.

Our Health and Care Community includes a single acute provider (Gloucestershire Hospitals NHS Foundation Trust), a single community provider (Gloucestershire Care Services NHS Trust), a single mental health provider (2gether Foundation Trust), various specialist services providers and one local authority (Gloucestershire County Council), along with representation from borough, city and district councils and Healthwatch Gloucestershire (the consumer champion for health and social care in the county). There are also a number of other NHS service providers within the county (such as the South West Ambulance Service Trust), a number of private providers who offer NHS services and an extensive voluntary and community sector.

In Gloucestershire there is already a significant proportion of the population aged over 65 years; 20.1% of our population in 2015 were aged 65 or over (17.1% nationally), 9.2% aged 75 or over (7.8% nationally) and 2.8% aged 85 or over (2.3% nationally) (Public Health England, 2016).

As life expectancy increases, so will the number of people living with a long term condition that limits their lifestyle, such as dementia, heart disease and respiratory problems. As a consequence of these current demographics, and the projected changes over the next five years, increasing pressure is being felt right across the health and social care system. This is seriously impacting primary care across Gloucestershire, with not just rises in consultations but also patients requiring longer appointments with multiple conditions for chronic care planning and management.

Around 124,000 people in Gloucestershire are aged under 18. Although this is a lower proportion of the population than the national average, there are areas of the county with higher proportions, particularly Gloucester and Stroud. The population of under 18 year olds is expected to increase over the next 20 years, but not as significantly as the older population.

Over recent years, the number of babies being born with complex needs has increased significantly, and these babies are living for longer. Across England there are more under 18 year olds who are classified as obese or overweight; in Gloucestershire the greatest issue is with 4-5 year olds. There

are issues too with young people's mental health - growing numbers are being admitted to hospital as a result of self-harm. All these issues impact on the all parts of the system, including primary care teams, who are not only caring for the baby/child/young person, but also their families.

This is but a brief overview of the macro level demographics for Gloucestershire. Our 81 practices are organised into seven distinct GP localities, each of which have their own unique challenges and opportunities owing to the geographic and demographic diversity within Gloucestershire, which we will explore in the next sub-section.

Local Geographic and Demographic Context: Localities

While our county is predominantly rural, the population is concentrated in our urban neighbourhoods, Gloucester City and Cheltenham. Gloucestershire Hospitals NHS Foundation Trust has their two district hospitals located in these two urban centres, while Gloucestershire Care Services operates community hospitals in: Forest of Dean, North Cotswold, South Cotswold, Stroud & Berkeley Vale and Tewkesbury. Consequently, urban patients make greater use of the Emergency Department, while rural patients utilise the Minor Injury and Illness Units. The wide disparities in population density across our county pose challenges in the location of services to ensure accessibility and viability.

Notably over a third of Lower Super Output Areas (LSOAs) – i.e. defined geographical areas - in Gloucestershire are classified as among the worse 20% nationally for geographic barriers to services, with the highest number in Cotswold, Stroud and Forest of Dean.

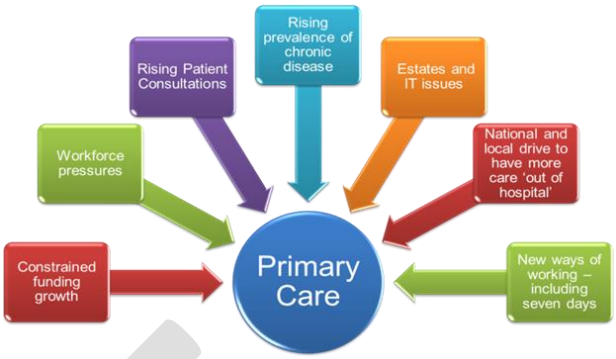
We also have eight of our LSOAs, all in Gloucester and Cheltenham, classified amongst the worse 10% nationally for 'health deprivation and disability'.

So it is clear we have some countywide issues to consider, notably an ageing population with increasing long-term conditions. We also need to be very conscious in our planning of the health inequalities that are presented by our geography and demography within our rural and urban areas. Annex Three contains a summary of these factors by each of our seven localities.

Local Primary Care Challenges

As per the national pressures discussed earlier, GP practices in Gloucestershire are feeling these same challenges.

The second part of this Strategy sets out how we intend to respond to these pressures. The rest of this sub-section describes how some of these pressures are manifesting in Gloucestershire, in particular related to workforce, estates and IT:



Workforce pressures

In 2015, the Royal College of General Practitioners named Gloucestershire as one of the top ten areas nationally requiring the greatest increase in numbers of full-time GPs by 2020 (105 additional GPs, a 31% uplift).

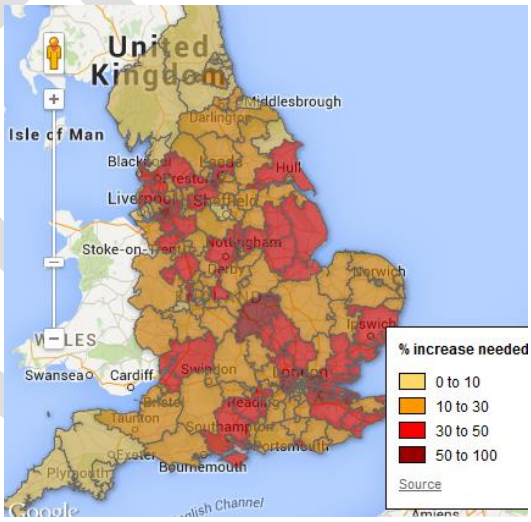


Figure 9: Percentage increase in GPs required by GP by county (source: RCGP, 2015)

In late 2015, the GCCG Primary Care and Localities Team undertook a short survey of our practice members. 78 of our 81 practices responded, with the headline findings as follows:

Gloucestershire GP practice responses		
Does your practice have any GP vacancies?	31 practices	40% of all responses
Partner vacant sessions*	146	42 due to long term sickness
Salaried vacant sessions	49	
Any planned GP retirements?	44 practices	56% of all responses
Total known retirements	57	

** Not all practices confirmed number of sessions, therefore 8 sessions assumed where unstated*

A similar picture of a more mature workforce is clear for our practice nursing team too. As published by Health Education England in April 2016, almost 30% are over the age of 54 and less than 9% are under the age of 35.

With regards to GP locum cover, 56 practices (72%) reported difficulties securing locums, thereby only exacerbating the problems of resilience. Some practices who are particularly struggling with locum cover rely on agencies and reported escalating costs.

Estates issues

Recognising the importance of Estates and the under development Primary Care has been subject to (locally and nationally), Gloucestershire CCG commissioned a "six facet survey" of our primary care estate. This survey, which is aimed at helping to inform maintenance programmes and future strategic investment, provides a standardised set of core information and comprises of six separate surveys: a physical condition survey, a functional suitability review, a space utilisation review, a quality audit, a statutory compliance review, and an environmental management review.

Primary Care services in Gloucestershire are currently provided across 108 buildings. There are 73 main buildings for the 81 practices, and a further 35 branch locations (although some practices operate more as split sites).

On current registered list sizes, 90% of our practices are in buildings smaller than current recommended sizes. Almost a quarter of practices are in buildings significantly smaller. When considering future population growth until 2031, the proportion of practices in buildings significantly smaller increases to a third.

Current Primary Care Commissioning Methodology

As a CCG, we recognise the importance of strong, resilient, good quality primary care services. We therefore took the opportunity to be one of the first CCGs to take delegated commissioning responsibilities for primary care services from April 2015. Further details of what we now commission and how we commission, can be found below at Annex 4.

Creating a Plan

We have seen so far in this Strategy how the national challenges in primary care are very much reflected at a local level within Gloucestershire. We will now go on to describe how, over the next five years, the CCG will work with practices and other partners to ensure we *"have a sustainable, safe and high quality primary care service, provided in modern premises that are fit for purpose".*

Gloucestershire CCG Primary Care Strategy 2016 - 2021

Part 2: Our Plan for the Future

Key Strategic Components

As can be seen from the national and local evidence, staying the same is not an option. At the Primary Care Strategy event in November 2015, and the locality events that followed, this same message came across from our members, with common themes raised across the county:

Themes from our Primary Care Strategy Event
Focus on ensuring sustainable services, with primary care being an attractive place to work
Joined-up care across services and working within Multi-Disciplinary Teams, supported by a single IT platform
Supporting each other to provide primary care 'at scale', including 8am-8pm services, whilst retaining sense of practice autonomy/identity
Providing a greater focus on prevention/education
Maximising continuity of care between individual patients and individual GPs, especially for those patients with long term conditions
Delivering services from modern premises, fit for the future

We are committed to our member practices thriving as sustainable organisations; this is evident from 'Our Gloucestershire Primary Care Vision" described earlier:

We will support the diversification of new models of primary care in Gloucestershire, recognising one size will not fit all, while "not allowing a thousand flowers to bloom" either. Therefore, we have developed the following key six strategic components, which align to those contained within the 'General Practice Forward View' (April 2016):

Our Six Strategic Components

In the next set of sub sections, we will look at each of these six components in turn.

Component 1: Access

In Gloucestershire we have already made good progress in improving access within primary care (see below); however our patients have told us we can do more in a drive to improve our out-of-hospital care offering to our patients.

NHS England GP Access Fund

Working with the CCG, GDoc were successful in a bid for the second wave of the GP Access Fund (formerly called the Prime Minister's Challenge Fund). The largest workstream within the agreed programme was for the 'Choice+' element, where additional appointments are provided both in and out of hours. This has delivered:

- Offering in excess of 5,000 additional appointments per month across primary care, with at least one dedicated site in each locality;
- Appointments have been offered during evenings and weekends, thereby providing additional flexibility for patients;
- Doctor time freed-up from urgent appointments has been re-invested into longer appointments for those patients that require them, such as those with long-term conditions, to prevent exacerbations that lead to ED attendance or emergency admission.

With agreement from NHS England, Gloucestershire CCG will be holding an APMS contract with GDoc for continued delivery of this, and the other elements of the bid, during the first six months of 2016/17. It is likely though the funding will continue until at least March 2017.

Social Prescribing

Another significant scheme within the successful GP Access Fund bid was to expand and rapidly deliver our Social Prescribing pilot to cover the whole county. This scheme, one of the 'Ten High Impact Actions' for primary care (NHS England, 2016), helps to support practices manage demand for those patients that have broader, non-medical, needs that can be better managed by a more appropriate voluntary or community service.

Gloucester Health Access Centre

As mentioned earlier (see page X), Gloucester Health Access Centre (GHAC), in Gloucester City centre, is contracted to offer walk-in and booked on-the-day appointments 8am – 8pm, 7 days a week. This contract will cease in the Spring of 2017 and will therefore form part of the long-term planning considered within this Strategy.

GCCGs Strategic Commitments to 'Access':

Our strategic commitments to this component during the time-frame of this strategy, including full implementation across the county, are as follows. GCCG will:

- Commit to providing patients with extended evening and weekend access to primary medical care in Gloucestershire that is integrated across providers, easy to navigate and understand, and is commissioned on a 'place based' approach. We will do this by:
    - Evaluating the success of the Choice+ pilot across localities, determining the impact on the wider system – especially urgent acute care utilisation – and assessing patient and GP feedback;
    - Working with patients, practices, localities and our local providers to design the long-term models of care that will deliver our commitment. This will include the consideration of:
        - The assessment of the options for re-provision of the current GHAC non-registered patient service;
        - The evaluation of Choice+;
        - GP extended hours locally commissioned service;
        - The overlap between services and how they can be integrated, commissioned and provided, including but not limited to: MIIUs, Out-of-Hours and Choice+;
        - Triage of patients directly to the most appropriate service or professional within the practice;
- Stimulate and pursue continued implementation of the 'Ten High Impact Actions' for general practice, releasing time for patients;
- Secure sustainability of our member practices in order to provide a strong platform from which to deliver our long-term aims.

It is likely that the final design will differ by locality, owing to diverse demographics and our 'placed-based' approach. However, the patient offer will be consistent. Furthermore, the final design in each locality will be dependent on the implementation of the other five key components of this Strategy, particularly the relationship of practices coming together to offer 'Primary Care at Scale', which is the component we will now consider in the next sub-section.

Component 2: Primary Care at Scale

As we have seen from the national evidence, there is an increasing trend towards delivery of primary care at scale, with the traditional small GP partnership model often recognised as being too small to respond to the financial and demographic challenges facing the NHS. By 'Primary Care at Scale' we are referring to practices working together to create more sustainable services delivering the highest quality care.

Primary care operating at scale could result in:

- Increased local services for patients that mean they can be seen and treated within their practice or local community rather than their local hospital;
- Improved financial sustainability for practices through delivering more services along with rationalisation of some back-office functions and reduced duplication of work;
- Reduced management responsibilities for partners as the load is spread amongst more;
- Increased resilience in primary care, such as through additional staff in-house providing the ability to more easily flex to cover absence;
- Improved work-life balance for primary care staff;
- Increased practice staff satisfaction and learning opportunities through offering a more diverse range of services.

As can be seen from our list of practices at Appendix 2, Gloucestershire CCG currently has three single-handed practices and a host of other practices with just two partners. In 2015, we had two practices give notice on their GMS contracts, two practices requiring short-term list closures, three practices closing branch surgeries and a further two practices applying to reduce their boundaries. In addition, as demonstrated earlier, we also have a growing workforce crisis in Gloucestershire that is impacting the ability of our practices to recruit and retain staff.

Nationally, we have seen the Vanguard programme supporting the emerging Multispecialty Community Provider (MCP) and the Primary and Acute Care System (PACS) models, where primary care comes together to work at scale and work with either community services and/or acute hospitals so that GPs are at the centre of integrated care delivery. In some cases, this has involved some of the 'super-practices' that have established across the country, such as Vitality in Birmingham. Others are federations of GP practices, such as the MCP in Hampshire. Either way, the direction of travel is clear.

Furthermore, the Government has announced the launch of a new voluntary MCP contract for GPs in 2017, which is likely to be for groups of GPs delivering an extended range of integrated services across seven days for registered patients of at least 30,000. While fuller details are yet to be announced, it has been suggested that only those GPs "most ready" will be considered eligible, with those providers holding a single whole population budget for the breadth of services it provides.

In 2015, the National Association of Primary Care (NAPC) – with the backing of NHS England – launched the 'Primary Care Home' initiative. It is a form of the MCP model with key features such as:

- Provision of care to a defined, registered population of between 30,000 and 50,000;
- Aligned clinical financial drivers through a unified, capitated budget with appropriate shared risks and rewards;
- An integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care;
- A combined focus on personalisation of care with improvements in population health outcomes.

While these are different initiatives, the narrative is a repetitive one: sustainability and resilience of primary care fit for the future, which is working as part of an integrated team of multi-specialists for a defined population of at least 30,000, needs to be working collaboratively at scale and focusing on better population health management. However, the essence of local primary care, care continuity and preservation of "family medicine" is very important to us.

We recognise there are a wide range of practical implications of practices coming together 'at scale' to deliver more services, for both practices and patients alike, such as IT, contractual, estates and patient transport issues. We will seek to understand these impacts in more detail and address them within our next phase of planning.

GCCGs Strategic Commitments to 'Primary Care at Scale':

Our strategic commitments to this component during the time-frame of this strategy are as follows. GCCG will:

- Set up a Provider Clinical Leadership development group, with leaders identified in each of the seven GP localities, which will form the basis of primary care representation on the newly established "New Models of Care Board" as part of the "One Place, One Budget, One System" Programme that reports to our Sustainability and Transformation Plan (STP) Delivery Board.
- Develop and deliver a programme of clinical leadership training, incorporating formal training, peer support and mentoring from existing General Practice leaders.
- Develop the skills that are needed for future General Practice leadership, for GPs, practice nurses and practice managers, including:
    - Creating time and space for innovation;
    - Utilising effective business and project management skills to improve efficient operation of General Practice, especially when operating at scale;
    - Seizing opportunities for closer collaboration;
    - Design and delivery of new, extended primary care services that brings more care closer to home and out of hospital for our patients, recognising the diverse demography and health needs of Gloucestershire's population, including diagnostics, rehabilitation, mental health, therapies and outpatients;
- Work with practices to support them through merger or federation conversations;
- Support localities in developing their 30,000+ provider models, with appropriate patient engagement, managerial, informatics and finance support, on their journey to an MCP (or PACS) model holding a whole population budget for the services it provides including primary medical and community services.
- Provide information and intelligence, inclusive of public health needs assessments, to inform a place-based approach that reduces health inequalities and improves patient health outcomes for the 30,000+ populations.

Component 3: Integration

Working alongside acute, community, and local authority colleagues, Primary Care has a pivotal role to play in the coordination and continuity of care for patients, a point that has been recognised in the Five Year Forward View, the design of the Vanguards and in the anticipated new MCP contract.

Component 3 then is about building on Component 2 – once Primary Care can form their 'networks' of 30,000 patients, they can then work with partners in providing place-based care for their patients in an integrated way. This is likely to involve:

- An extended team of GPs, nurses, allied health professionals and specialists offering easy access to a wide range of health and care close to people's homes;
- A range of current health providers working together under a contractual (e.g. Alliance) arrangement to improve health outcomes of the population;
- Provision centred around GP practices and primary care hubs;
- Support for populations based around a natural community;
- Promotion of self-care and prevention.

We need to remove the organisational and professional boundaries that are currently in place, those that prevent a joint focus on patient need. Furthermore we recognise that these boundaries not only create gaps in services, but also inefficient and unreliable transitions resulting in duplication and delays in patient care.

At the Primary Care Strategy events held by GCCG and the Localities in late 2015 and early 2016, there was a clear appetite from our members to be more involved in, or even leading, whole pathways of care, especially the urgent care agenda. Urgent care in Gloucestershire is currently confusing for patients, with an Out of Hour primary care service, Choice+, Minor Injury and Illness Units at our community hospitals and the Emergency Departments in Cheltenham and Gloucester, all potentially open at the same time, as well as the role of NHS 111 within the system; this potential duplication and confusion also creates a strain on the finite financial and skilled staff resources available to us.

There is also the appetite for change outside of Primary Care. Alongside rising demand, the NHS and local authorities are facing financial challenges on scale not previously experienced. There is growing recognition that the current inefficiencies in non-integration cannot afford to continue – for patients and the local NHS.

With this in mind, the Gloucestershire Strategic Forum (GSF), have been discussing how services can be integrated in the future and where the priorities should be (for example see Stroud and Berkeley Vale work – page X).

GCCGs Strategic Commitments to 'Integration':

Our strategic commitments to this component during the time-frame of this strategy are as follows. GCCG will:

- Work initially with a number of pilot localities, our providers and VCS organisations and all other stakeholders and partners to determine the:
  - Operational structures and changes required;
  - Legal and governance frameworks;
  - Delivery model;
  - Outcome and evaluation measures;
  - Timescales involved.
- Create a Primary and Community Urgent Care Working Group, with a locality lead representative from each locality, with the responsibility for developing an integrated urgent care model which could be implemented across all localities. This will include responsibility for:
  - Developing a 7 day urgent care system that works together to deliver the right outcomes and avoid unnecessary emergency hospital care;
  - Reducing duplication, under (and over) utilisation of each element of the system and eliminates fragmentation;
  - A single point of contact for accessing integrated urgent care and GP out of hours;
- Commit to rolling integration out to all localities to deliver place-based integrated care that makes sense locally for their population, consisting of integrated community based teams of GPs and physicians, nurses, pharmacists and therapists offering outpatient, diagnostics, geriatric care and other services locally.

Component 4: Greater Use of Technology

Information Management and Technology (IM&T) is without doubt a key enabling component of our 'New Ways of Working' and the delivery of this Strategy. There are many elements to this, including the internal GP clinical systems, interaction between different practices and their systems, interactions with patients, interactions with providers and contemporaneous access to information across the healthcare system. We do recognise though that not all patients have access to the internet and therefore throughout our IM&T strategy-related work, we are mindful to ensure patients are not 'digitally excluded'.

Gloucestershire IM&T Strategy

The Gloucestershire IM&T Strategy sets out a vision for Information and IT to be critical enablers of service change and improvement through:

- Secure access to records by every clinician / care worker, when and where needed, with clear opt-out and consent-to-view arrangements;
- Empowering patients and their carers to take greater responsibility for their own health / healthcare through the use of technology-based support tools, and enabling patients to view their own records;
- Commissioning decision-making that is well-informed and evidence-based, through access to knowledge, timely, high quality information and analytical tools;
- Exploiting innovative technologies where there is evidence of benefits.

The Gloucestershire IM&T 'Plan on a Page' can be found at Appendix 3. This has been reviewed to ensure delivery against the National Information Board (NIB) "Personalised Health and Care 2020" framework to action, which sets out the programmes that will help transform health and care services through data and technology:

1. Enable me to make the right health and care choices;
2. Transforming general practice;
3. Out of hospital care and integration with social care;
4. Acute and hospital services;
5. Paper-free healthcare and system transactions;
6. Data for outcomes and research.

One key underpinning element of the IM&T Strategy is the 'Joining Up Your Information' project:

Joining Up Your Information

The Joining Up Your Information (JUYI) project will help securely share important patient healthcare information across primary, community and secondary care, as well as mental health and social care teams on a read-only basis. This will include:

- Medication and any changes to it made by a clinician
- Medical conditions
- Operations/treatment received
- Contact details for next-of-kin and others involved in care
- Tests that GPs or hospital clinicians have requested or carried out
- Appointments (past and planned) and recent visits to out-of-hours GPs and minor injury and illness units
- Documents, such as care plans and letters about treatment (for example "discharge summaries" following a hospital stay).

Patient, carer and voluntary sector representatives have been involved in the project from the start, providing valuable insight into the best way to communicate JUYI to local residents. The project piloted sharing primary care information in a small number of practices and community teams in 2015/16 ahead of a wider rollout. A procurement process has been undertaken for the first phase of implementation. The intention is that a future phase of JUYI will enable patients to access their shared records. More information can be found at: http://www.gloucestershireccg.nhs.uk/joiningupyourinformation/index.php.

GP Access Fund

As well as creating the additional capacity within the Choice+ element of the bid, Gloucestershire also ensured maximising the use of technology was included in the programme.

Online Video Consultations

Utilising the internet (e.g. through Skype) - within an Information Governance compliant framework - some practices have begun piloting online video consultations with patients, where it is safe, appropriate and convenient for patients to do so.

E-consultation

Eighteen practices are piloting software, such as 'askmyGP', that is available from their practice website where patients can seek help through answering a series of questions about their

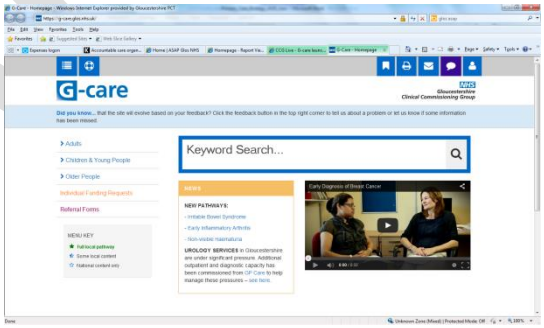
symptoms – on their smartphone, tablet or computer – which allows a much quicker triage by the GP practice and allows a decision to be made on whether to see or call the patient, and which member of the primary care team is best placed to support them.

ASAP – Health App - stands for **A**pp, **S**earch the website, **A**sk NHS 111, **P**harmacy.

The Health Community ASAP App and information campaign were launched in April 2015, particularly targeting adults of working age and parents of young children with advice on what to do if they are ill or injured and are unsure where to turn. The ASAP App and website allow users to 'Search by Service' or 'Search by Condition' – providing a step-by-step guide through symptoms, care advice and signposting to the appropriate NHS service/s. Users can also find opening hours, service locations and ED waiting times. Pharmacy is central to the campaign for treatment of minor ailments and signposting on to other NHS services when needed.

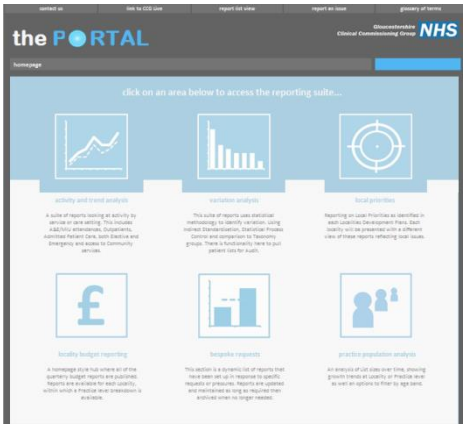
Further GCCG IM&T investment

G-Care



G-Care is a new Gloucestershire Clinical Pathways website that has been designed to support GPs and other front-line clinicians in providing access to Gloucestershire pathways alongside clinical guidance, video content, referral forms, patient leaflets and lifestyle information. The next stage of development will see a public facing version of G-Care.

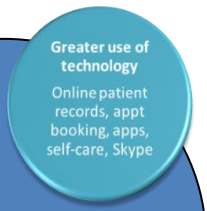
GP Portal



GCCG has invested in a talented Primary Care and Localities Information Team to improve information flow and provide GP practices with easily accessible activity information that enables them to examine and audit areas of variation which are material and unwarranted. In April 2016, 'the Portal' was launched, providing activity, trend and variation analysis that can be aggregated and disaggregated as required, with access for practices to their own patient data.

Other recent schemes at a glance

- We funded equipment in 2015/16 for practices to be able to work remotely, giving practice staff the opportunity to be able to take their laptops with them on patient visits.
- We have resourced a pilot of email consultations, supporting a practice in our South Cotswold locality to set-up a dermatology photo service with patients to test whether this enables patients to get a quicker clinical decision without the need to visit their GP surgery.
- Electronic prescribing has enabled patients to collect their fulfilled prescription directly from their pharmacy between 5 minutes to 2 hours after their GP consultation.

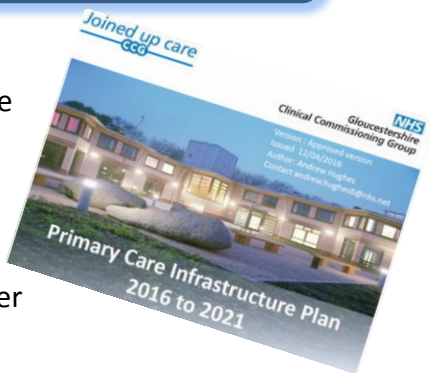


GCCGs Strategic Commitments to 'Greater Use of Technology':

Our strategic commitments to this component during the time-frame of this strategy are as follows. GCCG will:

- In the implementation of our Local Digital Roadmap and as part of our IM&T Strategy, we will improve clinical effectiveness, decision making and the health and wellbeing of the population through:
  - Moving towards a fully interoperable health and care system, connecting primary care with each other and all other providers.
  - 'Paper-free' at the point of care and available to all providers 7 days a week, with mobile working solutions for clinicians to access securely.
  - Access for patients (and their carers) to their digital health records.
  - Extending our online offering to patients, taking learning from our development of the ASAP app to bring more services to fingertips.
  - Utilising remote monitoring technology, building on the Telehealth, Telecare and health alerting systems already in place.
- Evaluate all the technological trials, funded either directly by GCCG or through the Prime Minister's GP Access Fund, for establishing which to mainstream across the county over the course of this strategy;
- Further invest in the development of 'the Portal', including funded variation audit work within practices as part of the Primary Care Offer;
- Implement the commitments within the General Practice Forward View, such as Wi-Fi within all our practices and accessing data on practice demand, activity and gaps in service provision by 2018. We will submit bids to the national Estates and Technology Transformation Fund to support this work;
- We will also bid to the Fund for supporting this Strategy, such as for 'Primary Care at Scale' and 'Integration', where practices require further interoperability for triage, websites, patient portals or self-care tools.

Component 5: Estates



Recognising the importance of our Primary Care estate to the ambitions of this Strategy and of our CCG, we have developed a five-year prioritised Primary Care Infrastructure Plan (PCIP). The PCIP sets out where investment is anticipated to be made in either new or extended buildings, subject to business case approval and available funding. The Plan reflects our strategic intent to deliver primary care at scale, where there is an opportunity to do so.

As at March 2016, there are a number of committed developments that reside outside of the prioritisation process as they are already approved:

Locality	Practice	Scheme
Cheltenham	Sevenposts Surgery	New build
	Stoke Road Surgery	Refurbishment and extension
Gloucester City	Churchdown	New build
	Hadwen Medical Practice	Refurbishment and extension
	Longlevens Surgery	Extension
	Rosebank Health	New build to deliver services to new population (Kingsway)
North Cotswold	Stow Surgery	New build
Tewkesbury	Church Street and Mythe	New build on Community Hospital site

The PCIP supports local implementation of the national multi-year £900 million Estates and Technology Transformation Fund, which recognises that sustainable GP practices require improved infrastructure in order to be able to deliver more out-of-hospital care. Our PCIP therefore provides the mechanism for prioritising Transformation bids.

For the purposes of prioritisation, the PCIP considers five strategic elements, relating to the current condition, functionality, specific and/or unique factors, current capacity and future capacity. Applying these criteria to the results of the six facet survey undertaken (see 'Local Primary Care Challenges' section in Part 1), the PCIP has set out eleven key strategic priority practice

developments (strategic groupings 1 and 2), which the plan assumes will be the minimum taken forward. These are:

Locality	Practice(s)	Scheme
Cheltenham	Berkeley Place, Crescent Bakery, Overton Park, Royal Crescent and Yorkleigh	New build for up to all five practices within one new development
	TBD	Development of surgery provision for the West / North West of Cheltenham due to new housing developments
Forest of Dean	Dockham Road and Forest Health Care	Replace the Cinderford Health Centre with a new facility for the two surgeries
	Coleford Health Centre	Replace with a new surgery building
Gloucester City	Gloucester City Health Centre	Replace with a new surgery building
	Brockworth and Hucclecote	A new build (or builds) to replace current surgeries and cover major population growth
South Cotswolds	The Park, Phoenix, St Peters Road, Avenue Surgery	With significant planned housing developments, a case for change exists for a new model of primary care with infrastructure requirements
	Romney House	Replace with a new surgery building
Stroud & Berkeley Vale	Beeches Green, Locking Hill, Stroud Valley Family Practice	Replace with a new surgery building to accommodate all practices
	Minchinhampton	Replace with a new surgery building
	Regent Street and Stonehouse	Review surgery provision in Stonehouse, particularly for these practices

GCCGs Strategic Commitments to 'Estates':

Our strategic commitments to this component during the time-frame of this strategy are as follows. GCCG will:

- Implement the Primary Care Infrastructure Plan (as found at Appendix 4) to undertake, as a minimum, the eleven key strategic practice developments as prioritised by the six facet survey.

Component 6: Developing the Workforce

In order to develop new ways of working within Gloucestershire, developing our workforce will be an absolutely critical component. This includes not only the continued development of our existing primary care workforce members, such as our GPs and practice nurses, but also the development of succession planning, growth planning and – importantly – the new roles required in Primary Care to deliver new, innovative approaches to patient care.

Following the commencement of delegated authority for Primary Care Commissioning in April 2015, GCCG set up a number of committees and structures to support this increased responsibility. This included the Primary Care Workforce and Education Workstream Group (see 'Primary Care Decision Making and Governance Structure' section on page X below). The purpose of this group is to drive forward projects to support the recruitment and retention of the Gloucestershire Primary Care workforce in the short, medium and longer term.

The Group, working closely with stakeholders such as its member practices, Health Education England (HEE) South West and the Gloucestershire LMC, has developed a draft Primary Care Workforce Plan that is focused on three distinct but related elements:

1. The recruitment, retention and return of the GP workforce using the structure of the GP workforce 10 point plan (BMA, 2015), but with local interpretation.

2. The education and training of the Practice Nurse workforce.

3. New skill mixes in primary care, with new roles to support the current primary care professionals in providing patient care. For example, physiotherapists working in practices to improve health outcomes for patients with musculoskeletal conditions.

GCCGs Strategic Commitments to 'Developing the Workforce':

Our strategic commitments to this component during the time-frame of this strategy are as follows. GCCG will:

- Implement the Primary Care Workforce Plan, as found at Appendix 5. A summary of the key actions we will be pursuing are detailed in the table below.

Workforce Plan	Headline developments	Summary of development initiatives
Recruitment, Retention and Return of the GP workforce	**Recruit**	
	1) Promoting Gloucestershire Primary Care	1) Significant investment with the British Medical Journal (BMJ) for the provision of advertising to support general practice in 2016/17 [www.beagpingloucestershire.co.uk]
	2) Setting up a Community Education Provider Network (CEPN)	2) Working with the West of England Academic Health Science Network (AHSN), our CEPN will support practices in promoting collaborative working in primary and community based roles.
	3) Training Gloucestershire Doctors	3) Reviewing the suitability of, and demand for, a Newly Qualified Doctor scheme to encourage GPs who train in Gloucestershire to practice here once qualified.
	Retain	
	1) Investment in GP Retainer Scheme	1) Partnering with HEE to support practices to become hosts for GP retainers and creating increased awareness of the scheme amongst GPs.
	2) Portfolio career for those considering leaving general practice	2) We will work to encourage GPs considering leaving general practice or retiring early to work in a different way in order to retain their skills and experience within primary care in Gloucestershire.
	Return	
	1) Returning GPs	1) We will assess the suitability of a local GP returner's scheme during 2016 and, if deemed viable, will introduce for Gloucestershire.
Education and training of the Practice Nurse workforce	1) Practice Nurse Facilitators	1) We have committed to recurrent investment in Practice Nurse Facilitators for our seven localities to support the development of Practice Nurses and the retention and expansion of the Practice Nurses workforce.
	2) Advanced Nurse Practitioners	2) We will fund the courses and backfill for five years for a number of Practice Nurses across our seven localities to undertake Masters-level modules to become Advanced Nurse Practitioners.

Workforce Plan	Headline developments	Summary of development initiatives
	3) Mandatory training	3) We will implement a consistent approach to mandatory training for Practice Nurses
	4) Practice Nurse education and training needs analysis	4) We will support practices in ensuring a standardised, high quality, level of skills across our Practice Nurse workforce, including a commitment to increase the number of practice nurses with long-term condition courses undertaken
New skill mix introduced in general practice	1) Social Prescribing	1) We will continue to support the Social Prescribing programme as a way of supporting both patients and clinicians to ensure people are seen by the right professional to meet their need.
	2) Practice Prescribing Pharmacists	2) We will provide additional support to the seven Gloucestershire practices who were successful in the NHS England scheme to employ Prescribing Pharmacists over the next three years. We will also provide funding for eight pharmacists to qualify as prescribers in 2016/17, 10 in 2017/18 and a further 10 in 2018/19, with the aim of providing a workforce capable of supporting more practices in future.
	3) Additional roles working in an integrated primary care	3) We will work with HEE to support new skill mixes in primary care, such as GP training for allied health professionals, nurses and paramedics. We will also progress, through the CEPN, consideration of other roles and responsibilities in primary care, such as reception care navigation – enabling triage of patients directly to other professionals 'in-house'.

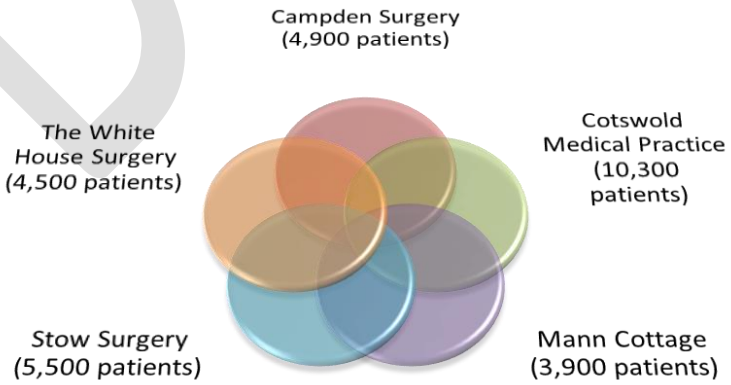
Note: An essential element of our workforce training responsibilities for primary care is safeguarding. In all healthcare settings there is a duty of care - detailed in legislation - to make arrangements to safeguard and promote the welfare of adults, children and young people. To fulfil these responsibilities, we will continue to ensure primary care staff has access to safeguarding training, learning opportunities and support.

Delivery Model

In order to achieve our six components and the commitments made to each, we will work with our identified Locality Leads to establish the correct delivery model for each locality. This is likely to differ between our urban and rural localities, those of different sizes, and how they will each respond to the particular needs assessments for their localities. However, all will be consistent in delivering the six 'New ways of working' components and will likely be based on a multi-speciality community provider (MCP) approach. In developing these models, each locality has arrangements in place to engage with patient groups, for example through Locality Reference Groups or through communication with practices' Patient Participation Groups (PPGs).

Making 'Primary Care at Scale' a Reality

In North Cotswold Locality, for example, the five practices (equalling a population of almost 30,000 people) have agreed to work in a 'loose network' approach to build collaboration and resilience to realise a vision of 'Primary Care at Scale'. The locality will initially test this through the implementation of a 12-month 'Pharmacy Support Plus Pilot', which is looking at the provision of two Clinical Pharmacists to become an integral part of all five practice teams. The locality is also keen to pursue an integrated working model with Gloucestershire Care Services initially, pursuing components 1, 2 and 3 of the New Ways of Working programme (Access, Primary Care at Scale and Integration):



Multi-Specialty Community Provider Pilot

While in larger localities, a 'hub and spoke' model will be more appropriate to ensure true place-based commissioning and provision at a local level.

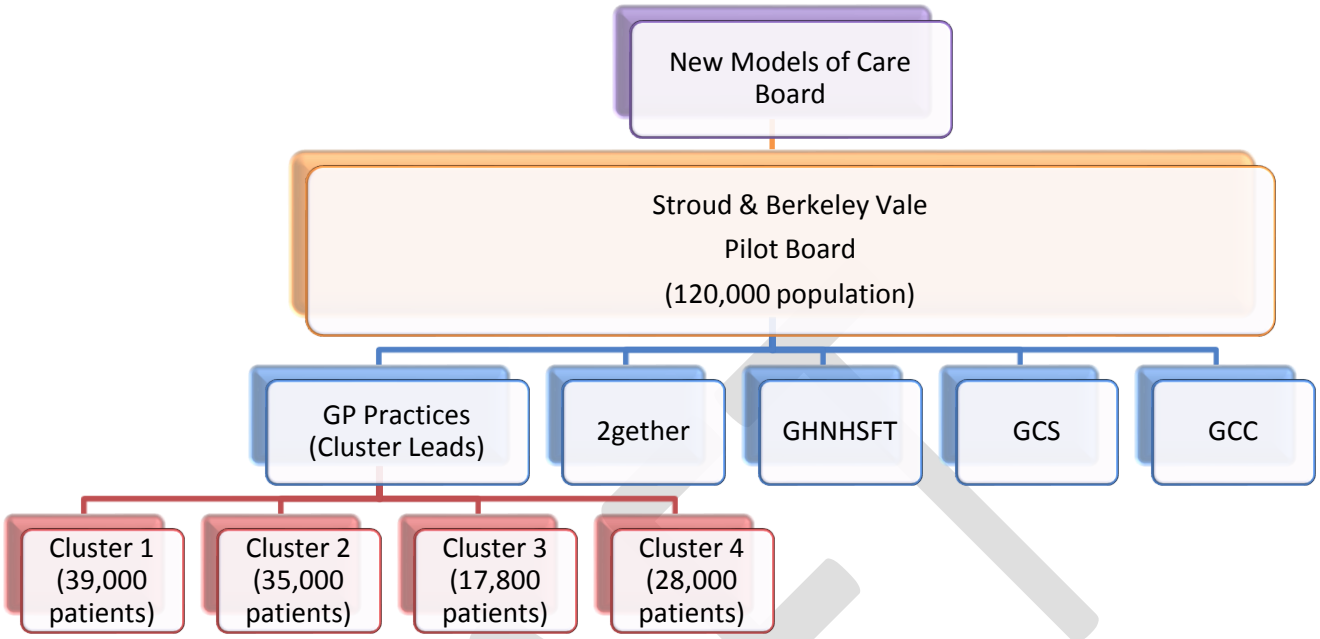
Stroud and Berkeley Vale Locality (with a total population of around 120,000 people and comprising 18 practices) has been chosen as a 'New Models of Care' Multi-specialty Community Provider (MCP) pilot site with four clusters of roughly 30,000 people, identified through natural communities. The pilot aims to improve the health, well-being and independence of local people through delivering a step-change in more accessible, sustainable and higher quality out-of-hospital care. The outcome will be a range of services from primary, community, children and families and mental health care working in a way that wraps around the patient with the support of local statutory and Voluntary and Community Sector providers to ensure that patients stay healthier, independent and at home for longer. The Stroud and Berkeley Vale pilot will ensure that regardless of clinical or provider models, there will be local solutions in place, based around local populations, removing organisational boundaries to provide provision for patients.

The work is requiring significant engagement with partners, including Gloucestershire County Council (GCC), 2gether, Gloucestershire Care Services (GCS), Stroud District Council (SDC), Gloucestershire Fire and Rescue Service, Healthwatch Gloucestershire and a range of Voluntary and Community Sector (VCS) organisations. A cultural change programme was established and a shared vision agreed:

Shared Vision

To ensure that a person in Stroud and Berkeley Vale shares the planning and review of their care and is supported by professionals who know each other and who operate within a culture where they connect people to the strengths and resources in their community.

The pilot governance structure (outlined below) will consist of a Pilot Board supported by four cluster 'working groups' (30,000 population level), which will have representation from each practice within the Cluster and be chaired by the Cluster Lead; they will have overall responsibility for delivering the changes for their local populations.



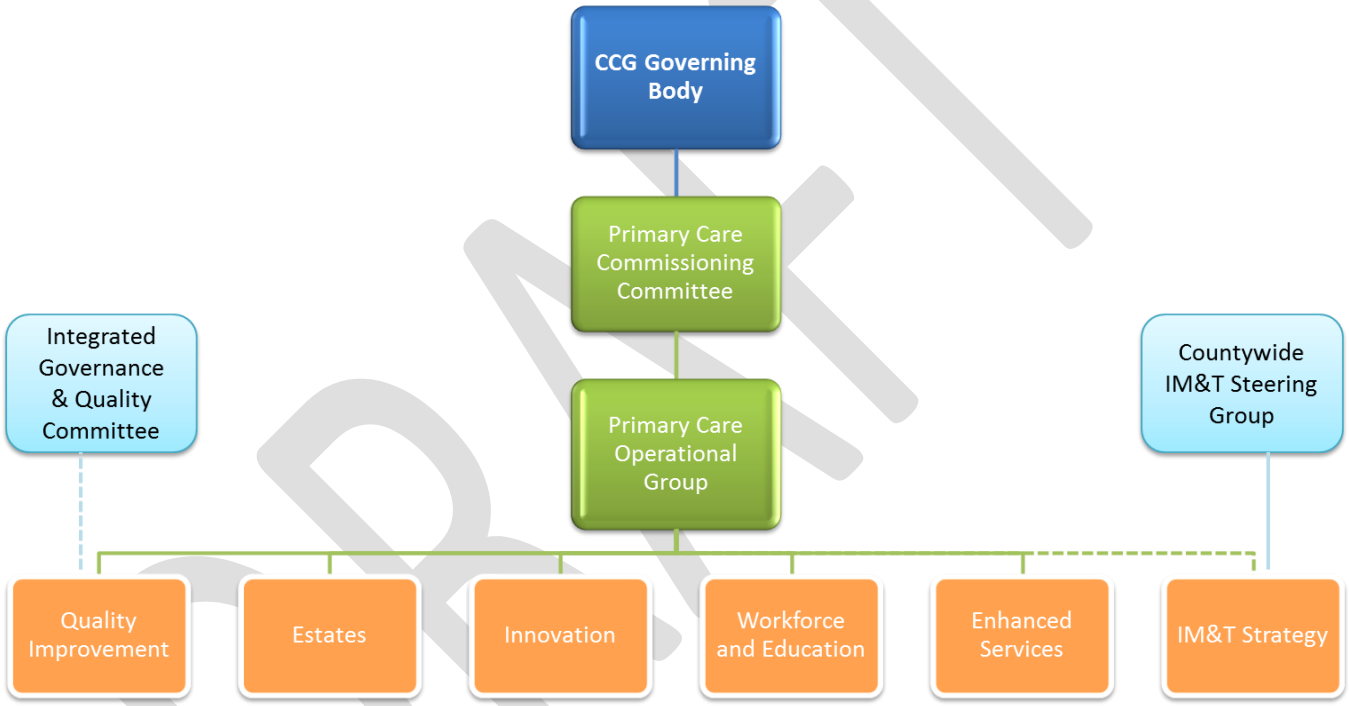
Other localities

The other localities are currently determining how they will respond to these new ways of working, and we will support them in developing their models during 2016/17 for implementation in 2017/18 and delivery planning through to 2021.

Primary Care Decision Making and Governance Structure

The CCG is committed to establishing effective governance procedures to ensure that it discharges its duties effectively and with due regard to mandatory regulations and voluntary guidance. This also applies to the risk of real, or perceived, conflicts of interest.

The Primary Care governance structure below demonstrates how we achieve this. It is in accordance with the Delegated Agreement between NHS England and GCCG dated 26 March 2015. The structure minimises the risk of conflicts of interest occurring while maintaining important clinical input to the design and delivery of our primary care commissioning responsibilities.



Primary Care Commissioning Committee

The purpose of the Primary Care Commissioning Committee (PCCC), as a committee of the Governing Body, is to manage the delivery of those elements of the primary care healthcare services delegated by NHS England to the GCCG. The Committee have delegated responsibility for primary medical care decisions relating to:

- The award, design and monitoring of GMS, PMS and APMS contracts;
- Locally defined and designed enhanced services;
- Local incentive schemes;
- Procurement of new practice provision;
- Discretionary payments (e.g. returner/retainer schemes);

- Practice mergers;
- Contractual action such as issuing branch/remedial notices and removing a contract.

The Committee - who meet in public and are made up of CCG Executives, lay representatives, and representatives from Healthwatch/the Health and Wellbeing Board/NHS England - also report on, and make recommendations, to the Governing Body on the following:

- Primary Care Strategy;
- Premises improvement grants and capital developments.

Primary Care Operational Group

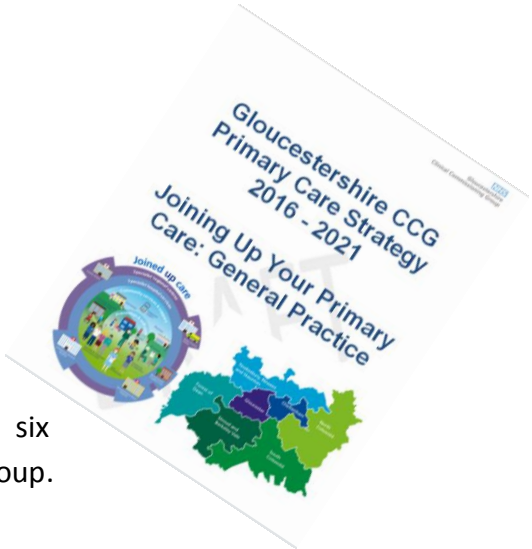
The Primary Care Operational Group (PCOG) has been established to implement and monitor the progress of the operational functions that delegated commissioning responsibilities provide, while making recommendations to the PCCC where decisions are required. In addition, the Group also has responsibility, on behalf of the PCCC, for oversight and delivery of the following groups:

- Primary Care Clinical Quality Review Group (direct report);
- Primary Care Estates workstream (direct report);
- Primary Care Innovation Group (direct report);
- Primary Care Workforce & Education Planning workstream (direct report);
- Enhanced Services (direct report);
- Primary Care IM&T Steering Group (reports to Countywide IM&T Steering Group).

Governance of this Primary Care Strategy

Approving the Primary Care Strategy

In accordance with the above, the approval process for this Strategy will be via the CCG Governing Body, with progress reported through the Primary Care Commissioning Committee, who will be held to account for delivery by the Governing Body. Operational delivery of the Commitments set out against the six components will be managed by the Primary Care Operational Group.

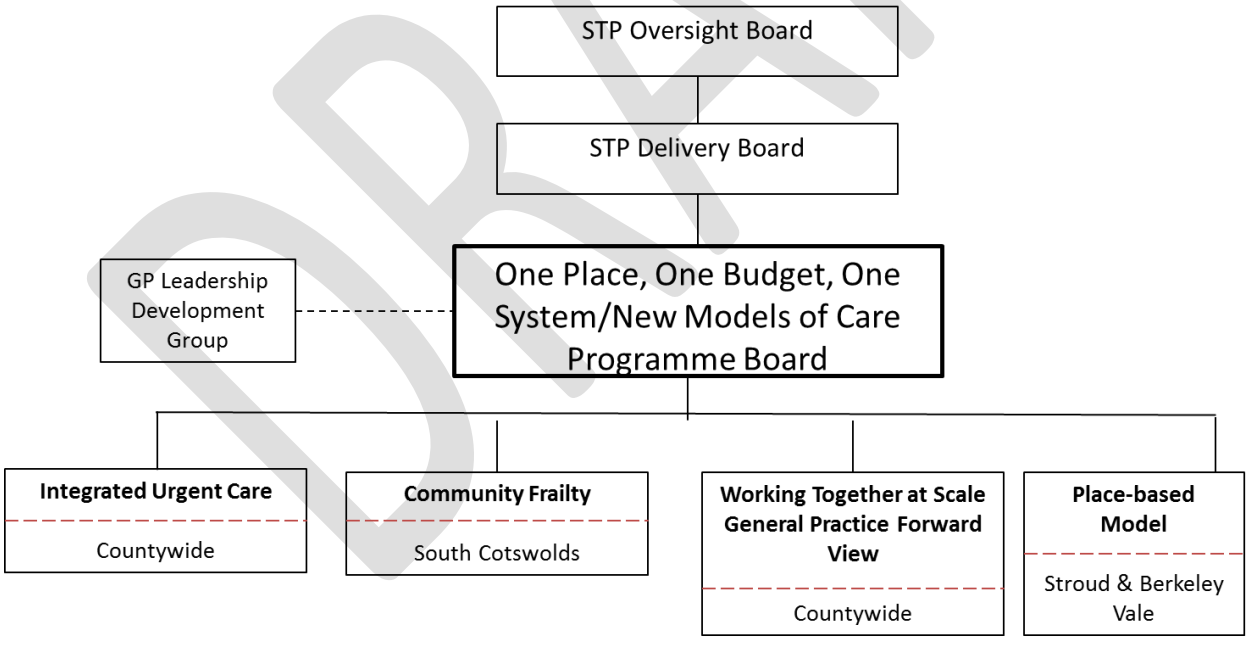


Oversight of GCCGs Sustainability and Transformation Plan and New Models of Care

Overseeing production and direction of GCCG's Sustainability and Transformation Plan is the STP Oversight Board, with a separate STP Delivery Board for implementation.

As a key element of our Sustainability and Transformation Plan is the design and delivery of new models of care, a 'New Models of Care Programme Board' has been established to drive and oversee these models across our County, which will be designed by each locality as described within our 'Delivery Model' section (see page X).

This New Models of Care Programme Board, reporting to the STP Delivery Board, will have Executive membership from across our Providers, with Primary Care represented by a nominated, mandated, lead GP from each locality and lay person involvement in the design and delivery of New Models of Care. The governance structure established for the workstreams, such as the Stroud & Berkeley Vale pilot, will therefore report to the New Models of Care Board. The structure, at the time of writing, is:



Engagement and Stakeholder Involvement Approach

GCCG Engagement and Experience Strategy

The GCCG Strategy for Engagement and Experience: *Our open culture* sets out GCCG's approach to engagement. It sets out our intention to promote 'Equality' and working in 'Partnership' and the desire to enable 'Anyone and Everyone' to have a voice. To achieve this we provide 'Information and good Communication', focus on 'Experience' feedback and undertake good 'Engagement and Consultation'.

http://www.gloucestershireccg.nhs.uk/feedback/gccg-engagement-and-experience-strategy/.

Lay involvement

Currently there is lay involvement through the CCG's Governing Body and Primary Care Commissioning Committee as follows:

- CCG Governing Body – Lay Vice Chair, Lay Members
- Primary Care Commissioning Committee – Lay Chair, Lay Members, Healthwatch Gloucestershire and Health and Wellbeing Board Chairs. The PCCC:
    - Receives a regular Quality Report, including patient experience
    - Meetings are held in public.
    - Meeting papers available on the GCCG website
    - Discusses engagement activity to support specific primary care proposals.

It is proposed that there will be opportunities for lay involvement at the Primary Care Operational Group and in workstreams where lay involvement can have the strategic impact.

Scrutiny

Primary care proposals for change/development receive appropriate scrutiny through:

- Presentations to the NHS Reference Group (representatives from HCOSC and Healthwatch Gloucestershire) as required;
- Regular reporting to Gloucestershire Health and Care Overview and Scrutiny Committee (HCOSC) in the GCCG Chair/Accountable Officer Report;
- GCCG Chair/Accountable Report to HCOSC - Section 2b: Local NHS Commissioner Update, Gloucestershire Clinical Commissioning Group (GCCG) - Primary Care (GP services) shared with Gloucestershire Health and Wellbeing Board Chair

Patient Participation Groups (PPG) engagement

Since April 2015 when the CCG took on 'delegated' commissioning of primary care from NHSE, the CCG has been encouraging local practices to work closely with their PPGs, and where a practice does not have a PPG, assisting them to establish one.

There is now a well-established county PPG Network, which encourages lively debate, information and good practice sharing. Healthwatch Gloucestershire is invited to attend all PPG Network events.

Experience: Primary Care Clinical Quality Review Group

Experience data to inform commissioning and monitoring of primary medical services is discussed at the quarterly Primary Care Clinical Quality Review Group. Experience data includes: GP Friends and Family Test (FFT), Primary Care PALS and Complaints data, Primary Care incidents and serious incidents data, GP Patient Survey, Healthwatch Gloucestershire data; QOF (Quality and Outcomes Framework) data and CQC Inspection data. This information has been used for the development of this Strategy and will support the monitoring of the impact of its implementation going forward.

Engagement in the development of the draft Primary Care Strategy

As well as engagement with our health and care partner organisations, our Patient Experience and Engagement team have supported us in engaging with patients in the development of this draft strategy, chiefly through discussions with members of the Gloucestershire Patient Participation Group (PPG) Network.

As plans develop in the implementation of this Strategy, appropriate engagement and consultation will be undertaken in accordance with our "Our Open Culture" framework. This Strategy therefore sets out our direction for Primary Care and has begun the initial engagement, while individual projects will commence to deliver the commitments of the six components for which we will undertake further engagement and consulation.

Expected Outcomes by Component and Commitment

The table below lists the commitments we are making over the coming five years to deliver our vision for primary care in Gloucestershire. We also describe how, by delivering these commitments, we hope our patients and member practices will react. As part of our plan to implement this Strategy, we will ensure that we set out how we will monitor and measure delivery of these commitments.

Component	Commitments Summary	How will patients feel?	How will practice staff feel?
	• Provide patients with extended evening and weekend access to primary medical care. • Stimulate and pursue continued implementation of the 'Ten High Impact Actions', releasing time for patients and relieving some pressure from staff. • Secure sustainability of our member practices in order to provide a strong platform from which to deliver our long-term aims.	"I am easily able to access the right person at my doctor's surgery to care for me in a way, and at a time, that is convenient to me." "My doctor makes time for me in helping me to manage my long-term condition to avoid becoming poorly."	"Our receptionists have more control over their workload and are proactively directing patients to self-care services, online tools, and a range of other professionals that are right for them. This is releasing capacity for our, now extended, clinical team to deliver convenient access for patients across new types of consultation, such as online and email, while supporting self-care and prevention."
	• Set up a Provider Clinical Leadership development group, forming the basis of primary care representation on the newly established "New Models of Care Board" for our STP. • Develop and deliver a programme of clinical and	"I have access to a greater range of staff who are able to help me manage my illness, without having to wait hours at the Emergency Department." "My surgery is able to offer more	"While offering more services, more of the time, by having a wider range of professionals and working 'at scale', we are able to help patients stay well for longer and achieve a good work-life balance."

Component	Commitments Summary	How will patients feel?	How will practice staff feel?
	managerial leadership and skills training for future general practice. • Support practices and localities in developing their 'at scale' provider models.	services within the practice, or close by, that means I do not have to wait as long, or travel as far, for tests or treatment."	"My job is more rewarding, with more training, more responsibility, in a vibrant, growing and financially sustainable practice."
	• Initially we will create a Primary and Community Urgent Care Working Group to develop the model. • We will then deliver integrated place-based care consisting of community based teams of GPs, physicians, nurses, pharmacists and therapists offering outpatient, diagnostics, geriatric care and other services locally.	"All of the staff who help me to stay well know who I am, know my condition, and work as one team. They talk to each other so I don't have to keep repeating myself." "I only ever call one number and I can easily access urgent help or support when I need it. I no longer call 999, as local nurses, doctors or pharmacists support me to manage at home. "	"We have broken down the boundaries between the different services. We now work as one team, coming together to deliver the services for our local population that they really need." "I have more professional opportunities, working across general practice and in the community, including our local hospital. I am expanding my knowledge while delivering the excellent patient care I joined the profession for."
	• Moving towards a fully interoperable health and care system, available to all providers.	"All of the health professionals I speak with have access to my medication, test	"I enjoy a now paperless environment, with less form filing and

Component	Commitments Summary	How will patients feel?	How will practice staff feel?
	• Access for patients (and their carers and clinical teams) to their digital health records and more online services. • Maximise remote monitoring / health alerting technology. • Continued investment in technology that reduces workload on practices.	results and history, regardless of whether I'm at home, at the practice or in hospital. My carer can even access these online too." "I can easily find out how best to look after my child, including when and how I should seek further help." "Using my smartphone, I can find out when my pharmacist opens and call them, arrange an appointment with a nurse and have an online consultation with my therapist."	systems that talk to each other, meaning I have more time for patients and get to finish on time." "I direct my patients to self-care tools and online patient support groups that places them more in control of their own health." "With instant online access to patients, colleagues and specialist consultants, and my systems available wherever I work, I can offer better patient care, whilst also enhancing my learning."
	• Implement the Primary Care Infrastructure Plan (as found at Appendix 4) to undertake, as a minimum, the eleven key strategic practice developments as prioritised by the six facet survey.	"My surgery has modern premises that are a nice environment in which to see my healthcare professional." "My surgery has a range of staff all working together in	"We not only have suitable premises for our current patient list, but also can accommodate our future list growth." "We have more professionals working together in the same building, providing

Component	Commitments Summary	How will patients feel?	How will practice staff feel?
		the same building with access to the equipment that enables me to be seen, diagnosed and treated all in one place."	the ability to offer more services including diagnostics, and also deliver more holistic patient care."
	• Implement the Primary Care Workforce Plan, as found at Appendix 5 and very briefly summarised below: ○ Recruitment, Retention and Return of the GP workforce; ○ Education and training of the Practice Nurse workforce; ○ New skill mix introduced in general practice.	"Seeing and contacting the same nurse and GP who are experts in my condition is important to me in having a good personal relationship to better self-care." "Having the opportunity to see a therapist at my practice, with a pharmacist to review my medication, was a fantastic service and all on the same day." "Being offered referrals to other professionals and services locally has opened up new opportunities I didn't think existed for me."	"We are able to recruit to vacancies through the national and local campaigns, and retain our best staff." "Our training opportunities are fantastic; I now have broader knowledge to help me support my patients to stay well." "Having the opportunity to take a portfolio of work has given me a greater sense of satisfaction, interest and enjoyment in my work."

In summary, the six components and the supporting commitments we have set out within this document, will deliver:

By 2017:

- Offer 5,000 additional appointments per month across primary care through our Choice Plus scheme and our new integrated urgent care model;
- Ensure 10% of patients actively accessing primary care services online or through apps;
- Invest £1.2 million in General Practice sustainability and transformation plans;
- Practices starting to collaborate to deliver primary care at scale.

By 2021:

- Deliver 35 additional pharmacists qualified as prescribers working in practices, 65 additional GPs and 45 whole time equivalent advanced/specialist nurses, supported by our retention and return to practice programme;
- Ensure a minimum of 95% patients are able to access digital primary care services, online or through apps;
- Ensure 100% population has access to weekend/evening routine GP appointments;
- Achieve Good or Outstanding ratings from CQC for all 81 of our practices;
- Deliver, as a minimum, the eleven key strategic primary care practice developments as prioritised by our six facet survey;
- Practices collaborating in 30,000+ patient population units, delivering place-based integrated, provision for the population they serve.

Financial Impact

In line with all other CCG's in the country, Gloucestershire CCG has been allocated funding over a five-year period (from 2016/17 to 2020/21). Although the first three years of this period represent firm allocations, the latter two years are for indicative use only. Furthermore, it is not intended that firm allocations be reopened unless exceptional circumstances prevail.

The Five Year Forward View describes the opportunities and challenges facing the NHS for the future, expressed as three key 'gaps': The Health and Wellbeing Gap, the Care and Quality Gap and the Finance and Efficiency Gap.

As described earlier, all of the health and care organisations in Gloucestershire have worked together to produce a five-year Sustainability and Transformation Plan (STP). The plan describes a vision for how public-funded health and care services can support a healthier Gloucestershire, which is socially and economically strong and vibrant. Through delivery of this Primary Care Strategy, we believe this will significantly contribute to achieving an improved and more sustainable health and care system.

Primary Care

The funding the CCG has been given for primary care commissioning is outlined below, on the basis of three years firm allocations and two years indicative and includes the growth announced in the General Practice Forward View:

Primary Medical	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Allocation £k	31,244	32,537	33,151	33,799	34,728	36,394
Allocation per capita £		137	139	141	145	151
Growth		4.1%	1.9%	2.0%	2.7%	4.8%
per capita growth		3.8%	1.5%	1.5%	2.3%	4.4%
Target £k		32,140	33,058	34,014	35,052	36,392
Target per capita £		135	139	142	146	151
Opening DfT		1.2%	2.0%	1.0%	0.1%	-0.2%
Closing DfT	0.5%	1.2%	0.3%	-0.6%	-0.9%	0.0%

The above funding covers GMS/PMS/APMS contract expenditure, as well as premises costs and other nationally set allowances. In addition, in 2016/17, as part of its programme allocation, the CCG funds:

- The drug costs of GP prescribing: c.£92m
- Local Enhanced Services: c.£6.8m
- Primary Care IT: c.£1.6m
- Social Prescribing: c.£0.6m

Future additional funding to support this Strategy

Since the initiation of this Strategy in early 2016, we have already committed to:

- Primary Care at Scale: Practices have been asked to form collaborations of practices in units of c. 30,000+ to develop sustainable and transformative bids for funding that will improve patient health outcomes.

- Greater use of technology: funding programmes such as the Joining Up Your Information project which seeks to make the right information about a recipient of care available to the health or social care professional caring for them, when they need it.

- Estates: Submitting the priority proposals to the Primary Care Estates and Technology Transformation Fund for our practice developments, which will have associated revenue consequences as outlined within the Primary Care Infrastructure Plan (see Appendix 4). Investment in the GP estate is needed, not just to improve existing facilities, but to increase flexibility to accommodate multi-disciplinary teams. This will add to the range of care they provide for patients, add more training facilities and greater use of technology. This is needed to facilitate primary care at scale and enable a wider range of services for patients.

- Developing the workforce:
    - Clinical pharmacists in practice – supporting Gloucestershire practices participating within the national scheme while also developing local schemes that supports new ways of working and delivers safer patient care along with cost savings. We will also invest in training more pharmacists to be prescribers to ensure we have a growing workforce to meet this challenge.
    - Primary Care recruitment and retention, such as supporting the 'Be a GP in Gloucestershire' campaign (www.beagpingloucestershire.co.uk), increasing the number of GP retainers, and advanced nurse practitioner training.

In order to deliver all the components and commitments detailed within this Strategy, we will need to invest additional money for Primary Care. As can be seen in the table above, over the five year period of this Strategy based upon indicative allocations by year five (2020/21), the CCG will receive an additional £11.5m a year for Primary Care. While this uplift includes cost inflation and growth, we also commit to specific investment against the commitments made within this Strategy.

Conclusion

The challenges facing the NHS, and especially Primary Care, cannot be underestimated – nationally or locally. As a CCG, we recognise that a resilient, sustainable Primary Care that can adapt to the current and future needs of our patients is central to the ambitions of the whole Gloucestershire health and care system.

By producing this Strategy, we want to demonstrate to our patients and partners our commitment to co-create – and achieve – a vision; a vision for Primary Care that our practice members can relate and aspire to within their own business plans, which will also deliver for our patients across the county.

We will not stop there. Our commitments against the six components will be resourced appropriately, providing clinical and managerial support to achieve them. We have already started and do not intend to rest – the arc of the curve on our journey is long, but we can already see progress.

We will now move to develop detailed action plans and key performance indicators based on the 'Strategic Commitments' we have made to each of the six components, as well as for the 'Ten High Impact Actions' recommended by NHS England.

We look forward to working with our patients, our member practices, our Local Medical Committee, our providers and all our stakeholders to improve health outcomes for our population through delivering:

- Sustainable, resilient general practice;
- Enhanced, wider, primary medical care, working together to offer extended access and more services locally;
- 21st Century technological capability, offering more online patient services;
- Integrated support to patients from primary and community health services and integrated urgent care delivery;
- Practices working in modern premises that allow for predicted growth and have the capacity to deliver these new ways of working;
- An exciting and rewarding place to work for clinicians who are attracted to work and settle within Gloucestershire.

Through delivering all this, we anticipate what has been detailed in the 'Expected Outcomes' section will be achieved over the coming five years for the benefit of our patients and member practices.

Appendices

Appendix 1: GP Patient Survey Results

Patient
_Survey_July2016.pp

Appendix 2: Gloucestershire Practices Information

Practice_Information
_March2016.xlsx

Appendix 3: GCCG IM&T Plan on a Page

Glos IMT Plan on a
Page.docx

Appendix 4: Primary Care Infrastructure Plan

Primary care
infrastructure Plan 20

Appendix 5: Primary Care Workforce Plan

Primary Care
Workforce Plan DRAF

Annex One: Summary of Major Policy Documents

Strategic Themes of Future Primary Care			
Workforce	**Finance**	**Delivery Model**	**Contracting**
• Greater range of staff delivering multi-disciplinary, integrated care – including community nurses, pharmacists, care co-ordinators, physician assistants • More opportunities for GPs, nurses and other healthcare professionals to have portfolio careers • Collaboration with hospital specialists • Workforce planning that meets population need, with comprehensive strategy to support recruitment and retention • Reduce workload to 'safe' levels, maximising delivery of high quality care	• Capitation based budgets; funding to follow patient pathway delivery • Risk and gain sharing arrangements in place • Budget could be devolved in stages, as responsibility increases • Funding of Primary Care estate required to achieve new delivery models • Funding reduction in primary care to be reversed	• Patients empowered to self-care • Integrated IT and increased/better use of technology • General practice at the core, working 'at scale' (mergers, federations, networks) but retaining 'family medicine' • 'At scale' organisations providing a wider range of services, with a MDT approach, offering extended access (hours and methods) • Integrated, co-ordinated, care based on registered lists and delivering continuity of care	• Outcomes based • Will need to reflect different delivery model arrangements • Placed based commissioning – basis of 30,000+ groups • Providers take 'make or buy' decisions as to whether to deliver services themselves or sub-contract • Clear governance and accountability required • Integrated urgent care commissioning and contracting

Annex Two: NHS England objectives for Primary Care

NHS England objective	2016/17 deliverables	Overall 2020 goals

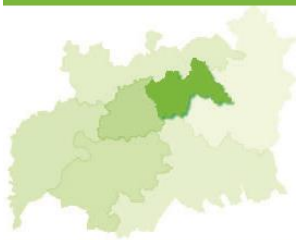
New models of care and general practice	• New models of care to cover 20% of population:
	  • Providing access to enhanced GP services, including evening and weekend access and same-day GP appointments for all over 75s who need them;
	  • Making progress on integration of health and social care, integrated urgent and emergency care, and electronic record sharing.
	• Publish practice-level metrics on quality of and access to GP services with the Health and Social Care Information Centre, provide GPs with benchmarking information for named patient lists.
	• Develop a new voluntary contract for GPs (Multidisciplinary Community Provider contract) ready for implementation in 2017-18.
		• 100% of population has access to weekend/evening routine GP appointments.
		• Measurable reduction in age standardised emergency admissions and inpatient bed-day rates.
		• Significant measurable progress in health and social care integration, urgent and emergency care and electronic health record sharing.
		• 5,000 extra doctors in general practice.

Technology	• Minimum of 10% of patients actively accessing primary care services online or through apps. • Ensure high quality appointment booking app with access to full medical record and agreed data sharing opt-out from April 2016.	• 95% of GP patients to be offered e-consultation and other digital services; and 95% of tests to be digitally transferred between organisations.

Annex Three: Locality-Level Demographics

Urban

Cheltenham



Pop. approx: 154,173

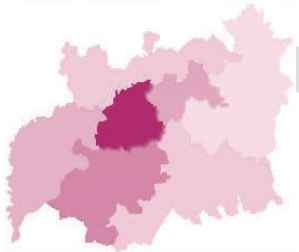
17 practices

112 GPs

Covering Bishops Cleeve, Charlton Kings, Cheltenham, Hesters Way, Leckhampton, Prestbury, Springbank, Up Hatherley, Winchcombe

- Cheltenham has a **slightly younger population** than the CCG average.
- **Above average growth is projected in 0-17 year olds** (15.6% compared to a CCG average of 9.5%).
- However, as the second largest locality, it has the **highest number of registered patients aged 65 or over and 85 or over** in the county.
- The locality has above average levels of patients who describe their **ethnicity** as 'non-white British', compared to the CCG average.
- Nine practices have **deprivation** scores above the county average.
- Life expectancy is significantly higher than national average, however the **life expectancy gap** between least and most deprived quintiles is 9.2 years in men and 7.3 years in women.
- Most common causes of death contributing to this gap: **circulatory disease, cancer, respiratory and digestive diseases.**
- Hospital stays for **self-harm** (all ages) and **alcohol related admissions** are significantly above the national average.

Gloucester



Pop. approx: 169,599

18 practices

119 GPs

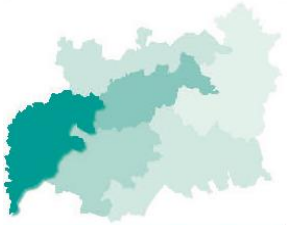
Covering Abbeydale, Churchdown, Gloucester, Hardwicke, Highnam, Hucclecote, Longlevens, Matson, Quedgeley, Saintbridge

- Gloucester is experiencing **the fastest growth in population rate** in the county (11% in ten years, nearly double the county average).
- The locality has a **younger age profile** than the county as a whole.
- However, as the most populated area, the locality still has a relatively **high number of patients aged 65 and over and 85 or over**.
- Practices have the **highest deprivation** scores in the county.
- The locality is the most **ethnically diverse**, with the highest proportion of patients describing ethnicity as 'non-white British'.
- **Male life expectancy** at birth significantly below national and county average (female in line with both).
- **Life expectancy gap** between least and most deprived quintiles is 13.5 years in men and 10.6 years in women.
- Most common causes of death contributing to this gap: **circulatory disease, cancer and respiratory.**
- **Self-harm** (all ages) and **suicide rates** are significantly higher than the

national average, while **smoking prevalence, obesity and lack of physical activity** are all higher in Gloucester than any other locality.

Rural

Forest of Dean



Pop. approx: 62,864

11 practices
44 GPs

Covering Blakeney, Coleford, Cinderford, Drybrook, Lydney, Mitcheldean, Newnham-on-Severn, Westbury-on-Severn, Yorkley, Bream, Ruardean, Lydbrook

- Forest of Dean locality has an **older age profile** than the CCG average, with projected higher growth rates in over 65 and 85s too.
- Nearly all practices higher than county average **deprivation** score.
- **Life expectancy gap** between least and most deprived is 4 years in females and 5 years in men, with the male gap widening.
- Most common causes of death contributing to this gap: **circulatory disease, cancer, respiratory and external causes (e.g. injuries, suicide).**
- Significantly higher than CCG average for the prevalence of 11 of the top 15 **long term conditions** in the county (using QOF data).
- Percentage of patients reporting long-term **mental health** problems are higher than the county average.
- Levels of **physical activity** in adults are below county and national rates.

North Cotswolds

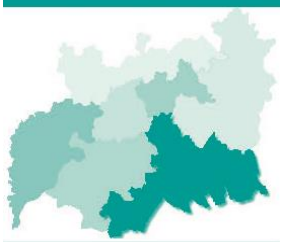
Pop. approx: 28,967

5 practices
20 GPs

Covering Chipping Campden, Bourton-on-the-Water, Moreton-in-Marsh, Stow-on-the-Wold, Blockley, Northleach

- The North Cotswold locality has an **older age profile** than the county, and the highest proportion of patients aged 65+ and 85+.
- **Significantly better** than national and county average for life expectancy at birth, lowest life expectancy gap, deprivation, childhood obesity and premature mortality rates for cardiovascular disease, cancer and respiratory diseases.
- Prevalence rates (based on QOF data) for **hypertension, hypothyroidism, CHD, cancer, AF and stroke** are significantly above the CCG average, likely to be reflecting older population profile.
- Rates of **death and serious injuries on the road** are significantly higher than the national average.
- **Access to housing, services and local transport links** due to rurality poses problems for Cotswold residents, with 22 of the 51 Lower Super Output Areas in the top 20% most deprived nationally for this.

South Cotswolds



Pop. approx: 58,074

8 practices
43 GPs

Covering Cirencester, Fairford, Lechlade, Rendcomb, Tetbury, South Cerney, Kemble

- The South Cotswold locality has a **slightly older age profile** than the county.
- **Significantly better** than national and county average for life expectancy at birth, lowest life expectancy gap, deprivation, childhood obesity and premature mortality rates for cardiovascular disease, cancer and respiratory diseases.
- Upward trend in **colorectal cancer** incidence rate, which is significantly higher than the national average.
- Prevalence rates (based on QOF data) for **hypertension, cancer and AF stroke** are significantly above the CCG average, likely to be reflecting older population profile.
- Rates of **death and serious injuries on the road** are significantly higher than the national average.
- **Access to housing, services and local transport links** due to rurality poses problems for Cotswold residents, with 22 of the 51 Lower Super Output Areas in the top 20% most deprived nationally for this.

Stroud and Berkeley Vale

Pop. approx: 119,488

18 practices
94 GPs

Covering Berkeley, Minchinhampton, Nailsworth, Stonehouse, Stroud, Dursley, Cam, Frampton-on-Severn, Uley, Wotton-under-Edge, Bussage, Painswick

- Stroud and Berkeley Vale locality has a **slightly older age profile** than the county, with projected above average growth levels in 75+ and 85+ age groups.
- **Female life expectancy** has a downward trend and now significantly below county average (male in line with county average).
- **Life expectancy gap** is 5.6 years in men and 5 years in women, with the female gap widening.
- Most common causes of death contributing to this gap: **respiratory and circulatory diseases, cancer and external causes (e.g. injuries, suicide).**
- Prevalence of **cancer** is significantly higher than the county average, although this may be reflective of age profile.
- Hospital stays for **self-harm** (all ages) is significantly above the national average.

Tewkesbury, Newent and Staunton

Pop. approx 42,835

4 practices
20 GPs

Covering Tewkesbury, Newent, Staunton, Corse

- The Tewkesbury, Newent and Staunton locality are seeing above average **population growth** (11%), with the fastest growth in 0-17 age group and those aged 75+ and 85+.
- **Significantly better** than national average for life expectancy at birth.
- **Life expectancy gap** between the most and least deprived quintiles is 6.5 years in men and 9.5 years in women
- Most common causes of death contributing to this gap: **circulatory diseases, cancer, respiratory diseases and mental and behavioural problems** (in particular dementia).
- The locality has the highest incidence rate of **malignant melanoma** in the county, while prevalence of **hypertension** is significantly higher.
- The percentage of patients reporting a **mental health** problem is above the county average across all practices.
- **Overweight or obese** adults are at a significantly higher rate than national and county averages.

Annex Four: Current Primary Care Commissioning

Since April 2015, GCCG have been responsible for:

- Managing practice contracts, including Primary Medical Services (PMS) reviews
- Managing enhanced services and local incentive schemes
- Decisions relating to the establishment of new practices
- Decisions relating to the merger and closure of existing practices
- 'Discretionary' payments and Premises Costs
- Planning GP services and practice performance

Primary care commissioning is managed within the Primary Care and Localities Directorate, with primary care contracting work kept within the remit of the Head of Primary Care Contracting. This ensures good governance and minimise any risk for the potential of real, or perceived, conflicts of interest (see 'Primary Care Decision Making and Governance Structure' section later in this document).

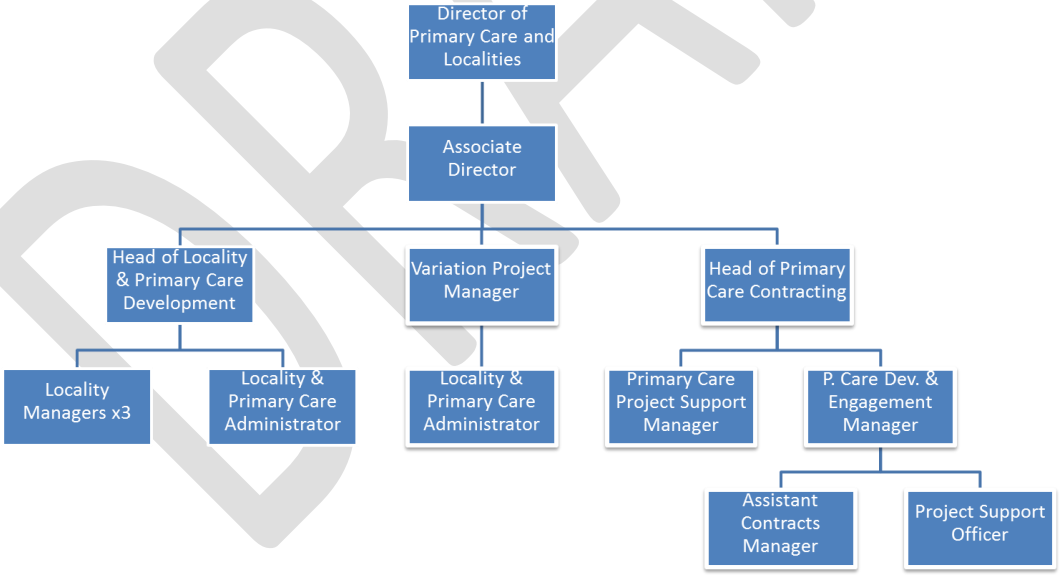
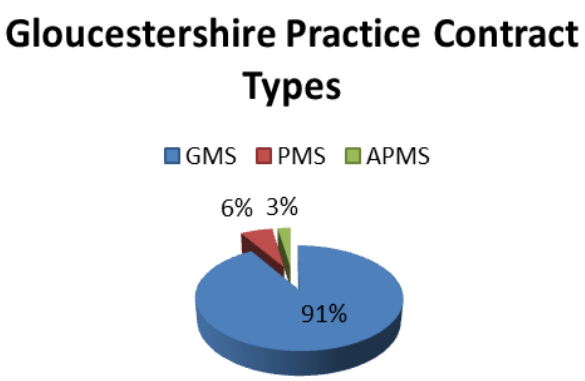


Figure 10: Primary Care and Localities Directorate

Within our CCG, our primary care contractual basis is predominantly 'General Medical Services' (GMS) practices, with only five PMS and two 'Additional Personal Medical Services' (APMS) contracts. There is one GP Provider organisation for the county -



"GDoc" (see glossary) - of which all Gloucestershire GP practices are shareholders. One of the APMS contracts is for a 'walk-in' centre in Gloucester City, offering appointments from 8am – 8pm seven days a week for Gloucestershire residents.

As a CCG, we directly commission with our 81 practices the following locally commissioned services under NHS Standard Contracts:

- Primary Care Offer (see below)
- Care Homes enhanced care
- Diabetes
- Deep Vein Thrombosis (DVT) primary care service
- Extended Hours
- Minor Surgery
- Unplanned Admissions (additional work in relation to the national Directed Enhanced Service (DES))

Gloucestershire's Primary Care Offer

The CCG has developed a Primary Care Offer to encourage member practices to:

- Provide an 'enhanced' primary care service to their patients, with a particular focus on cancer, carers and frailty;
- Improve quality;
- Reduce variation;
- Be active members of the CCG and their localities.

The 2016/17 offer (see below) builds on the success of the previous two years, where 100% of practices signed up to the scheme.

Cancer Management	• Improving health and wellbeing • Education programme (GPs and nurses) • Prostate cancer pathway
Practice based clinical audit	• Undertake clinical audit activity quarterly with GCCG PCCAG
Local Quality Improvement	• Antibiotics Prescribing • Acute Kidney Injury • Sepsis
Practice Variation	• Identifying variances from the new GP Portal • Analyse and act for continuous improvement
Caring for Carers	• Health checks for carers to include mental and physical health, prevention advice, social care needs
Frailty	• Undertaking frailty assessments for an identified cohort of patients

In addition to a clear focus on reducing antibiotic prescribing through the Primary Care Offer, the CCG and primary care staff routinely work closely together to ensure wise choices are made by our primary care teams about the most clinically and cost effective pharmacological intervention for all patients, based on sound evidence. In 2015/16, the CCG achieved all three improved antibiotic prescribing national targets and has set up a Medicines Optimisation Programme Group to take forward safe, high quality, sustainable prescribing initiatives.

The CCG wants to ensure quality and patient safety is embedded in everything that we do. The Primary Care Offer is one way in which we continually drive a focus on both. We have also recently appointed a Named GP for Safeguarding Adults and Children who work closely with other designated and named professionals in Gloucestershire, supporting all activities necessary to ensure that Gloucestershire NHS providers meet their responsibilities to safeguard children, young people and vulnerable adults in Gloucestershire. The Named GP also supports the development and delivery of effective safeguarding training to Primary Care and providing supervision to GPs, particularly with regard to writing GP reports for Serious Case Reviews, Adult Case Reviews and Domestic Homicide Reviews.

In addition, we are working with practices to support safety as patients pass between clinicians and/or organisations and have begun to embed the use of the National Early Warning Score (NEWS) as a tool to help establish a baseline of a patient's condition. This helps to improve communication

between services caring for a patient in an emergency situation by the use of a 'common language' between all parties.

The CCG is also committed to using clinical audit to both monitor performance (for example against NICE standards) and, crucially, to continually improve services – our work is led by a dedicated team: the Primary Care Clinical Audit Group. They undertake a wide range of audits, focused around the priorities for the CCG, for example, related to prescribing for people with dementia, support for carers, and health checks and for people with learning disabilities.

Our focus on maintaining and improving quality in primary care is driven through our Primary Care Clinical Quality Review Group (CQRG). There is a strong evidence base on the best interventions to improve quality as set out by the Health Foundation in 2014:

Intervention	Improving experience	Improving clinical outcomes	Improving safety
Interventions targeting patients	– Improving access interventions – Increased appointment length – Continuity of care – Person-centred consultations – Patient access to records – Gaining feedback from patients	– Patient education – Using technology – Other support tools – Layperson-led services	– Patient education
Interventions targeting professionals	– Nurse-led services	– Training in quality improvement – Interprofessional learning – Audit and feedback / peer review – Improvement collaboratives – Decision support tools – Nurse-led services – Health educators – Joint consultations – Increased staffing levels	– Extra training for trainee doctors – Pharmacist-led education – Prescribing outreach visits – Improvement collaboratives – Peer review and feedback
Interventions targeting whole practices or systems	– Providing a wider range of services – Point of care testing – Quality improvement projects	– Providing a wider range of services – Telehealth	– Pharmacist services in general practice – Guideline implementation – Clinical audit – Significant event analysis – Quality improvement projects – Electronic medical records – Electronic referral systems – Improving data collection and error reporting

'Cross Border' Patients

There are around 9,000 Gloucestershire residents who live in the Forest of Dean and are registered with a Welsh GP branch surgery. Up until April 2016 the responsibility for the commissioning and provision of healthcare to this population was with Aneurin Bevan Health Board, in Wales. From April the responsibility for commissioning hospital and community services, including mental health services, has transferred to Gloucestershire CCG. The responsibility for the provision of primary care services though, including General Practice, remains with the Aneurin Bevan Health Board. Despite this, the CCG has developed good relationships with the relevant Welsh GPs and has established two cross-border network groups – one for GPs and one for practice managers. In addition, the CCG is exploring with the Welsh GPs the opportunity to undertake some of the CCG commissioned community enhanced services, such as the Care Home Enhanced Service, to enable this population to have wider access to local services.

Glossary

Listed below are some of the commonly used abbreviations used within this document, which are stated here in full for ease.

Term	Description
CCG	Gloucestershire Clinical Commissioning Group
GCC	Gloucestershire County Council
GCS	Gloucestershire Care Services
GDoc	Gloucestershire Doctors – an organisational delivering primary care services across more than one practice
GHNHSFT	Gloucestershire Hospitals NHS Foundation Trust
MCP	Multi-speciality Community Provider
PACS	Primary and Acute Care System
PCIP	Primary Care Infrastructure Plan
STP	Sustainability and Transformation Plan
VCS	Voluntary and Community Sector
OD	Organisational Development
GMS	General Medical Services – *is the term used to describe the range of* ***healthcare*** *that is provided by GPs*
PMS	Personal Medical Services - *this is a locally-agreed alternative to General Medical Services (GMS) for GP practices*
APMS	Alternative Provider Medical Services – *this is another contracting route available to enable the commissioning of primary care provide primary medical services to meet local patient needs*
Delegated Commissioning	The term used for when CCGs have taken over responsibility from NHS England for deciding which primary care services to provide

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NHS
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Clinical Commissioning Group

Agenda Item 6

Primary Care Commissioning Committee

Meeting Date	**Thursday 28th July 2016**
Title	**Delegated Primary Care Commissioning financial report as at 30th June 2016**
Executive Summary	At the end of June 2016, the CCG's delegated primary care co-commissioning budgets reported an underspend of £34k and a breakeven forecast.
Risk Issues: **Original Risk** **Residual Risk**	None
Financial Impact	The current position and forecast has been wholly assumed within the CCG's overall financial position.
Legal Issues (including NHS Constitution)	None
Impact on Health Inequalities	None
Impact on Equality and Diversity	None
Impact on Sustainable Development	None
Patient and Public Involvement	None
Recommendation	The PCCC are asked to: • note the contents of the paper
Author	Andrew Beard
Designation	Deputy Chief Financial Officer
Sponsoring Director (if not author)	Cath Leech Chief Financial Officer

Agenda Item 6

Primary Care Commissioning Committee - 28th July 2016

Delegated Primary Care Commissioning financial report as at 30th June 2016

1 Introduction

1.1 This paper outlines the financial position on delegated primary care co-commissioning budgets at the end of June 2016.

2 Financial Position

2.1 The CCG reported an underspend of £34k against delegated budgets at the end of June (see table below).

2.2 This represents an improvement to the position reported in the previous month.

2.3 At this stage, the CCG is forecasting a breakeven position for 2016/17 although further detail will become available during the course of the financial year.

2.4 The reasons for the year to date variance are:

- the overspend against Enhanced Services relates primarily to the Patient Participation DES. Investigations are ongoing as to whether this relates to 2014/15 and, if so, this will be recharged to NHS England;
- other outstanding 2015/16 Enhanced Services continue to be paid and are estimated within the position;
- an underspend against the 2015/16 Quality Outcomes Framework (QoF) estimate has been reported at 30 June but it is assumed that this will be utilised fully in the current year; and
- premises costs includes estimates for those practices that have recently undergone developments.

3 Recommendation

3.1 The PCCC are asked to note the contents of the paper.

NHS
Gloucestershire
Clinical Commissioning Group

Gloucestershire CCG
2016/17 Delegated Primary Care Co-Commissioning budget

			June 2016						
	Area	2016/17 Total Budget £	In Month Budget £	In Month Actual £	In Month Variance £	Year to Date Budget £	Year to Date Actual £	Year to Date Variance £	Forecast Variance £
SPEND	Contract payments - GMS	46,747,154	3,784,076	3,774,640	(9,436)	11,686,675	11,677,239	(9,436)	
	Contract payments - PMS	3,356,147	334,743	333,633	(1,110)	839,029	837,919	(1,110)	
	Contract payments - APMS	1,379,509	168,707	165,294	(3,413)	344,876	341,463	(3,413)	
	Enhanced Services	4,216,184	353,656	270,727	(82,929)	1,053,784	1,065,069	11,285	
	Other GP Services	8,147,486	290,484	355,040	64,556	555,119	553,807	(1,312)	
	Premises	2,174,661	678,993	678,948	(45)	2,036,559	2,036,514	(45)	
	Dispensing/Prescribing	3,125,231	260,399	258,437	(1,962)	781,234	779,272	(1,962)	
	QOF	8,198,783	683,159	683,159	(0)	2,049,562	2,021,215	(28,347)	
	TOTAL	**77,345,155**	**6,554,217**	**6,519,877**	**(34,340)**	**19,346,838**	**19,312,498**	**(34,340)**	**0**

FUNDING	Allocation (revised)	78,523,000
	Less :- nationally mandated adjustements	
	1% headroom	(785,230)
	0.5% contingency	(392,615)
		77,345,155
	SURPLUS/DEFICIT	0

Global Sum (GMS contract payments) has now been published and represents a 5.33% increase on 2015/16
Global sum per weighted patient moves from £76.51 to £80.59 in April 2016
Other GP Services includes:

- Legal & professional fees
- Seniority
- Doctors retainer scheme
- Locum/adoption/maternity/paternity payments
- Other general supplies & services

NHS
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Agenda Item 7

Primary Care Commissioning Committee

Meeting Date	**Thursday 28th July 2016**
Title	**Care Home Enhanced Service for nursing homes, residential homes and supported living for people with learning disabilities or physical disabilities**
Executive Summary	Building on the successful implementation of the Gloucestershire Care Homes Enhanced Service for older people nursing and residential homes (CHES), this service aims to roll out the key components of the CHES for service users with learning disabilities or physical disabilities. This service will also form a key part of the Gloucestershire health and social care community response to the confidential enquiry which highlighted that LD service users are at high risk of poor experience in acute or community hospital care and also of not receiving community services such as screening.
Risk Issues: **Original Risk** **Residual Risk**	Risk: Level of take-up by GPs Mitigation: Engagement via CCG workstreams and GP Clinical Leads; building on success of CHES and need for service improvements: All GP practices will be encouraged to participate to ensure there is good coverage across the LD/PD homes in the county and therefore equity for patients. Risk: Level of engagement from Care Homes Mitigation: Engagement via CCG workstreams; building on success of CHES and need for service improvements

	Risk: Quality Improvements not realised Mitigation: Regular monitoring of service outcomes, engagement via CCG workstreams; learning from CHES; project could be closed down if unsuccessful Risk: Service increases demand for community services Mitigation: service to reduce variation in provision of services; impact of service to be monitored Risk: Confidential Enquiry which provided evidence of the substantial contribution of factors relating to the provision of care and health services to the health disparities between people with and without intellectual disabilities. Mitigation: this enhanced service will constitute a component of the Gloucestershire response to the report.
Financial Impact	Funding for this enhanced service is available within the Primary Care budget. There are approx. 480 people in this service user group in Nursing or Residential homes and 1050 people with LD in Supported Living. The proposed funding will be £176.00 per patient per annum (70% of the current Older People CHES payment). Based on the numbers above the cost for this service is £270,000 and is within the allocated budget.
Legal Issues (including NHS Constitution)	Gloucestershire CCG needs to act within the terms of the Delegation Agreement with NHS England dated 26 March 2015 for undertaking the functions relating to Primary Care Medical

	Services.
Impact on Health Inequalities	This enhanced service seeks to reduce identified health inequalities
Impact on Equality and Diversity	**Yes** The introduction of this enhanced service will have a positive impact
Impact on Sustainable Development	**No**
Patient and Public Involvement	Via Care Homes Programme Stakeholder Group
Recommendation	The PCCC is asked to: • consider the recommendation from the Primary Care Operational Group meeting of 19 July 2016; and • make a decision regarding the approval of the Care Home Enhanced Service for Nursing Homes, Residential Homes and Supported Living for People with Learning Disabilities or Physical Disabilities.
Author	Jeanette Giles/Penny Fowler
Designation	Head of Primary Care Contracting/Health and Social Care Commissioning Manager
Sponsoring Director (if not author)	Helen Goodey, Director Locality Development and Primary Care

Agenda Item 7

Primary Care Commissioning Committee

28th July 2016

Care Homes Enhanced Service for nursing homes, residential homes and supported living for people with Learning Disabilities or Physical Disabilities

1 Introduction and background

1.1 Building on the successful implementation of the Gloucestershire Care Homes Enhanced Service for Older People Nursing and Residential Homes (CHES), this service aims to roll out the key components of the CHES for service users with Learning Disabilities (LD) or Physical Disabilities (PD).

1.2 This service covers enhanced aspects of clinical care of the GP patient which are beyond the scope of essential services or additional services and will improve quality of care for LD/PD service users.

1.3 There are 74 care homes registered (as at July 2016) with the Care Quality Commission to provide services for adults aged 18 – 65 years. These range from small homes only for people with LD 18 – 65 years to larger homes providing services for a range of service user groups, including LD, physical disabilities, dementia, mental health conditions, age-groups of children, 18-65 years and over 65s. There are 15 homes which are mainly for Older People with Learning or Physical Disabilities.

1.4 For the purposes of this enhanced services 'Care Homes' will be used to refer to nursing homes, residential homes, and supported living for people with LD/PD.

2. Aims and objectives

2.1 All Gloucestershire GP practices will be invited to participate in the LD/PD Care Home Enhanced service wef October 2016 with the aim of improving the quality of care to residents in Care Homes for

people with LD/PD by ensuring optimum and consistent access to primary medical services.

2.2 The specification for this service is attached (Appendix 1)

2.3 The aims of the service are to implement a more pro-active approach with a greater integration and communication between each Care Home, GP practices, out of hours services and community service providers.

2.4 This service will also form a key part of the Gloucestershire health and social care community response to the confidential enquiry which highlighted that LD service users are at high risk of poor experience in acute or community hospital care and also of not receiving community services such as screening.

2.5 Participating practices will need to:

- undertake regular planned GP visits (at least once a month);
- meet with the Care Home Manager (at least once a quarter);
- hold a register of its patients with LD/PD in each Care Home;
- produce a care plan agreed between the resident, GP, family and Care Home staff;
- produce an end of life care plan for those patients in the last year of life;
- assess each resident within two weeks of admission;
- review the care of all residents every six months;
- medication review every six months for each resident (and adhoc where there have been changes, e.g. discharge from hospital);
- produce individualised summary patients notes for each resident which will be available to unscheduled care providers;
- where appropriate ensure all residents have a falls assessment; and
- undertake Adult Safeguarding, Mental Capacity Act and Deprivation of Liberty Training.

2.6 It is recommended that a named GP takes a lead role for delivery of this enhanced service and that admission episode reflection is undertaken for all residents who are admitted to an acute or community hospital from a Care Home to improve quality of care

and patient experience

3. Development of this enhanced service

3.1 This enhanced service is based on best practice and clinical evidence.

3.2 The Commissioning lead is Kim Forey, Associate Director: Partnerships, Joint Commissioning and Community Services.

3.3 The service has been developed through the LD and PD workstreams and the CCG Care Homes Programme, plus the Gloucestershire CCG LES Review Group.

3.4 The Gloucestershire GP Care Homes Enhanced Service is delivering real benefits to residents and staff, with people living in Older People care homes receiving more planned and proactive support from GPs.

3.5 Evaluation of the first full year of implementation of the CHES identified that the model works successfully in Gloucestershire with effectiveness shown across all the Localities. The evaluation highlighted significant GP engagement which contributed to the success of the pilot.

3.6 Excellent progress was made on a range of Commissioning Outcomes (COs) showing improvements in quality of care for Older People Care Home residents and also improvements in working relationships between Care Homes and GPs. A successful pharmacy pilot has also been added to the scheme.

3.7 The first year of the scheme showed a 25% reduction in emergency hospital attendances and 5% reduction in emergency admissions amongst Older People care home residents: this marked reduction levelled off as expected and the scheme is continuing to have a positive impact in 2015/16.

3.8 In terms of improving quality of care, systems were set up as part of the CHES to record a number of service delivery activities and quarterly monitoring has shown a large rise in the numbers of care plans, 6monthly medication reviews, falls assessments and numbers of special notes on Adastra. This also indicates reduction

in variations of service received by residents in Care Homes.

3.9 Care Home Managers reported an improvement in patient experience, quality of care and working relationships. A small survey of care home residents, using semi-structured interviews, showed that overall patients were very happy with the care they receive from their GP and there were no major problems with the introduction of the CHES.

3.10 The Commissioning Outcomes for the Enhanced Service for Learning Disabilities/Physical Disabilities Care Homes is attached (see Appendix 2).

4. Next steps

4.1 On approval the primary care team will write to practices and LD/PD care homes to notify them of this enhanced service and encourage participation.

5. Recommendation

5.1 Following the recommendation by the Primary Care Operational Group on 19 July, the PCCC is asked to:

- consider the recommendation from the Primary Care Operational Group meeting of 19 July 2016; and
- Make a decision regarding the approval of the Care Home Enhanced Service for Nursing Homes, Residential Homes and Supported Living for People with Learning Disabilities or Physical Disabilities.

6. Appendices

Appendix 1: Specification for Care Home Enhanced Service for Nursing Homes, Residential Homes and Supported Living for People with Learning Disabilities or Physical Disabilities.

Service Spec Care Homes ES_LD.PDdraf

Appendix 2: Commissioning Outcomes

CHs ES_LD.PD Comm Outcomes draftv4.0 .

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	Tbc
Service	Care Home Enhanced Service for Nursing Homes, Residential Homes and Supported Living for People with Learning Disabilities and /or Physical Disabilities
Commissioner Lead	Kim Forey Associate Director: Partnerships, Joint Commissioning and Community Services
Provider Lead	[EACH PARTICIPATING GP PRACTICE]
Period	01 October 2016 – 31 March 2017
Date of Review	Six-monthly reviews

1. Population Needs

Enhanced Services are services commissioned from GP Practices over and above their main contract. There are three types of enhanced services – national, direct and community. Community Enhanced Services (which are community or practice-based) are developed locally in response to local needs and priorities, and are voluntary for Practices.

This specification relates to a Community Enhanced Service for Nursing Homes, Residential Homes and Supported Living for people with Learning Disabilities and/or Physical Disabilities and outlines the more specialised services to be provided. The service covers enhanced aspects of clinical care of the GP patient which are beyond the scope of essential services or additional services over and above that provided in most Primary Care settings. No part of the specification by commission, omission or implication defines or redefines essential or additional services.

This service is to build on the successful implementation of the Gloucestershire Care Homes Enhanced Service for Older People Nursing and Residential Homes (CHES) which demonstrated improvements in the quality of care to Care Homes residents promoting optimum and consistent provision of NHS GP Services and resulting in benefits including significant reduction in emergency attendances and admissions. The CHES is based on a structured pro-active care planning approach with services provided by local GPs over and above GMS including at least fortnightly visits to residents, assessment on admission, a medication review every six months and Admission Episode Reflections.

This service is to roll-out key components of the CHES for service users with Learning Disabilities (LD) and/or Physical Disabilities (PD) using the learning from the CHES for these service users to gain benefits from the proactive care planning approach and more effective working relationships between health and social staff groups. For the purposes of this specification, the term Physical Disabilities refers to Physical and/or Sensory Disabilities.

The key rationale for this service is to improve the well-being of the service users by improving quality of services provided, improving safety and reducing variation in provision via the pro-active visits and care planning approach. It will improve quality of care for LD and PD service users who have a diverse set of health and social care needs, ranging from people living in Supported Living with minimal health needs through to people with complex needs living in specialised Nursing Homes with a complex medication regimen. In addition, as more people with LD and PD are living longer this service user group includes more people who are older and/or who are frail.

This service will also form a key part of the Gloucestershire health and social care community response to the confidential enquiry which highlighted that LD services users are at high risk of poor experience in acute or community hospital care and also of not receiving community services such as screening.

1.1 National/local context and evidence base

There are 74 Care Homes registered (as at July 2016) with the Care Quality Commission to provide services for

adults aged 18-65 years. These range from small homes only for people with LD 18-65 yrs to larger homes providing services for a range service user groups including LD, physical disabilities, dementia, mental health conditions, age-groups of children, 18-65yrs and over 65s (a number of which were included in the Older People CHES). Staffing ranges from intermittent daytime non-clinical staff only through to 24-hour nursing cover. The group also includes educational establishments which serve a wider population. For the purposes of this Service Specification 'Care Homes' will be used to refer to Nursing Homes, Residential Homes and Supported Living (many of which are registered with CQC as Residential Homes) for people with LD or PD. There were also 15 homes which, although taking older people (over 65 years) were excluded from the Older People CHES as they were mainly for people with LD or PD.

There has been a significant amount of research to support the development of this Enhanced Service in order to improve the quality of care for this vulnerable service user group. This has been strongly supplemented by local intelligence of related issues and solutions. NHS support to Care Homes is sporadic and varies between each Home, as does the quality of care provided. This is due to factors related to the Care Homes themselves (e.g. strength of leadership), relationships between the Care Homes and primary/community services, and what primary and community services are commissioned and how these are delivered.

The NHS support required for people in Care Homes and the Care Home staff needs to come from GP Practices, community services (such as Speech and Language Therapy and continence services) and secondary care providers (such as mental health and consultant-led services).

The main providers of these services are GP Practices in Gloucestershire, Gloucestershire Care Services, the 2gether NHSFT, GHNHSFT, local community pharmacists and private providers (e.g. for basic podiatry). At present, there is no consistent model of care from any of these providers to each Care Home.

A significant driver for change is the Confidential Enquiry which provided evidence of the substantial contribution of factors relating to the provision of care and health services to the health disparities between people with and without intellectual disabilities. The key recommendation of this report was that it is imperative to examine care and service provision for this population as potentially contributory factors to their deaths—factors that can largely be ameliorated. This service constitutes a component of the Gloucestershire response to the report.

The evaluation of the Gloucestershire GPled Enhanced Service for Older People Care Homes (CHES) pilot identified that the CHES model works successfully in Gloucestershire with effectiveness shown across all the Localities. Key areas of successful impact included a noted reduction in emergency admissions and attendances, important improvements in service quality & reduction variation and a successful pharmacy pilot. A PharmCare pilot which was embedded in the CHES model in the later stages of the pilot has also proved to be successful. In this scheme, experienced local pharmacists add value and important clinical support to the 6monthly rolling programme of medication reviews carried out by GPs under the CHES.

Key to the success was significant positive GP engagement and support from the Care Homes also strengthening working relationships between care homes and GPs.

For the LD or PD service user group, the pattern of health care utilisation does not mirror that of older people eg emergency admission rates are lower; however there are some similarities for patients with more complex needs & medications. A separate set of Commissioning Outcomes has been developed for this Service User Group to reflect the different pattern of current experience and expected impact to improve quality of care.

#

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	✓
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

Service outcomes based on the successful CHES and adapted for this Service User Group:

a) Maximum number of residents with LD or PD in Nursing Home, Residential Home or Supported Living benefitting from a GP Practice providing them with the Care Home Enhanced Service
b) All staff caring for residents are involved in the planning of care, which is also documented, involving service user and carers as appropriate
c) Consistent delivery of care plans eg ensuring service users receive care for LTCs, relevant screening, access to specialist services, other primary care (eg dentistry, optometry)
d) Optimising medication to meet residents clinical needs, including focus on problematic polypharmacy
e) Promoting system improvements, including evidence from Admission Episode Reviews completed for each hospital admission
f) Optimum use of urgent care: A&E attendances, Unplanned Admissions to hospital, calls made to SWAS, the GP OoH Service and NHS 111
g) Ensure all residents are protected from harm, including staff training (eg safeguarding), using sources of support and reporting concerns
h) Ensure all residents (and/or their carers/family) feel they have the treatment and support that is best for them from the Enhanced Service provider
i) Ensure residents receive an integrated service from local primary and community care services, working in partnership with the Care Home staff, residents and their families/carers.

#

3. Scope

1.1 Aims and objectives of service

The overall aim of this Enhanced Service is to improve the quality of care to residents in Care Homes for people with LD or PD in Gloucestershire by ensuring optimum and consistent access to, and provision, of NHS primary medical

Further aims include:

- To provide **equitable access** for all patients in Care Homes to NHS primary care services;
- To improve the **quality** of life and clinical outcomes for patients;
- To implement a more **pro-active approach** to care rather than reactive, preventing problems arising before they occur;
- To achieve **greater integration** and communication between each Care Home, the local GP Practices, Out-of-Hours services and community service providers to:

    - optimise the clinical time/input that is delivered to each patient/resident;
    - ensure continuity of care;
    - avoid duplication;
    - minimise unnecessary delays;

- To **optimise use of Out of Hours** services by Care Home staff, ensuring non-urgent requests are dealt with in a timely fashion 'In Hours';
- To **improve prescribing practice** with reduced costs and burdens of problematic polypharmacy, including reducing waste and unwanted medicines;
- To support the process of **upskilling staff** working in Care Homes.

3.2 Service description/care pathway

This Enhanced Service must be delivered by GPs employed by the Provider, i.e. a salaried GP or GP Partner. The only exception to this is if the Provider decides to subcontract any element of the medication review process to the local community pharmacy.

Service elements are to be monitored by the Practice running the MiQuest query monthly, set up by the CCG and the information required is listed below.

SERVICE ELEMENTS

1) ***Regular Planned GP Visits***

The cornerstone of the model of care is an expectation that the participating GP practice will have regular contact with the Care Home and Care Home staff to deliver pro-active Care Planning, building effective GP/patient and inter-staff working relationships and acting as impetus for quality of care improvements.

This contact with the Care Home will be a visit at least once a month, and could be on a fixed date of the week/time. For the Care Home visits, the process will involve review of the resident and/or the case management of their notes, in partnership with the Care Home lead nurse/person in charge; it will therefore involve assessing all those residents in need of being seen, but not necessarily all residents routinely. However, in order to deliver a person-centred service, using a strengths-based approach for normalising contact with the GP, some of these contacts would be a booked time-slot for an extended home visit or for the Service User to attend the surgery, with Care Staff, family member as appropriate, for an extended consultation.

This approach is proposed as a way of ensuring excellent relationships are formed and maintained between the GP practice and the Care Home staff, and the Service user and GP, and will act as a key enabler to delivering the required elements of the Enhanced Service, for example assessment of resident on admission, six-monthly reviews of care, care planning, and admission episode reflections. Success will be reliant on a reciprocal relationship between the GP practice and the Care Home staff to ensure all parties are fully supported to maximise the health benefits to patients. It is important that no less often than once a quarter the GP will need to meet with the Care Home manager: this would be a GP visit to the Care Home, Care Staff visit to the GP Practice, or telephone review as appropriate to the health/social care need of the Service User and the type of accommodation where s/he lives. This will provide an opportunity for the GP to be an active partner in helping the Home to improve clinical care,

together reflecting on the issues faced over the period and seeking to agree how they can be addressed. This will also include a review of all hospital attendances and admissions, unscheduled care events, deaths or other quality of care issues in that period, for example in order to identify common themes.

PATIENT DEPENDENCY: Where relevant the Care Home will be responsible for completion of the Barthel Index (or equivalent recognised Tool) to assess patient dependency, which should then be reviewed as relevant through the Planned GP Visit as part of the assessment and review process (within many elements of this Enhanced Service). This will need to be updated periodically by the Care Home staff. The GP will be responsible for acting upon the relevant and appropriate outcomes from completion of the Tool.

NUTRITIONAL ASSESSMENT: The Care Home will be responsible for completion of the Malnutrition Universal Screening Tool (MUST) (or equivalent recognised Tool) to assess nutritional requirements, which should then be reviewed as relevant through the Planned GP Visit as part of the assessment and review process (within many elements of this Enhanced Service). This will need to be updated periodically by the Care Home staff. The GP will be responsible for acting upon the relevant and appropriate outcomes from completion of the Tool.

PAIN MANAGEMENT: Where relevant the Care Home will also be responsible for completion of the Abbey Pain Tool (or equivalent recognised Tool) to understand if residents have any pain management issues, which should then be reviewed as relevant through the Planned GP Visit as part of the assessment and review processes (within many elements of this Enhanced Service). This will need to be updated periodically by the Care Home staff. The GP will be responsible for acting upon the relevant and appropriate outcomes from completion of the Tool. This Tool is also being used by GHNHSFT, thus ensuring consistency of care if the resident ever requires hospital admission.

2) ***Practice Register***

All practices are required to hold a register of its patients with LD or PD in each Care Home, including highlighting those patients at the End of Life, which will need to be regularly updated. All Care Home residents will need to be coded as 'Lives in a Care Home' by the practice to enable monitoring and review of all hospital admissions by practice/CCG Information Officers.

Clinical Term	V2 Code	V3 Code (TPP Only)	Additional "free text" requested (if applicable)
Residential Status Read Code			
Lives in care home	13FX	XaMFG	If resident is at End of Life please also add "End of Life" as free text

3) ***Care Planning, including End of Life***

3a) General Care Plan

The GP will lead the production of a documented health and social care plan that is agreed between the resident, GP, family and Care Home staff following holistic assessment of the resident covering their psychological, emotional, social, spiritual and physical needs. For clarification, the care plan is to include plans pro-active LTC management, for screening, vaccinations, dental or optometrist appointments.

3b) End of Life Care Plan

Additionally, for patients in the last 6-12 months of life, it is expected the GP will lead the production of an End of Life care plan agreed between the resident, GP, family and Care Home staff; this could include DNAR instructions and an Advance Care Plan (e.g. future wishes and preferences about what to do if hospital admission is proposed, funeral and will planning etc). In the last week of a residents' life, the GP may also wish to lead the production of a specific care plan. For those residents on an End of Life Plan, GP practices will also need to input the Plan onto the Adastra End of Life Template to ensure coordinated communication with OOH services.

Where relevant the GP will lead the completion of the Best Interest Decision Tool for those residents identified as lacking in capacity to prevent inappropriate unplanned admissions and interventions. DoLs guidance will be followed.

The CCG has issued guidance on the latest process to be followed for End of Life planning and documentation.#

Clinical Term	V2 Code	V3 Code (TPP Only)	Additional "free text" requested (if applicable)
Care Planning, including End of Life			
Personal care plan completed	8CMD	XaRB2	N/A
End of life care pathway	8CMW3	XaZe1	Please also add "End of Life Care Plan Agreed" as free text
"*Inputting End Of Life Care Plan onto Adastra"* GP out of hours service notified	9e0	XaItp (capital i)	Please also add "Via Adastra EoL template" as free text
Best interest decision made on behalf of patient (Mental Capacity Act 2005)	9NgE	XaYYQ	Please also add "Best Interest Decision Tool Completed" as free text

#

4) ***Assessment of Resident on Admission to Care Home***

Each resident will be assessed by a GP within two weeks of admission (even if records from the previous GP have not been received). The comprehensive assessment will need to include an initial examination and medication review, and review of medical condition(s), functional status, capacity (thus supporting the primary care dementia pathway), general health and medication. This will be documented on a standard template.

Clinical Term	V2 Code	V3 Code (TPP Only)	Additional "free text" requested (if applicable)
Assessment of Resident on Admission to Care Home			
Initial patient assessment	3891	XaIBH (capital i)	N/A

#

5) ***Review of Care of all residents every six months***

Each resident's care will be reviewed by a GP every six months. The review will use and build on the outcomes from the process for assessment of resident on admission. It will be an opportunity to holistically review the residents health and social care needs and be closely linked in with the medication review process. It will form a shared action plan and could be completed in-house or in the Care Home. This will be documented on a standard template.

Clinical Term	V2 Code	V3 Code (TPP Only)	Additional "free text" requested (if applicable)
Review of Care of all residents every six months			
Assessment (procedure)	7L1W	XaM2b	N/A

6) ***Medication Review***

A medication review needs be undertaken routinely every six months for each resident and ad hoc when there have been changes eg discharge from hospital. This should help reduce inappropriate repeat prescribing and poly-pharmacy. Whilst GPs are the prescriber and so have overall responsibility/accountability, a key partner in ensuring this process is of the highest quality is the local community pharmacy team; each Care Home has a single dedicated community pharmacy team that dispenses the prescriptions. Community pharmacists can undertake

Medicine Use Reviews (MUR) each year for each of their patients and the CCG is working closely with community pharmacists to ensure people living in a Care Home have access to this service. Before GP practices undertake the Medication Review, they will be expected to liaise with the relevant community pharmacist to discuss the outcome of the resident's MUR.

Best practice guidance on undertaking Medication Reviews will be made available to GPs, including a standard template. Finally, if GP practices participating in this Enhanced Service wish to sub-contract the Care Home's local community pharmacist to undertake a proportion of the Medication Review, this will be at their discretion.

The successful PharMcare pilot scheme is to be extended during 2016/17 to a wider number of care homes. In care homes where this pilot is being carried out, Practices providing the CHES will need to work in close collaboration with the senior pharmacist undertaking the pilot. The prescribing pharmacist will undertake annual indepth medication reviews, with a focus on improving quality & safety, medicines reconciliation on discharge from hospital and tackling polypharmacy including use of anti-psychotics and reduction in prescribing spend.

Clinical Term	V2 Code	V3 Code (TPP Only)	Additional "free text" requested (if applicable)
Medication review			
Medication review done	8B3V	XaF8d	N/A
Medicine use review done by community pharmacist	8BMF	XaKuo	N/A

#

7) ***Admission Episode Reflections***

It is recommended that an Admission Episode Reflection is undertaken for all residents who are admitted to an acute or community hospital from a Care Home. This would be undertaken by the GP with the support of the Care Home staff and a standard template is available to document this. Factors to be reviewed include whether the admission could have been avoided, the patient experience whilst in hospital and the quality of discharge process and information.

This reflective practice will help contribute to the Continuing Professional Development of all parties with the aim of reducing the likelihood of reducing emergency admissions in future. For those residents where it is the opinion of the GP that the admission may have been avoided or there were concerns about quality of care, including the discharge process, then this information is to be shared with the CCG via the quarterly return. This is to include instances where either if the situation had been handled differently at the time or if something could have been put in place earlier so that the urgent care need or quality of care issues did not arise.

Clinical Term	V2 Code	V3 Code (TPP Only)	Additional "free text" requested (if applicable)
Admission Episode Reviews			
Assessment of needs - review	3896	XaJnj	N/A

#

8) ***Special Notes***

Individualised summary patient notes will be produced for each resident and made available to unscheduled care providers (i.e. the OOH service at present, until access can be given to A&E) through completion of the 'Special Notes' section in Adastra. These will need to be updated at least six-monthly. A standard template will be available for completion. This will guide the decision-making process between the OOH GP and the Care Home when considering a hospital admission.

Clinical Term	V2 Code	V3 Code (TPP Only)	Additional "free text" requested (if applicable)

Special Notes			
Summary clinical document	9Ee04	XaX2q	N/A

#

9) ***Bone Protection/Falls Prevention***

If appropriate, the GP/practice will be responsible for ensuring all residents have a falls assessment using a recognised Tool and be prescribed Calcium and Vitamin D medication in line with current formulary choices, unless contra-indicated. All residents at risk of osteoporosis must be assessed for the need to prescribe a bisphosphonate (or an alternative if not tolerated, as per the Gloucestershire Formulary).

Clinical Term	**V2 Code**	**V3 Code (TPP Only)**	**Additional "free text" requested (if applicable)**
Bone Protection/Falls Protection			
Falls assessment	38A	XaJL7	Please also add "Including Medication Assessment" as free text
At risk of osteoporosis	14O9	XaELC	Please also add "Assessed for Bisphosphonates" as free text

10) ***Safeguarding, Mental Capacity Act and Deprivation of Liberty Training***

All GPs delivering the CHES will need to be trained annually in Adult Safeguarding Level 2. This can be through attending an adult safeguarding session, run by the Gloucestershire Safeguarding Adults Board training team. This would usually be via an educational event raising awareness of all aspects of caring for vulnerable people to ensure that they are protected from harm.

All GPs delivering the CHES will be expected to undertake annual training on the Mental Capacity Act and Deprivation of Liberty: this could be as part of the Safeguarding training session or via elearning.

11) ***Lead GP Role***

It is recommended that a named GP takes a lead role for delivery of the ES, with a deputy to cover leave/sickness/etc, thus maximising continuity of relationship with the Care Home. For those practices covering larger Homes, it maybe that there are two lead GPs and/or several deputies.

12) ***Zoning***

Experience elsewhere nationally, and within parts of Gloucestershire, suggests that having a small number (e.g. 1, 2 or 3) GP Practices covering a Care Home improves working relationships and therefore positively impacts on the quality of patient care. Practices who are doing this find it a far more efficient way of working and Gloucestershire Commissioning Localities have been strengthening their approach to GP zoning of Care Homes.

13) ***Engaging Secondary Care Physician Colleagues***

There are benefits from close working between GP practices and local secondary care specialists for LD services eg specialist nurses, consultant psychiatrists. This ranges from phone advice contact, through to physical presence of the GP and physician in the Care Home. Further work is required to scope and test a best practice pathway, which will be promoted to GPs partaking in this Enhanced Service if/when relevant.

3.3 Population covered

Gloucestershire patients registered at the [INSERT PRACTICE NAME] who reside in a Nursing Home or Residential Home / Supported Living for people with Learning Disabilities.
At the start of this contract these are the eligible homes that the Practice may work with. [LIST THE RELEVANT CARE HOMES – TBC BY PRACTICE].:

3.4 Any acceptance and exclusion criteria and thresholds

Included

- Gloucestershire GP patients with LD or PD who are residents of Gloucestershire Nursing Homes, Residential Homes or Supported Living for people with Learning Disabilities or Physical Disabilities.
- Gloucestershire GP patients with LD or PD who are residents of Nursing Homes, Residential Homes or Supported Living for people with Learning Disabilities or Physical Disabilities outside of the Gloucestershire boundary where it is practicable for the full ES service to be provided.
- Patients aged 18 years and over

Excluded

- Residents of Nursing Homes or Residential Homes already covered by the Older People Care Homes Enhanced Service (CHES)
- Residents of Nursing Homes, Residential Homes or Supported Living in Gloucestershire catering mainly for people with Mental Health challenges eg eating disorders, substance misuse
- Residents of Educational Establishments eg Ruskin Mill
- Temporary Residents
- Those residents who are discharged from hospital or from the community to a Care Home with the principle aim of supporting them through to their imminent death
- Those residents who are not registered with a Gloucestershire GP
- Residents who are under 18 years old

Notes for clarification:

- this service will enhance not duplicate current NHS arrangements eg LD ES
- private arrangements between the GP and Care Home Provider would cease for the adoption of this service

3.5 Interdependence with other services/providers

These include:

- Gloucestershire Nursing Homes, Residential Homes and Supported Living & Service Providers
- Gloucestershire County Council
- NHS Gloucestershire Care Services, including ICTs and specialist services
- Gloucestershire CCG
- PharMCare prescribing pharmacists
- Local Community Pharmacists
- Gloucestershire Hospitals NHS Foundation Trust
- Other local GP Practices

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

Practices must adhere to all of the relevant:

- NICE Standards and Guidance
- Care Quality Commission (CQC) Essential Standards of Quality and Safety

The following Assessment Tools are to be used:

- Abbey Pain Tool (or recognised equivalent Tool);
- Malnutrition Universal Screening Tool (or recognised equivalent Tool);
- Barthel Index (or recognised equivalent Tool);
- Early Warning Score Tool (for Nursing Homes only).

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

All relevant National Guidance to be followed including:

- The Confidential Inquiry into premature deaths of people with intellectual disabilities in the UK: a population-based study (2014)

4.3 Applicable local standards

All relevant Local guidance to be followed including:

- Local Safeguarding Policies and Procedures
- End of Life guidance and related care planning documentation
- Falls response protocol

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

See appended sheet

Note: Prescribing Pharmacy Pilot to be monitored by the pharmacists delivering the service

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

N/A

Practices are to be paid quarterly on receipt of claim stating the number of occupied beds for each care home as at the last weekday of the month.

Enhanced Service for Physical Disabilities, Sensory Disabilities or Mental Health Challenges Care Homes

Measuring Impact: Commissioning Outcomes

Patient Experience, Patient Safety and Clinical Effectiveness

These Commissioning Outcomes were developed to assess the overall impact of the CHES_LD/PD on quality of service experienced by residents in Learning or Physical Disabilities Care Homes including key components of patient experience such as better health and social care planning, improved access to health care and medicines optimisation.

The Impact Areas and Performance Measures set up to measure progress on the Commissioning Outcomes are shown in Table 1 and the additional CHES_LD.PD delivery indicators monitored via Read codes are shown in Table 2. Progress on performance is to be set out in a monitoring dashboard.

Table 1: Impact Areas and Performance Measures for Commissioning Outcomes
Note: data to be analysed separately for service users with LD or PD

Area of Impact	Performance Measure
People in LD/PD Care Homes benefitting from their GP providing them with the Enhanced Service	• Number (%) of residents in Care Homes benefitting from CHES_LD/PD • Number (%) of Care Homes with at least one GP Practice providing the CHES_LD/PD
Ensure a planned approach is taken to the provision of care	• Number of relevant residents on the AdAstra End of Life template • Number of residents who have an agreed & documented general health and social care plan • Number of residents in last months of life who have an agreed & documented End of Life Care Plan • Number of residents who are placed on a Practice Register as a Care Home resident, including flag for those who are End of Life
Residents are cared for in a safe environment	• Each GP providing CHES_LD/PD to undertake annual Adult Safeguarding Level 2, Mental Capacity Act and DoLs training
Clinically effective usage of medicines	• Number of medication reviews for residents of CHES_LD.PD Care Homes • Number of residents in CHES_LD.PD Care Homes prescribed 4 or more medicines • Number of Medicines Usage Reviews undertaken by community pharmacists • *Note: prescribing pharmacy pilot to monitor its service in addition to CHES_LD.PD*
Use of unscheduled care services	• Number of residents attending A+E from relevant Care Homes / number of attendances • Number of residents admitted to acute or community hospital on unplanned basis / number of admissions • Length of stay of each resident admitted as unplanned • Number of residents re-admitted within 30 days of discharge

	• Number (%) of residents who die in hospital
Understanding of how to improve quality of care	• Admission Episode Reflection completed for each planned or unplanned admission
Ensuring residents feel they have the treatment and support that is best for them	• *Tbc – patient / carer feedback on eg feeling they have the treatment and support that is best for them from CHES_LD/PD provider, feeling they have been treated with dignity & respect by the CHES_LD/PD provider, measures of Health and Wellbeing*

Table 2: CHES_LD/PD delivery indicators monitored via Read codes:

No. of patients living in Care Home included in Enhanced Service	No. of 6 monthly medication assessments
No. of pts with an End of Life Care Pathway agreed.	No. of 6 monthly medication assessments by community pharmacists
No. of initial patient assessments	No. of Admission Episode Reflections
No. of 6 months full assessment in last 6 months	No. of 6 Monthly Special Notes section in Adastra completed or updated
No. of personal care plans completed	No. of Falls Assessments
No. of Adastra EoL templates completed	No. of Osteoporosis Assessments
No. of Best Interest Decision Tools completed or updated	

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 8

Primary Care Commissioning Committee

Meeting Date	**Thursday 28th July 2016**
Title	**Sevenposts: Bishops Cleeve premises development – confirmation of Value for Money and BREEAM approach**
Summary	The Practice currently has a list size of around 10,000 patients providing a full range of general medical services from two sites in Prestbury, Cheltenham and Bishop Cleeve. NHS Gloucestershire Primary Care Trust approved a proposal to close these two sites and develop as new single site in Bishop Cleeve in March 2013. Following the completion of a further business case, NHS England also approved the GP led proposal in August 2014. This set out specific conditions and was subject to the District Valuer confirming value for money. The District Valuer has now reviewed all elements of the financial appraisal and confirms Value for Money (VfM).
Risk Issues: **Original Risk** **Residual Risk**	The key risk regarding this proposal is that should the new surgery development not proceed, the long term provision of suitable primary care premises for a growing population will be substantially affected.
Financial Impact	A full financial appraisal has been developed and the new surgery can be delivered at an agreed revenue cost of £186,000 for the first three years. This is £14,000 less per year than the local norm would be and reflects the benefit of reduced land costs associated with the scheme and fees reimbursed to the practice. The current rent (£69,100) paid to the practice per annum will offset some of these costs and the net increase in revenue costs will be £116,900.
Legal Issues (including NHS Constitution)	The CCG will need to apply NHS Premises Directions to rights and responsibilities of the practice and the

	CCG. In terms of the NHS Constitution the author considers 'You have the right to expect your NHS to assess the health requirements of your community and to commission and put in place the services to meet those needs as considered necessary' and 'You have the right to be cared for in a clean, safe, secure and suitable environment' as the most pertinent NHS Constitution rights applicable to this scheme.
Impact on Health Inequalities	No health inequalities assessment has been completed for this report.
Impact on equality and Diversity	No equality and diversity impact assessment has been completed for this report.
Impact on Sustainable Development	As this scheme is over £2m in value, the practice has commissioned a BREEAM Pre – assessment report for the new building. This has been reviewed by the CCG, NHS England and the District Valuer. The development is seeking excellent rating. Whilst this is fully anticipated for the building, for the overall project, this might not achievable due to factors outside its control due to transportation, land use and ecology reasons. The project will proceed with the objective of meeting the excellent rating. All reasonable endeavours will be made to achieve, or come close to achieving excellent by the opening date and there will be sufficient evidence to show this.
Patient and Public Involvement	The practice has had a programme of patient engagement and involved its Patient Participation Group during the lifetime of this programme of work. It should also be noted that the CCG has also met with a number of key stakeholders regarding this development over the last 6 month to 12 months.
Recommendation	Following the advice of the District Valuer confirming value for money, members are requested to grant final approval to this scheme and agree the financial implications set out in this report.
Author	Andrew Hughes
Designation	Locality Implementation Manager
Sponsoring Director	Helen Goodey Director of Locality Development and Primary Care

Primary Care Commissioning Committee
Thursday 28th July 2016

Sevenposts: Bishops Cleeve premises development - confirmation of Value for Money and BREEAM approach

1 Introduction, background and context

1.1 The Practice currently has a list size of around 10,000 patients providing a full range of general medical services from two sites:-

- Sevenposts surgery at Prestbury Road, Cheltenham (approximately serving 4,500 patients);
- Greyholmes surgery, Bishops Cleve (approximately 5,500 patients).

1.2 In order to tackle population growth and other service issues, NHS Gloucestershire Primary Care Trust approved a new surgery in March 2013.

1.3 Following the completion of a further business (available to committee members on request) and satisfaction around patient transport issues, NHS England approved the GP led proposal to develop a new primary care centre of up to 950m2 gross internal area in August 2014 (letter from NHS England to practice available on request). This set out specific conditions and was subject to the District Valuer confirming value for money.

1.4 It should be noted that the CCG confirmed this status in the Primary Care Infrastructure Plan 2016/ 2021, which was approved in March 2016.

1.5 The proposal entails construction of a purpose built facility on a greenfield site North West of Bishop Cleeve. The site was acquired for a nominal fee through section106 arrangements as a consequence of the 'Cleevelands' housing development. It should be noted that the Practice have informed the CCG that in order to keep the Section 106 arrangement in place, it now needs to submit its planning application in August 2016 (all necessary requirements to complete purchase of the site need to be completed by 1st November 2016).

1.6 On completion of the new surgery, the two current surgeries will close and all services will be provided from this new facility. This is planned to be within the next three years- the summer of 2019.

1.7 Over the last few months, the practice and their advisors have been liaising with the District Valuer and the CCG regarding financial elements, particularly around the impact of reduced land costs resulting from section 106 arrangements. The District Valuer has now reviewed all elements of the financial appraisal and confirms Value for Money (VfM). The report is available to committee members on request. The main points to note are as follows: -

- the DV has externally inspected the site from the highway, discussed the project with thee practice and its advisors, and considered all Value for Money (VFM) aspects for recommending the proposed project;

- the DV has set out their assessment of the estimated “Current Market Rent” (CMR) recommended for reimbursement in accordance with, and as defined in the NHS (GMS - Premises Costs) Directions 2013;

- the report reflects the current intention of the practice to be owner-occupier;

- the report sets out the agreed CMR review arrangements to reflect the fees grant and the S106 Agreement land provision;

- it is noted that the practice is currently considering creating a leasehold position, and the likely lease terms have been discussed. If this option is taken forward, it will require an amended report to confirm VFM on those terms;

- the present terms and conditions pertaining to the above are detailed in the report; and

- the DV is of the opinion that subject to all of the terms and conditions recommended in their report being fully complied with, the proposed scheme will now satisfy NHS requirements and represent value for money to the NHS, and the DV confirm that they recommend the scheme for CCG approval.

2 Financial issues

2.1 A full financial appraisal has been developed and the new surgery can be delivered at an agreed revenue cost of £186,000 for the first three years. This is £14,000 less per year than the local norm would be and reflects the benefit of reduced land costs.

2.2 After 3 years, the rent will increase £190,000 (a 2.1% increase). Triennial reviews in year 6, year 9 and year 12 will be linked to the consumer price index (CPI) changes from the beginning to the end of each period. There will be a compound 3% cap applied 1% collar- minimum and the baseline value will be £190k.

2.3 This is slight departure from typical NHS Premises Directions. However, is recommended by the DV as the best approach for taking into account the specifics of this scheme. From year 15 onwards matters will revert to typical current market rent review processes.

2.4 The opening balance of £186,000 is made up of £185 per m^2 based upon the NIA of 950sqm, developed in line with the 'Business Case Guidance and Space Allowances 2013', Primary Care Guidance, with reference to the (HBN11). There are also 45 car parking spaces @ space reimbursed at £228.

2.5 The current rent (£69,100) paid to the practice per annum will offset some of these costs and the net increase in revenue costs will be £116,900 It should be noted that the practice will have its business rates, clinical waste and, if applicable, refuse costs reimbursed.

3 BREEAM approach

3.1 The Building Research Establishments Environmental Assessment Method (BREEAM) is the national standard for assessing the sustainability of new construction developments.

3.2 It aims to differentiate between developments with higher environmental performance by providing a sustainability ratings across 9 indicators (management, health and wellbeing, energy, transport, water, materials, wastes, land use and technology and

pollution)There are 6 performance levels (unclassified, pass, good, very good, excellent and outstanding).

3.3 There is a national government requirement that generally for new public buildings, the rating should be excellent. The NHS oversees compliance with this, although the NHS stipulates this applies to schemes that cost over £2m to complete.

3.4 It is recognised, there may be instances where exceptional circumstances that might limit the ability of the designers to fully achieve an excellent rating, or where, again for exceptional reasons, the costs of meeting requirements would clearly not represent value for money. Such instances need to be considered by specialist BREEAM assessors and any derogation from the appropriate requirement needs to adequately explained and robust.

3.5 As this scheme is over £2m in value, the practice has commissioned a BREEAM Pre – assessment report for the new building. This has been reviewed by the CCG, NHS England and the District Valuer.

3.6 The development is seeking excellent rating. Whilst this is fully anticipated for the building, for the overall project, this might not achievable due to factors outside its control due to transportation, land use and ecology reasons.

3.7 The project will proceed with the objective of meeting the excellent rating. All reasonable endeavours will be made to achieve, or come close to achieving excellent by the opening date and there will be sufficient evidence to show this.

4 Recommendation

4.1 Following the advice of the District Valuer confirming value for money, members are requested to grant final approval to this scheme and agree the financial implications set out in this report.

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 9

Primary Care Commissioning Committee

Meeting Date	**Thursday 28th July 2016**
Title	**Primary Care Quality Report**
Executive Summary	This report provides assurance to the Committee and Governing Body that quality and patient safety issues are given the appropriate priority and that there are clear actions to address them.
Risk Issues: **Original Risk** **Residual Risk**	Failure to secure quality, safe services for the population of Gloucestershire.
Financial Impact	There is no financial impact
Legal Issues (including NHS Constitution)	Compliance with the NHS Constitution, NHS Outcomes Framework and recommendations from NICE and CQC.
Impact on Health Inequalities	A focus on the delivery of equitable services for the residents of Gloucestershire and which will reflect the diversity of the population served.
Impact on Equality and Diversity	There are no direct health and equality implications contained within this report.
Impact on Sustainable Development	There are no direct sustainability implications contained within this report.
Patient and Public Involvement	This report provides information about Patient and Public involvement, engagement and experience activity.
Recommendation	The PCCC is asked to note the content of this report.
Author	Marion Andrews-Evans
Designation	Executive Nurse and Quality Lead
Sponsoring Director (if not author)	

Agenda Item 9

Primary Care Commissioning Committee
Primary Care Quality Report
Thursday 28th July 2016

1 Introduction

1.1 At the request of the Committee the CCG Quality Team has been asked to submit a Primary Care Quality Report to each committee session. This report will include quality indicators from across primary care.

1.2 Should the committee wish to include any further information in future iterations of this report the Quality Team will be happy to support these requests where such information is available.

2 Serious Incidents

2.1 In General Practice, Serious Incidents are normally called 'Significant Events'. These should be reported via a GP eform (https://report.nrls.nhs.uk/GP_eForm) which will automatically alert the National Reporting and Learning System and NHS England.

3 Complaints & Concerns

3.1 Responsibility for complaints and concerns in relation to primary care remains with NHS England. GCCG has asked for detail regarding any such complaints and information has been provided as below;

3.2 NHSE is unable to share further detail of complaints due to potential IG concerns that could lead to patient identifiable information being shared. Some complaints may relate to performer issues, which in theory may relate to one of the CCG members.

3.3 We understand the NHSE national complaints team are developing a dashboard with CCGs and regional teams at the

moment and exploring how best to manage these issues together in the future.

4 Safeguarding

4.1 Appointment of Named GP for Safeguarding

4.1.1 GCCG has appointed a Named GP for Safeguarding Adults and Children and the post-holder has now started. This post will work closely with other Designated and Named Professionals in Gloucestershire, supporting all activities necessary to ensure that Gloucestershire NHS Providers meet their responsibilities to safeguard children, young people and vulnerable adults in Gloucestershire.

4.1.2 Additionally the post holder will be integral in supporting the development and delivery of effective safeguarding training to Primary Care, and provide safeguarding supervision to GP's, particularly with the writing of the GP reports for Serious Case Reviews, Adult Case Reviews and Domestic Homicide Reviews. This will form a significant part of the role.

5 Primary Care Clinical Quality Review Group

5.2 The meeting of this group scheduled for May 2016 was unable to proceed due to lack of quorum. This meeting is being rescheduled.

6 Patient Experience

6.1 GP Services Friends & Family Test

6.1.1 The FFT results for GP Practices in Gloucestershire present a mixed picture. The full data is available on the FFT website at: https://www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/. It should be noted that in most cases the response rates for practices in Gloucestershire, in line with other areas nationally, are very low and therefore cannot be considered to be statistically significant when looking at one month's data in isolation.

6.1.2 The Primary Care Contracts Team will be reminding practices

monthly of the deadline for submitting FFT data. The data, henceforth will be reviewed on an ongoing basis to look for any trends by the Primary Care Clinical Quality Review Group and will also be shared, together with GP Patient Survey data (see below), with Locality Executive Groups.

6.2 Patient Participation Groups (PPG)

6.2.1 GCCG has established the Gloucestershire Patient Participation Group (PPG) Network. The 2 meetings have now taken place and these have been well attended.

6.2.2 An audit has shown that over 90% of practices in Gloucestershire have an established PPG. The CCG is supporting the remaining practices, with advice about recruiting members, developing constitutions and considering work plans.

7 CQC Inspections

7.1 CQC has now commenced a planned schedule of CQC inspections for Gloucestershire practices. It is anticipated that this will conclude by end of September 2016, excluding any practices which have been subject to merger which will conclude by the end of 2016.

7.2 Members of the GCCG Quality Team have met with the Inspection Manager and will maintain dialogue with the inspection teams whilst these are underway to identify any concerns.

7.3 The Primary Care CQRG will continue to monitor outcomes from these inspections and offer support as necessary to practices who are considered to require improvement.

7.4 A dashboard of completed and published CQC Inspections Reports is attached at **Appendix 1** for information.

8 Medicines Optimisation

8.1 Quality Premium (QP) Antimicrobial Resistance (AMR)

8.1.1 UK 5 Year Antimicrobial Resistance (AMR) Strategy 2013–2018

includes 7 key areas for action:

1.Improving infection prevention and control practices
2.Optimising prescribing practice
3.Improving professional education, training and public engagement
4.Developing new drugs, treatments and diagnostics
5.Better access to and use of surveillance data
6.Better identification and prioritisation of AMR research needs
7.Strengthened international collaboration

8.1.2 Optimising prescribing practice has resulted in a QP for AMR. It is a composite Quality Premium consisting of three parts:

a) reduction in the number of antibiotics prescribed in primary care by 1% (or greater) from each CCG's 2013/14 value. Individual practice reduction to be agreed by the CCG with each practice. (Oct 13 -Sept 14 1.081 STARPU, Threshold 2015/16 1.078 STARPU)

b) number of co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of selected antibiotics prescribed in primary care to be reduced by 10% from each CCG's 2013/14 value, or to be below the 2013/14 median proportion for English CCGs (11.3%), whichever represents the smallest reduction for the CCG in question. (Oct 13- Sept 14 11.00%)

c) secondary care providers with 10% or more of their activity being commissioned by the relevant CCG have validated their total antibiotic prescribing data as certified by PHE.

8.1.3 The CCG achieved all three improved antibiotic prescribing QP targets for 2015/16;

1. Target to be equal or lower than 1.078 items/STAR PU. Actual 10.07.
2. Target 11.3% or below. Actual 10.7%.
3. Compliant

8.1.4 The guidance for 2016/17 and the levels of improvement for CCGs to achieve in order to qualify for the quality premium have been published. It is a composite Quality Premium consisting of two parts:

a) reduction in the number of antibiotics prescribed in primary care. The required performance in 2016/17 must either be:
a 4% (or greater) reduction on 2013/14 performance
OR
equal to (or below) the England 2013/14 mean performance of 1.161 items per STAR-PU

b) number of co-amoxiclav, cephalosporins and quinolones as a proportion of the total number of selected antibiotics prescribed in primary care to either:
- to be equal to or lower than 10%, or
- to reduce by 20% from each CCG's 2014/15 value

8.1.5 NHS England (BGSW) has established a working group to share approaches to the 2016-17 Quality Programme, linking with AMR project lead from NHS England. The County-wide antibiotic prescribing group will maintain a consistent approach to tackling AMR and achieving the QP.

8.1.6 The Primary Care Offer has included an incentive requiring a 1% reduction on antibiotic prescribing. This will be monitored through the Medicines Optimisation team. The CCG will continue to work with practices to reduce these rates.

8.1.7 It should be noted that the Quality Premium does not apply exclusively to improved prescribing but also includes indicators in relation to cancer treatment, GP Patient Survey and E-Referrals. Full details can be found in the guidance at **Appendix 2.**

8.2 A Medicines Optimisation Programme Group has been established, and meets fortnightly. The Terms of Reference are attached at **Appendix 3**. There are three strands to the work of this group, which are Primary Care, Secondary Care and Crossover between Primary and Secondary Care. There are individual project initiation documents for all the 26 identified projects. The Project Management Office supports this work and

maintains a summary of project progress.

8.3 Appointment of Independent GP Prescribing support

8.3.1 The CCG has engaged the services of an independent GP from Oxfordshire, who will visit practices who are struggling with their prescribing and medicines optimisation performance. This is entirely a supportive role, the GP using her extensive past role as a dispensing GP partner in rural Oxfordshire. This GP is a Fellow of The Royal College of GPs an education associate of the GMC and a previous GP Dean of Health Education Thames Valley.

8.3.2 The GP will be fully briefed on the CCG, the individual localities and practices within each locality and the challenges faced by individual practices.

8.3.3 It is stressed that the visits will be supportive, sympathetic and understanding with the aim to help the practice develop a recovery plan that they feel that they can successfully fulfil, contributing to the successful achievement of the financial challenge of the prescribing budget performance**.**

9 Workforce

9.1 Appointment of Practice Nurse Facilitators

The CCG has appointed three Practice nurse facilitators, covering Forest of Dean, Cheltenham and Cotswolds. Interviewing for the remaining posts is in July.

Appendices

1. Dashboard of completed and published Gloucestershire GP CQC inspection reports

2. NHS England Quality Premium Guidance 2016/17

3. Medicines Optimisation Programme Group Terms of Reference

Appendix 1 Gloucester GP CQC Inspection reports

Lead GP	Practice Name	Address (Main Surgery)	Locality	Date of Inspection	Date of Publication of report	Overall Rating	Safe	Responsive	Caring	Effective	Well-Led	Older People	LTC	Families, CYP	Working Age People	Vulnerable	Poor Mental Health	Link to report
Dr Alan Gwynn	Avenue Surgery	1 The Avenue, Cirenester GL7 1EH	Cotswold	19/04/2016	27/05/2016	Good	●	●	●	●	●	●	●	●	●	●	●	http://www.cqc.org.uk/location/1-556469798/reports
	Newent Doctors Practice	The Holts Health Centre, Watery Lane, Newent, GL18 1BA	Tewkesbury	01/03/2016	19/04/2016	Good	●	●	●	●	●	●	●	●	●	●	●	http://www.cqc.org.uk/location/1-542806401
	Royal Well Practice	St Pauls Medical Centre, 121 Swindon Road, Cheltenham, GL50 4DP	Cheltenham	23/02/2016	19/04/2016	Good	●	●	●	●	●	●	●	●	●	●	●	http://www.cqc.org.uk/location/1-555957231
Dr S Nelson & Partners	Overton Park	Overton Park Road, Cheltenham, GL50 3BP	Cheltenham	17/02/2016	20/04/2016	Good	●	●	●	●	●	●	●	●	●	●	●	http://www.cqc.org.uk/location/1-589508826
	Staunton & corse Practice	The Surgery, Corse, Staunton, Gloucester, GL19 3RB	Tewkesbury	03/02/2016	01/06/2016	Good	●	●	●	●	●	●	●	●	●	●	●	http://www.cqc.org.uk/location/1-564501229
	Partners in Health	Pavilion Family Doctors, 153a Stroud Road, Gloucester, GL1 5JJ	Gloucester	28/01/2016	20th April 2016	Good	●	●	●	●	●	●	●	●	●	●	●	http://www.cqc.org.uk/location/1-594053855
	Frithwood	45 Tanglewood Way, Bussage, Stroud, GL6 8DE	Stroud & BV	28/01/2016	22/03/2016	Good	●	●	●	●	●	●	●	●	●	●	●	http://www.cqc.org.uk/location/1-545514544
Dr C Buckley & Partners	Frampton Surgery	The Surgery, Whitminster Lane, Frampton-on-Severn, Gloucester, GL2 7HU	Stroud & BV	22/12/2015	22/03/2016	Good	●	●	●	●	●	●	●	●	●	●	●	http://www.cqc.org.uk/location/1-552817287
	Rendcombe		Cotswold	10/12/2015	11/02/2016	Good	●	●	●	●	●	●	●	●	●	●	●	http://www.cqc.org.uk/location/1-558360411/reports

Dr Weir & Partners	Minchinhampton Surgery	Bell Lane, Minchinhampton GL6 9JF	Stroud & BV	25/11/2015	11/02/2016	**Outstanding**	●	●	✡	✡	✡	✡	✡	✡	✡	✡	✡	http://www.cqc.org.uk/location/1-542147718/reports
	Forest Health Care	Cinderford Health Centre, Dockham Road, Cinderford GL14 2AN	Forest of Dean	04/11/2015	21/01/2016	**Good**	●	●	●	●	●	●	●	●	●	●	●	http://www.cqc.org.uk/location/1-554837077/reports
	Heathville Medical Practice	GL1 3PX	Gloucester	27/10/2015	17/12/2015	**Good**	●	●	●	●	●	●	●	●	●	●	●	http://www.cqc.org.uk/directory/1-1482438584
	Acorn Practice	May Lane, Dursley GL11 4JN	Stroud & BV	25/08/2015	10/12/2015	**Good**	●	✡	●	●	●	●	●	●	●	●	●	http://www.cqc.org.uk/location/1-557468481/reports
	Walnut Tree Practice	May Lane, Dursley GL11 4JN	Stroud & BV	18/08/2015	10/12/2015	**Good**	●	✡	●	●	●	●	●	●	●	●	●	http://www.cqc.org.uk/location/1-565831306
	Mitcheldean Surgery	Brook Street, Mitcheldean, GL17 0AU	Forest of Dean	05/08/2015	17/09/2015	**Good**	●	●	●	●	●	●	●	●	●	●	●	http://www.cqc.org.uk/location/1-568423037
	Locking Hill	Locking Hill, Stroud, GL5 1UY	Stroud & BV	14/01/2015	04/06/2015	**Good**	●	●	●	●	●	●	●	●	●	●	●	http://www.cqc.org.uk/location/1-561930325
	College Yard Surgery	Mount Street, Westgate, GL1 2RE	Gloucester	07/01/2015	30/07/2015	**Good**	●	●	●	●	●	●	●	●	●	●	●	http://www.cqc.org.uk/location/1-569496604
	Highnam Surgery	Lassington Lane, Highnam, Gloucester, GL2 8DH	Gloucester	07/01/2015	30/07/2015	**Good**	●	●	●	●	●	●	●	●	●	●	●	http://www.cqc.org.uk/location/1-569496621
Dr Richard Probert	Culverhay Surgery	Wotton-under-Edge GL12 7LS	Stroud & BV	09/12/2014	09/04/2016	**Good**	●	●	●	●	●	●	●	●	●	●	●	http://www.cqc.org.uk/location/1-542890220/reports

NHS England

Quality Premium

Guidance for 2016/17

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	**Commissioning Strategy**
Finance		

Publications Gateway Reference:	**04798**
Document Purpose	Guidance
Document Name	Quality Premium: 2016/17 Guidance for CCGs
Author	NHS England / Commissioning Strategy / Contracts and Incentives
Publication Date	09 March 2016
Target Audience	CCG Clinical Leaders, CCG Accountable Officers, Local Authority CEs, NHS England Regional Directors
Additional Circulation List	CCG Clinical Leaders, CCG Accountable Officers, Local Authority CEs, NHS England Regional Directors
Description	The Quality Premium is intended to reward CCGs for improvements in the quality of services they commission and for associated improvements in health outcomes and in reducing health inequalities.
Cross Reference	N/A
Superseded Docs (if applicable)	Quality Premium: 2015/16 Guidance for CCGs published 27 April 2015 (reissued 21 September 2015)
Action Required	For action by CCGs
Timing / Deadlines (if applicable)	**None**
Contact Details for further information	england.qualitypremium@nhs.net Contracting and Incentives Quarry House Leeds LS2 7UE http://www.england.nhs.uk/resources/resources-for-ccgs/ccg-out-tool/ccg-ois/qual-prem/

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Quality Premium

2016/17 guidance for CCGs

Version number: 1

First published: March 2016

Prepared by: NHS England Contracts and Incentives Team

Classification: OFFICIAL

Contents

1 Executive summary

1. The Quality Premium (QP) scheme is about rewarding clinical commissioning groups (CCGs) for improvements in the quality of the services they commission. The scheme also incentivises CCGs to improve patient health outcomes and reduce inequalities in health outcomes and improve access to services.

2. The 2016/17 scheme has been designed to support the delivery of the major priorities for the NHS, as set out in the Five Year Forward View and in the NHS Mandate. The CCG Improvement and Assessment Framework is the mechanism by which progress will be monitored; therefore it is appropriate to align the national QP indicators with those in the CCG Improvement and Assessment Framework. By taking this approach, the QP scheme focuses on those things already identified as critical to delivering the vision.

3. The local indicators remain a strong tool by which CCGs are able to engage and drive improvements in areas agreed with their local partners. This year, the local element of the scheme is focused on the Right Care Programme, providing an opportunity for CCGs to engage partners in driving improvements that will help maximise the value for patients and the whole population. Early focus on the Right Care approach and opportunities highlighted in the tailored Commissioning For Value (CFV) packs, alongside priorities being addressed through the local Health & Well Being Board, will enable local areas to make the best choices to improve patient outcomes, and get the best value out of the money they are spending.

4. As in previous years, it is important that we retain a focus on the fundamentals of everyday commissioning. These include delivery of the NHS Constitution commitments on Referral to Treatment Times, A&E, Ambulance and Cancer waiting times; adhering to quality regulatory standards, and delivering financial balance. Thus, the QP scheme will view CCG performance in the round - on the national and local priorities as well as on the fundamentals of commissioning to recognised standards.

2 Background

5. Under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), NHS England has the power to make payments to CCGs to reflect the quality of services that they commission, the associated health outcomes and reductions in inequalities.

6. The maximum QP payment for a CCG is expressed as £5 per head of population, calculated using the same methodology as for CCG running costs, and made as a programme allocation. (This is in addition to a CCG's main financial allocation for 2016/17 and in addition to its running costs allowance.)

7. Regulations set out that QP payments should be used in ways that improve quality of care or health outcomes and/or reduce health inequalities.

8. NHS England has sought to design the QP taking into account the regulations, and promoting the objectives in the Five Year Forward View and the NHS Mandate through:

    - rewarding CCGs for improved outcomes in the services they commission in line with the CCG Improvement and Assessment Framework;

    - supporting local priority-setting by identifying the opportunities via the CFV packs so they can be aligned with the joint health and wellbeing strategies;

    - promoting reductions in health inequalities and recognising the different starting points of CCGs; and

    - reinforcing the importance of patients' rights and pledges under the NHS Constitution.

9. Specific communities, or individuals with similar specific needs, may be disproportionately represented within the groups relevant to each QP measure. In developing their improvement plans for each measure, CCGs should consider their knowledge of their local population and whether there are specific communities or patient groups for whom a bespoke focus may be appropriate. CCGs should consider whether specific engagement is required with relevant communities or patient groups in order to inform the approaches to be taken. As part of developing their local improvement plans for each QP measure, CCGs should take into account meeting their legal duties in respect of equality and reducing health inequalities in meeting the needs of their local diverse communities.

3 Composition of the QP

3.1 National and local priorities

10. The QP paid to CCGs in 2017/18 – to reflect the quality of the health services commissioned by them in 2016/17 – will be based on measures that cover a combination of national and local priorities.

11. There are four national measures and in total are worth 70% of the QP (full details are set out in Appendix 1):

- Cancer (20% of quality premium);
- GP Patient Survey (20% of quality premium);
- E-Referrals (20% of quality premium);
- Improved antibiotic prescribing in primary care (10% of quality premium).

12. This year, the local element of the QP focuses on the Right Care programme and is worth 30% of the QP. CCGs are expected to identify three measures and each will be worth 10%. These measures should be identified from the CFV packs. CCGs will need to work with NHS England regional teams to agree the local proposal, and the levels of improvement needed to trigger the reward. The process should take the following into account:

- Step 1
    - CCGs should initiate the selection process, following the "Where to Look" phase of Right Care;
    - This will identify areas of unwarranted variation locally, and so define the potential list of improvement programmes to be included;
    - This process should aim to deliver population health gain and garner local clinical support, and might be informed locally by the Health and Well Being Board priorities;
    - Selection of improvement programmes will be supported by the Right Care Delivery Partners for those areas in wave 1, and by NHS England Regional Teams elsewhere;

- Step 2
    - The list of improvement programmes will need to be refined into the three specific indicators, and agree levels of improvement;
    - In selecting the actual metrics, clearly these must offer the potential for CCGs to drive improvement;
    - To support this selection, we have included an initial assessment of each of the Right Care metrics for data timeliness and variation at appendix 3.

13. CCGs will be required to submit their local proposal and levels of improvement (as agreed with the Regional Team) to NHS England as part of

the CCG Operational Planning process. This will be submitted as part of CCGs 11th April submission of final Operating Plans.

3.2 Quality gateway

14. CCGs are responsible for the quality of the care and treatment that they commission on behalf of their population. NHS England reserves the right not to make any quality premium payments to a CCG in cases of serious quality failure, i.e. where it is identified that:

    a) a local provider has been subject to enforcement action by the Care Quality Commission; or

    b) a local provider has been flagged as a quality compliance risk and/or have requirements in place around breaches of provider licence conditions; or

    c) a local provider has been subject to enforcement action based on a quality risk;

    and

        i) it has been identified through NHS England's assessment of the CCG, in respect of the quality and governance elements of the Improvement and Assessment Framework, that the CCG is not considered to be making an appropriate, proportionate response with its partners to resolve the above quality failure; and

        ii) this continues to be the position for the CCG at the 2016/17 end of year assessment.

15. As an alternative to withholding the quality premium in the circumstances above, NHS England may, at its discretion, make the quality premium available to the relevant CCG if the CCG agrees to use the quality premium payment to help resolve the serious quality failure.

16. It is important that the quality premium and assessment processes are well aligned. Should the assessment process criteria with respect to quality failure change during 2016/17, NHS England may amend the above criteria in order to maintain alignment with it, including if assessment criteria are introduced to identify quality failures within CCGs.

3.3 Financial gateway

17. Effective use of public resources should be seen as an integral part of securing high-quality services. A CCG will not receive a quality premium if:

    a) in the view of NHS England, during 2016/17 the CCG has not operated in a manner that is consistent with the obligations and principles set out in Managing Public Money[1]; or

    b) ends the 2016/17 financial year with an adverse variance against the planned surplus, breakeven or deficit financial position[2], or requires unplanned financial support to avoid being in this position; or

    c) it receives a qualified audit report in respect of 2016/17.

3.4 NHS Constitution gateway

18. As in previous years, a CCG may have its quality premium award reduced via the NHS Constitution gateway. In 2016/17, some providers will have agreed bespoke trajectories for delivery of RTT, 4hr A&E, 62 day Cancer waits and Red 1 Ambulance response times. On this basis, the CCG gateway test in respect of these measures will be adjusted to reflect these differential requirements. More details are set out in Appendix 2.

NHS Constitution requirement	**Reduction to Quality Premium**
Maximum 18 weeks from referral to treatment – incomplete standard	25%
Maximum four hour waits in A&E departments- standard	25%
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer.	25%
Maximum 8 minute response for Category A (Red 1) ambulance calls	25%

Full details are in Appendix 2.

[1] https://www.gov.uk/government/publications/managing-public-money
[2] CCGs are measured against all delegated budgets.

4 Calculation and use of QP payments

19. The maximum QP payment for a CCG will be expressed as £5 per head of population, calculated using the same methodology as for CCG running costs. (This is in addition to a CCG's main financial allocation for 2016/17 and in addition to its running costs allowance.)

20. For each measure where the identified quality threshold is achieved, the CCG will be eligible for the indicated percentage of the overall funding available to it.

21. Where a CCG has failed to meet the requirements of the quality or financial gateways set out in paragraphs 14 - 17 above, it will not receive a QP payment except where NHS England exercises its discretion with respect to the quality gateway as set out in paragraph 15 above.

22. Where a CCG does not deliver the identified patient rights and pledges on waiting times, or bespoke trajectories towards these in the case of CCGs who commission from providers in receipt of the S&TF, a reduction for each relevant NHS Constitution measure will be made to the QP payment.

23. It is planned that CCGs will be advised of the level of their QP award in quarter 3 of the 2017/18 financial year. In order to maximise its ability to make the most effective use of the payment within 2017/18, each CCG should consider making plans for use of the payment in advance of this date, so that these plans can be implemented as soon as the level of award is confirmed.

24. QP payments can only be used for the purposes set out in regulations[3]. These state that QP payments should be used by CCGs to secure improvement in:

    a) the quality of health services; or

    b) the outcomes achieved from the provision of health services; or

    c) reducing inequalities between patients in terms of their ability to access health services or the outcomes achieved.

25. CCGs may utilise the QP payment with other organisations to deliver the improvements above where appropriate wider powers are available for the use of the funding in this manner.

26. Each CCG is required[4] to publish an explanation of how it has spent a QP payment.

27. A worked example of a quality premium calculation is set out overleaf.

[3] The National Health Service (Clinical Commissioning Groups-Payments in Respect of Quality) Regulations 2013 (S.I. 2013/474)

[4] Section 223K(7) of the NHS Act 2006

Worked example of quality premium calculation (for illustration only)

- a CCG has a population of 160,000
- the CCG satisfies the financial and quality gateways for 2016/17
- the CCG achieves all the national measures with the exception of early cancer diagnosis
- the CCG does not achieve one of its local measures
- the CCG meets three out of the four NHS Constitution measures.

Measure	Percentage of quality premium	Potential value for illustrative CCG	Measure achieved	Eligible quality premium funding
Improving antibiotic prescribing in primary care	10%	£80,000	Y	£80,000
Cancer	20%	£160,000	N	£0
E-Referrals	20%	£160,000	Y	£160,000
GP Patient Survey	20%	£160,000	Y	£160,000
Local measure 1	10%	£80,000	Y	£80,000
Local measure 2	10%	£80,000	Y	£80,000
Local measure 3	10%	£80,000	N	£0
TOTAL	**100%**	**£800,000**		**£560,000**

NHS Constitution rights and pledges	Measure achieved[5]	Adjustment to funding	Quality premium funding
RTT-incomplete	Y	-	
A&E waits	Y	-	
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer.	Y	-	
Category A Red 1 ambulance calls	N	25%	£140,000
Total adjustment			
NET TOTAL PAYABLE			**£420,000**

[5] In the case where a CCG commissions from providers in receipt of the S&TF, assessment will be based on performance in Q4 2016/17 against bespoke trajectories towards the NHS Constitution rights and pledges.

Appendix 1: Quality premium measures

Quality premium measure	**Cancers diagnosed at early stage**
Threshold	This is a two-part Quality Premium. To earn this portion of the quality premium, CCGs will need to either: 1. Demonstrate a 4 percentage point improvement in the proportion of cancers (specific cancer sites, morphologies and behaviour*) diagnosed at stages 1 and 2 in the 2016 calendar year compared to the 2015 calendar year. Or 2. Achieve greater than 60% of all cancers (specific cancer sites, morphologies and behaviour*) diagnosed at stages 1 and 2 in the 2016 calendar year.
Value	20% of quality premium.
Rationale	Cancer survival rates in England have never been higher, but we know that we often lag behind the highest performing countries in the world in international comparisons. We also know that the earlier cancer is diagnosed, the more likely it is to be successfully treated, and survival rates can be dramatically improved. The independent cancer taskforce, in their report *Achieving World-Class Cancer Outcomes*, published in July 2015, set an ambition for the NHS that 62% of all cancers with known stage at diagnosis would be diagnosed at stages 1 and 2 by 2020. Achieving this target will require every CCG to focus on and make significant improvement in early stage diagnoses. Specific public health interventions, such as screening programmes and public information campaigns can aim to improve rates of early diagnosis. Supporting clinicians to spot cancers earlier and greater GP access to diagnostic and specialist advice were outlined in the Five Year Forward View as key planks of improving our diagnostic strategies. In addition, NICE published new guidance on appropriate referral for suspected cancer in 2015, which lowered the threshold of risk for symptoms suggestive of cancer to trigger an urgent referral for suspected cancer to 3%, with the aim of diagnosing more cancers at an early stage. An indicator on the proportion of cancers diagnosed at an early stage is therefore a useful measure for assessing improvement in early diagnosis and ultimately cancer survival. Improving cancer survival is one of the three key

	ambitions outline in *Achieving World-Class Cancer Outcomes*. Thresholds have been set based on levels of improvement previously seen amongst high-performing CCGs and felt to be achievable for the majority of CCGs.
Technical definition	New cases of cancer diagnosed at stage 1 and 2 as a proportion of all new cases of cancer diagnosed (specific cancer sites, morphologies and behaviour*) **Numerator:** Cases of cancer diagnosed at stage 1 or 2, for the specific cancer sites, morphologies and behaviour* **Denominator:** All new cases of cancer diagnosed at any stage or unknown stage, for the specific cancer sites, morphologies and behaviour* *invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphomas, and invasive melanomas of skin.
Data source	Cancer Analysis System, National Cancer Registry, Public Health England
Published Frequency & Timeliness	Previously published annually, quarterly data will be available from May 2016. Data will be a rolling window of one year's worth of data. The data will be lagged by 12 months.

Quality premium measure	**Increase in the proportion of GP referrals made by e-referrals**
Threshold	To earn this portion of the quality premium, CCGs will need to, either: • Meet a level of 80% by March 2017 (March 2017 performance only) and demonstrate a year on year increase in the percentage of referrals made by e-referrals (or achieve 100% e-referrals), or; • March 2017 performance to exceed March 2016 performance by 20 percentage points.
Value	20% of quality premium.
Rationale	Increasing the use of the NHS e-Referrals Service is vital to delivering a paper free NHS. Use of the NHS e-Referrals Service benefits patients, NHS staff and NHS organisations: • Patients are empowered through having confidence and certainty about their referral, being able to exercise patient choice and experiencing reduced waiting times. • Staff are able to better ensure patient safety through reducing inconsistencies and errors in referrals processes. • CCGs and Providers are able to deliver more efficient planned care and access management information to drive service improvements. CCGs will be able to influence the uptake of e-Referrals within their GPs practices and in collaboration with providers from which they commission services.

Technical definition	Proportion of new first outpatient appointment GP referrals into consultant-led services (all two week waits referrals are also included). This excludes referrals into community services and Mental Health which are set up as triage or non-consultant led services. **Numerator**: number of referrals for a new first outpatient appointment (or two week wait) booked through the e-referrals system **Denominator**: total GP referrals for a first outpatient appointment. Denominator figures from the Monthly Activity Return (MAR) are GP referrals made to 1st outpatient, incorporating revisions where these have been processed on Unify2, with any necessary adjustments to remove General Dental Practitioner referrals.
Data source	Numerator: NHS e-referral system (HSCIC) Denominator: Monthly activity return (MAR) (NHS England)
Published Frequency & Timeliness	Monthly (two month lag due to lag in MAR data)

Quality Premium measure	**Overall experience of making a GP appointment**
Threshold	To earn this portion of the quality premium, CCGs will need to demonstrate in the July 2017 publication, either: • Achieve a level of 85% of respondents who said they had a good experience of making an appointment, or; • A 3 percentage point increase from July 2016 publication on the percentage of respondents who said they had a good experience of making an appointment
Value	20% of quality premium.
Rationale	The GP Patient Survey (GPPS) seeks the views of 2.4 million people every year about their experience of GP services and results are published at GP practice level. The survey gives patients the opportunity to provide feedback on a number of aspects of their experience of their GP practice, and provides a rich source of quantitative data on patients' experiences of the access and quality of care they receive. Access to GP services, and, in particular, the ease of making an appointment is a key measure of patient experience, and affects the wider healthcare system as patients who find it difficult to access GP services may seek care through emergency services inappropriately. Q18 ("Overall, how would you describe your experience of making an appointment?") of the GP Patient Survey (GPPS) is the "litmus test" indicator in this regard. Attaching a quality premium payment will also ensure that the profile and importance of insight about patient experience is underlined, and it will incentivise the wider system to review and learn from the findings of the GPPS.

Technical definition	Question 18: Overall, how would you describe your experience of making an appointment? • Very good • Fairly good • Neither good nor poor • Fairly poor • Very poor **Numerator:** the weighted number of people answering 'very good' or 'fairly good' to question 18 of the GP Patient Survey. This is expressed as $\Sigma_k(wt\_new_k)$ where k = 1, …, p which are all respondents who answer question 18 with either answering 'very good' or 'fairly good' . **Denominator**: the total weighted number of people who answer question 18 of the GP Patient Survey. This is expressed as $\Sigma_k(wt\_new_k)$ where k = 1, …, p which are all respondents who answer question 18 **Weighting** A weight is applied to construct the indicator. The GP Patient Survey includes a weight for non-response bias (wt_new). This adjusts the data to account for potential differences between the demographic profile of all eligible patients in a practice and the patients who actually complete the questionnaire. The non-response weighting scheme has been developed by Ipsos MORI, incorporating elements such as age and gender of the survey respondent as well as factors from the area where the respondent lives such as level of deprivation, ethnicity profile, ACORN classification and so on, which have been shown to impact on non-response bias within the GP Patient Survey. Further information on the current weighting scheme can be found in the survey's technical annex: http://gp-survey-production.s3.amazonaws.com/archive/2015/July/14-008280-01_Technical%20Annex%202014-2015.pdf
Data source	Data for this indicator is from the GP Patient Survey. This survey is commissioned by NHSEngland and is conducted by the independent survey organisation Ipsos MORI.
Published Frequency & Timeliness	Currently published twice annually, this will become annual in 2016/17. Publication will be in July representing data collection from January to March.

Quality premium measure	**Antimicrobial resistance (AMR) Improving antibiotic prescribing in primary care** This Quality Premium measure consists of two parts (each worth 50% of the Quality Premium payment available for this indictor): Part a) reduction in the number of antibiotics prescribed in primary care Part b) reduction in the proportion of broad spectrum antibiotics prescribed in primary care
Threshold	The two parts of the quality premium have specific thresholds as follows: Part a) reduction in the number of antibiotics prescribed in primary care. The required performance in 2016/17 must either be: • a 4% (or greater) reduction on 2013/14 performance OR • equal to (or below) the England 2013/14 mean performance of 1.161 items per STAR-PU Part b) number of co-amoxiclav, cephalosporins and quinolones as a proportion of the total number of selected antibiotics prescribed in primary care to either: - to be equal to or lower than 10%, or - to reduce by 20% from each CCG's 2014/15 value
Value	10% of the Quality Premium The value of the Quality Premium measure will be evenly weighted as follows: Part a) "reduction in the number of antibiotics prescribed in primary care" will be worth 50% of the quality premium payment available for this indicator. Part b) "reduction in the number of co-amoxiclav, cephalosporins and quinolones as a proportion of the total number of selected antibiotics prescribed in primary care" will be worth 50% of the quality premium payment available for this indicator.

Rationale	Antimicrobial resistant infections impact on patient safety and the quality of patient care. Evidence suggests that antimicrobial resistance (AMR) is driven by over-using antibiotics and prescribing them inappropriately. Reducing the inappropriate use of antibiotics will delay the development of antimicrobial resistance that leads to patient harm from infections that are harder and more costly to treat. Reducing inappropriate antibiotic use will also protect patients from healthcare acquired infections such as Clostridium difficile infections. The Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) published antimicrobial prescribing quality measures in October 2014 and these recommend primary care total antibiotic prescribing to be reduced to 2010 levels. https://www.gov.uk/government/groups/advisory-committee-on-antimicrobial-resistance-and-healthcare-associated-infection. Within this scheme, CCGs are not expected to reduce to levels lower than the England 2013/14 mean value = 1.161 items per STAR-PU, or to lower than 10% for the number of co-amoxiclav, cephalosporins and quinolones as a proportion of the total number of selected antibiotics. Broad spectrum antibiotics, such as co-amoxiclav, cephalosporins and quinolones should be prescribed in line with prescribing guidelines and local microbiology advice. Reducing inappropriate antibiotic use will protect patients from healthcare acquired infections such as Clostridium difficile infection.

Technical definition – part a)	**Part a) reduction in the number of antibiotics prescribed in primary care by 4% or to England 2013/14 mean value = 1.161 items per STAR-PU** **Individual practice reduction to be decided by the CCG.** **Numerator:** Number of prescription items for antibacterial drugs (BNF 5.1) within the CCG **Denominator:** Total number of Oral antibacterials (BNF 5.1 sub-set) ITEM based Specific Therapeutic group Age-Sex Related Prescribing Unit (STAR-PUs) http://www.hscic.gov.uk/prescribing/measures **Prescribing Data** This information can be obtained from the Information Services Portal (ISP) or the electronic Prescribing Analysis and CosT tool (ePACT) provided by NHS Business Services Authority which cover prescriptions prescribed by GPs, nurses, pharmacists and others in England and dispensed in the community in the UK. http://www.nhsbsa.nhs.uk/PrescriptionServices/3607.aspx http://www.nhsbsa.nhs.uk/3230.aspx For data at CCG level, prescriptions written by a prescriber located in a particular CCG but dispensed outside that CCG will be included in the CCG in which the prescriber is based. Prescriptions written in England but dispensed outside England are included. Prescriptions dispensed in hospitals, dental prescribing and private prescriptions are not included in the data. The data is to include prescribing by Out of Hours and Urgent Care services where relevant prescribing data is captured within ISP.

Technical definition – part b)	**Part b) number of co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of selected antibiotics prescribed in primary care to be equal to or lower than 10%, or to reduce by 20% from each CCG's 2014/15 value.** **Numerator:** Number of prescription items for BNF 5.1.1.3 (sub-section co-amoxiclav), BNF 5.1.2.1 (cephalosporins) and BNF 5.1.12 (quinolones) within the CCG **Denominator:** Number of antibiotic prescription items for BNF 5.1.1; 5.1.2.1; 5.1.3; 5.1.5; 5.1.8; 5.1.11; 5.1.12; 5.1.13 prescribed within the CCG **Prescribing Data** This information can be obtained from the Information Services Portal (ISP) or the electronic Prescribing Analysis and CosT tool (ePACT) provided by NHS Business Services Authority which cover prescriptions prescribed by GPs, nurses, pharmacists and others in England and dispensed in the community in the UK. http://www.nhsbsa.nhs.uk/PrescriptionServices/3607.aspx http://www.nhsbsa.nhs.uk/3230.aspx For data at CCG level, prescriptions written by a prescriber located in a particular CCG but dispensed outside that CCG will be included in the CCG in which the prescriber is based. Prescriptions written in England but dispensed outside England are included. Prescriptions dispensed in hospitals, dental prescribing and private prescriptions are not included in the data. The data is to include prescribing by Out of Hours and Urgent Care services where relevant prescribing data is captured within ISP. Details will be published in March 2016 of baseline (April2013-March2014 and April2014 – March2015) prescribing data values, and the 2016-17 target data value on which the threshold is measured.

Appendix 2- NHS Constitution requirements

Patient right or pledge	**Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral.**
Threshold and calculation method	The threshold will be different for each CCG and will reflect the performance requirements for each provider of activity to the CCG. Performance requirement: For providers in receipt of the S&TF the performance requirement will be the S&TF bespoke trajectory towards the waiting time standard in Q4 of 2016/17. For all other providers the performance requirement will be the actual waiting time standard, 92% of patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral. CCG performance requirement: CCGs are to submit operating plans that are reflective of the performance requirements of the providers from whom they commission. The CCG plan for Q4 2016/17 will act as the threshold against which performance will be assessed for the Quality Premium. The position for Q4 2016/17 will be measured from the incomplete Referral to Treatment (RTT) pathway snapshots (patients waiting to start consultant-led treatment at month end) in the monthly RTT returns from January 2017 to March 2017. The performance will be calculated by summing the numerators (patients waiting within 18 weeks) from each month-end over Q4 2016/17 and then dividing by the sum of all the denominators (patients waiting) from each month end over the same period.
Attribution to CCG	Data will be available by CCGs as providers will submit data on the basis of the CCG that is responsible for a given patient.
Technical guidance	See 2016/17 planning guidance technical definitions
Reduction in Quality Premium for non-achievement	25%

Patient right or pledge	**Patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department.**
Threshold and calculation method	The threshold will be different for each CCG and will reflect the performance requirements for each provider of activity to the CCG. Performance requirement: For providers in receipt of the S&TF the performance requirement will be the S&TF bespoke trajectory towards the waiting time standard in Q4 of 2016/17. For all other providers the performance requirement will be the actual waiting time standard, 95% of patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department. CCG performance requirement: CCGs are to submit operating plans that are reflective of the performance requirements of the providers from whom they commission. The CCG plan for Q4 2016/17 will act as the threshold against which performance will be assessed for the Quality Premium. The position for 2016/17 will be measured from Weekly Situation Reports (sitreps) and will consist of data for all types of A&E. The performance will be calculated by summing the numerators (number of 4 hour waits) from each week over Q4 2016/17 and then dividing by the sum of all the denominators (number of attendances) from each week over the same period.
Attribution to CCG	Data will be mapped from providers to CCGs using a mapping derived from Hospital Episode Statistics figures. This calculates what proportion of each provider can be attributed to a given CCG. Any activity that is under 1% of the trust's overall activity will be ignored in this mapping. Only organisations submitting on HES will have their activity mapped to CCGs. Therefore, any type 3 units that do not submit on HES will not have their sitrep data allocated to any CCG.
Technical guidance	See 2016/17 planning guidance technical definitions
Reduction in Quality Premium for non-achievement	25%

Patient right or pledge	**Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer.**
Threshold and calculation method	The threshold will be different for each CCG and will reflect the performance requirements for each provider of activity to the CCG. Performance requirement: For providers in receipt of the S&TF the performance requirement will be the S&TF bespoke trajectory towards the waiting time standard in Q4 of 2016/17. For all other providers the performance requirement will be the actual waiting time standard, 85% of patients should wait a maximum of two months (62-day) from urgent GP referral to first definitive treatment for cancer. CCG performance requirement: CCGs are to submit operating plans that are reflective of the performance requirements of the providers from whom they commission. The CCG plan for Q4 2016/17 will act as the threshold against which performance will be assessed for the Quality Premium. As performance data is collected on a quarterly basis then Q4 performance will be used and no further calculation is required.
Attribution to CCG	Data will be available by CCGs as providers will submit data on the basis of the CCG that is responsible for a given patient.
Technical guidance	See 2016/17 planning guidance technical definitions
Reduction in Quality Premium for non-achievement	25%

Patient right or pledge	**Red 1 ambulance calls resulting in an emergency response arriving within 8 minutes.**
Threshold and calculation method	The threshold will be different for each CCG and will reflect the performance requirements for each provider of activity to the CCG. Performance requirement: For providers in receipt of the S&TF the performance requirement will be the S&TF bespoke trajectory towards the waiting time standard in Q4 of 2016/17. For all other providers the performance requirement will be the actual waiting time standard, 75% of Red 1 ambulance calls result in an emergency response arriving within 8 minutes. CCG performance requirement: CCGs are to submit operating plans that are reflective of the performance requirements of the providers from whom they commission. The CCG plan for Q4 2016/17 will act as the threshold against which performance will be assessed for the Quality Premium. As performance data is collected on a quarterly basis then Q4 performance will be used and no further calculation is required.
Attribution to CCG	Data will be mapped from providers to CCGs based on the proportion of Lower layer Super Output Areas (LSOAs) within a CCG boundary served by each Ambulance Trust.
Technical guidance	See 2016/17 planning guidance technical definitions
Reduction in Quality Premium for non-achievement	25%

Appendix 3 - Identification of Right Care Metrics

To support the identification of local Right Care metrics, we have done an initial review of the suitability of the indicators with respect to attaching a quality premium payment. Our approach is set out below. Where the data timeliness is lagged by 12 months or more, (i.e. identified as Low) we would caution against use, as we would not be measuring improvements delivered via this scheme.

KEY	**High** Suitability	**Medium** Suitability	**Low** Suitability
Data Timeliness	quarterly or monthly frequency, and lag <6 months	Annual data and/or lag<9 months and/or potential to calculate more frequently/sooner	Annual (or worse) data and lag>12 months
Variation	High variation/scope to improve, and no significant small number or random noise issue	Less variation/scope to improve or some small number/random noise issue	Little variation/scope for improving or other major issue

Programme Budgeting category	Ref#	Indicator	Data Timeliness	Variation
Cancer	1	Cancer - Breast cancer screening in last 36 months	Low	
	2	Cancer - Receiving first definitive treatment within two months of urgent referral from GP	High	Medium
	3	Cancer - Successful quitters at 4-weeks	High	High
	4	% of breast cancers detected at an early stage (1 or 2)	Low	
	5	% of people aged 60 - 69 who were screened for bowel cancer in the previous thirty months	Low	
	6	% of colorectal cancers detected at an early stage (1 or 2)	Low	
	7	% of lung cancers detected at an early stage (1 or 2)	Low	
Circulation	8	Circulation - Reported prevalence of CHD on GP registers as % of estimated prevalence	Medium	High
	9	Circulation - Reported prevalence of hypertension on GP registers as % of estimated prevalence	Medium	High
	10	Circulation - Transient ischaemic attack (TIA) cases with a higher risk who are treated within 24 hours	Low	

Programme Budgeting category	Ref#	Indicator	Data Timeliness	Variation
	11	Emergency readmissions to hospital within 28 days for patients: stroke (%)	Low	
	12	% of patients returning to usual place of residence following hospital treatment for stroke	High	High
Endocrine	13	Additional risk of complication for myocardial infarction among people with diabetes (%)	Low	
	14	Additional risk of complication for heart failure among people with diabetes (%)	Low	
	15	Additional risk of complication for stroke among people with diabetes (%)	Low	
Gastro-intestinal	16	Gastro-intestinal - Emergency admissions for alcohol related liver disease	High	High
Genito-Urinary	17	Reported to estimated prevalence of CKD (%)	Medium	Medium
	18	% of people receiving dialysis undertaking dialysis at home	Low	
	19	% of patients on Renal Replacement Therapy who have a kidney transplant	Low	
Maternity	20	Maternity - Live births <2500 grams	Medium	High
	21	Maternity - Teenage conceptions (aged under 18)	Low	
	22	% of pregnant women vaccinated for flu	Medium	High
	23	Number of women known to be smokers at time of delivery per 100 maternities	High	High
	24	% of mothers who give their babies breast milk in the first 48 hours after delivery	High	High
	25	% of infants that are totally or partially breastfed at age 6-8 weeks	High	Low
	26	Rate of emergency admissions for gastroenteritis in infants aged <1 year per 10,000 population aged <1 year	Medium	High
	27	Rate of emergency admissions for respiratory tract infections in infants aged <1 year per 10,000 population aged <1 year	Medium	High

Programme Budgeting category	Ref#	Indicator	Data Timeliness	Variation
	28	Children who received 3 doses of DTaP/IPV/Hib vaccine at any time by their second birthday as a % of children reaching age 2 years within the period	Medium	Low
	29	Rate of hospital admissions caused by unintentional and deliberate injuries in children aged 0-4 years per 10,000 population aged <5 years	Low	
	30	% of children aged 4-5 years classified as overweight or obese	Medium	High
	31	Children who received 2 doses of MMR vaccine at any time between their first and fifth birthdays as a % of children reaching age 5 years within the period	Medium	Medium
	32	The mean number of teeth per child aged 5 years sampled which were either actively decayed or had been filled or extracted (due to decay)	Low	
Mental Health	33	Mental Health - Emergency hospital admissions for self harm	Medium	High
	34	Mental Health - Improving access to psychological therapies - recovered patients	Low	High
	35	Mental Health - People with mental illness and or disability in settled accommodation	High	High
	36	Mental Health - Reported numbers of dementia on GP registers as a % of estimated prevalence	Medium	High
	37	Access to IAPT services: People entering IAPT services as a % of those estimated to have anxiety/depression	High	High
	38	Waiting < 28 days for IAPT: % of referrals (in quarter) waiting <28 days for first treatment	High	High
	39	Completion of IAPT treatment: Rate completing treatment per 100,000 population aged 18+	High	High
	40	% of IAPT patients receiving a course of treatment	High	High
	41	% of IAPT patients given a provisional diagnosis	High	High
	42	% of IAPT referrals with treatment outcome measured	High	Low
	43	% of people who are "moving to recovery" of those who have completed IAPT treatment	High	High
	44	IAPT reliable recovery: % of people who have completed IAPT treatment who achieved "reliable improvement"	High	Medium

Programme Budgeting category	Ref#	Indicator	Data Timeliness	Variation
	45	Physical health checks for patients with Serious Mental Illness: summary score (average of the 6 physical health check indicators)	Low	
	46	The number of people on Care Programme Approach per 100,000 population aged 18+	High	High
	47	Mental health admissions to hospital: Rate per 100,000 population aged 18+	High	High
	48	The number of people subject to the Mental Health Act per 100,000 population aged 18+	High	High
	49	% of people aged 18-69 on Care Program Approach in employment	High	High
MSK	50	Emergency readmissions to hospital within 28 days for patients: hip replacements (%)	Low	
Neurology	51	Neurological - Emergency admission rate for children with epilepsy aged 0–17 years	Medium	High
Respiratory	52	Respiratory - Emergency COPD admissions relative to patients on disease register	Medium	High
	53	Respiratory - Reported prevalence of COPD on GP registers as % of estimated prevalence	Medium	High
	54	Emergency admission rate for children with asthma per 100,000 population aged 0–18 years	Medium	High
Trauma and injury	55	Injuries due to falls per 100,000 population ages 65+	Medium	High
	56	Hospital admissions caused by unintentional and deliberate injury for those aged 0-24 per 10,000 population	Medium	High
	57	% of patients returning to usual place of residence following hospital treatment for fractured femur	Medium	High
	58	Emergency readmissions to hospital within 28 days for patients: hip fractures	Low	
Cross-cutting	59	% of respondents aged 16 and over, with valid responses to the questions, doing less than the required level of activity to count as physically active.	Low	Medium
	60	% of people aged 18 and over who are self-reported occasional or regular smokers.	High	High
	61	Rate of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause per 100,000 total population	High	High

Programme Budgeting category	Ref#	Indicator	Data Timeliness	Variation
	62	% of the eligible population, aged 40 – 74 years, who have received an NHS Health Check since 1st April 2013	High	High
	63	% of patients aged 17+ with diabetes, as recorded on practice disease registers	Medium	High
	64	% of patients 18+ with depression, as recorded on practice disease registers	Medium	High
	65	% of people aged 18 and over self-reporting experiencing three or more long-term conditions	High	High
	66	% of people aged 18 and over with a long-term condition who report having a written care plan	High	High
	67	% of people aged 18 and over with a long-term condition who report using their written care plan to manage their day to day health.	High	Medium
	68	% of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months	Medium	Medium
	69	% of patients aged 65 years and over using any inpatient services where dementia was mentioned in discharge code	Medium	High
	70	Emergency admissions to hospital of people with dementia per 1,000 population aged 65+	Medium	High
	71	% of emergency admissions of people aged 65 and over with dementia (mentioned in discharge notes) where the length of stay was of 1 night or less	Medium	High
	72	% of people aged 18 and over with a long-term condition who report that they had enough support from local services to help manage their condition(s)	Medium	Medium
	73	Health related quality of life people with long term conditions: average score	Medium	Medium
	74	Difference in the employment rate between those with a long-term health condition and all those of working age	High	High
	75	Delayed transfers of care from hospital per 100,000 population aged 18+	High	High
	76	% of older people (aged 65 and over) who received reablement/rehabilitation services after discharge from hospital	Medium	High

Programme Budgeting category	Ref#	Indicator	Data Timeliness	Variation
	77	% of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Medium	Medium
	78	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes per 100,000 population aged 65+	Medium	High
	79	Emergency admissions for chronic ambulatory care sensitive conditions for people of all ages per 100,000 total population	High	High
	80	Emergency admissions to hospital for people aged 75 years and over with length of stay under 24 hours per 100,000 population aged <75	Medium	High

NHS
Gloucestershire
Clinical Commissioning Group

Medicines Optimisation Programme Group

Terms of Reference

Purpose

To provide NHS Gloucestershire Clinical Commissioning Group with strategic oversight of medicines optimisation, reporting jointly into the CCG Drugs and Therapeutics committee and GCCG Core Team.

Objectives

- To understand and guide medicines optimisation across primary and secondary care within county.
- Where appropriate facilitate Medicines Optimisation initiatives with neighbouring CCGs specifically relating to acute trust providers
- To establish Medicines Optimisation annual QIPP plans
- To facilitate improved communication between clinicians and non clinicians

Membership

- Deputy Director of Quality (CHAIR)
- Associate Director (PMO)
- Director of Finance
- Lead board member GP for Quality
- Lead Medicines Management Pharmacist
- Finance Accountant Lead for Medicines Optimisation
- Associate Director Finance
- Principal Management Accountant

Other representatives may be co-opted as and when required to advise and work on issues or projects for the group

In the case of decision making, the following are the minimum required to agree a decision:

-

Frequency of Meetings

The group will meet bi monthly or as frequently as necessary.

Linkages

The group will have linkage, through membership of the group, with the Gloucestershire Medicines Interface Group (MIG), The CCG Drug and Therapeutics committee and D&T committees from ²gether NHS Foundation Trust and Gloucestershire Hospitals NHS Foundation Trust, CCG Locality Commissioning Groups; and the Gloucestershire NICE & Clinical Effectiveness Group. GHNHSFT CMB.

March 2016
To be reviewed March 2018
Deputy Director of Quality

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 10

Primary Care Commissioning Committee

Meeting Date	**Thursday 28th July 2016**
Title	**General Practice Forward View Investment Plan**
Executive Summary	**Introduction** This paper provides an update on our response to the General Practice Forward View and supports the 30,000 place-based model. **Background** We are currently developing our Primary Care Strategy, which reflects the ambitions within the Five Year Forward View and the more recent General Practice Forward View, along with our local Sustainability and Transformation Plan (STP). The General Practice Forward View sets out a range of investment in primary care and makes a commitment that CCGs will provide £171 million of practice transformational support. GCCG has responded to this, in support of both the Primary Care Strategy and our STP, by inviting all practices to collaborate into groups, or "clusters", with a total registered list size of 30,000 patients or more to develop an expression of interest for innovative, transformative ideas that improve patient outcomes along with the sustainability of primary care and the wider Gloucestershire health economy. We have a proposed funding value of £1.2 million, representing approximately £2 per head of population.

In addition, we also asked localities for nominations for a GP Forward View Workstream, who had the mandate from the locality to represent primary care within the New Models of Care Board.

These GPs have been instrumental in bringing together their localities to form 'clusters' of 30,000+ patients.

Our clusters and their submissions

Locality	Collaborations
Cheltenham	Three clusters based on geography (c. 50,000 patients each)
Forest of Dean	All eleven practices in one cluster (c. 60,000 patients)
Gloucester City	Four clusters predominantly based on geography (c.31,000 – 52,000 patients each)
North Cotswold	All five practices in one cluster (c. 29,000 patients)
South Cotswold	All eight practices in one cluster (c. 58,000 patients)
Stroud & Berkeley Vale	Four clusters based on geography (c. 18,000 – 39,000 patients each)
Tewkesbury, Newent and Staunton	All four practices within one cluster (c. 43,000)
Total	15 clusters

This has represented a significant amount of

	effort in a short period and has provided the stimulus for practices to start working together 'at scale'. We have so far received 14 bids from these 15 clusters. They can be broadly categorised into three themes: • clinical pharmacists in primary care; • urgent care; and • frailty provision For inner-city Gloucester, mental health workers also feature as part of their proposed scheme. Common across the clusters has been an ambition within their ideas to keep patients at home, improve quality and safety and as a result reduce spend across the healthcare system. To ensure we maintain the momentum with these clusters and to capitalise on the excellent work so far, we are seeking delegated authority (later today) from the Governing Body to the following members of staff to approve the individual schemes: • Accountable Officer; • Chief Finance Officer; • Audit Committee Chair and Lay Member for Governance; and • Primary Care Commissioning Committee Chair The schemes are firmly placed within our ambitions for place-based care and provide the foundations for developing new models of care across the county.

Risk Issues: **Original Risk** **Residual Risk**	Two of our practices are yet to be included within a cluster. GCCG Primary Care and Localities Directorate and the GP lead are working to resolve this. One cluster has yet to submit a bid, which is in development. It is essential we do not lose momentum at this point. We therefore require delegated authority from the Governing Body to avoid the risk of practices and clusters disengaging due to time delays.
Financial Impact	The £1.2m will be identified from existing budgets reprioritised to drive the transformation agenda as per our commitment to delivering the General Practice Forward View.
Legal Issues (including NHS Constitution)	There are no known legal issues at this time. These bids, and our approach to delivering place-based care, particularly reinforces our support to the fifth of the seven key principles in the NHS constitution regarding working in partnership and across organisational boundaries in the interests of patients, local communities and the wider population. In addition, the right for patients to expect assessment of health requirements locally and to commission services accordingly.
Impact on Health Inequalities	Inherent within the place-based approach is the identification of health inequalities at a local level and devising plans to mitigate these. This has already started within these clusters and will only develop further as they mature.
Impact on Equality and Diversity	No known issues
Impact on Sustainable Development	Providing enhanced primary care provision locally will result in less travel for patients to acute sites.

Patient and Public Involvement	Where schemes result in locally different services, patient engagement will be undertaken by those clusters. This has already been identified and clusters will work with GCCG Patient Engagement and Experience team in achieving this.
Recommendation	The PCCC is asked to note the contents of this paper.
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