NHS
Gloucestershire
Clinical Commissioning Group

Primary Care Commissioning Committee (PCCC)

Meeting to be held at 11:00am on Thursday 26th January 2017 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 24th November 2016	Chair	Approval
4.	Matters Arising	Chair	
5.	Cheltenham Town Centre Development (*presentation* from Dr Sanjay Shyamapant, Dr Jim Ropner and Alistair Black)	Andrew Hughes	Information
6.	GP Forward View Update	Stephen Rudd	Information
7.	GP Access Fund contract extension and next steps	Jo White	Approval
8.	NHS England Commissioner guidelines for responding to requests from Practices to temporarily suspend patient registration	Jeanette Giles	Information
9.	Update on Primary Care Support England (Delivered on behalf of NHS England by Capita)	Jeanette Giles	Information
10.	Delegated Primary Care Commissioning Financial Report	Cath Leech	Information
11.	Draft Outline Budget Update	Cath Leech	Information
12.	Primary Care Quality Report	Marion Andrews-Evans	Information
13.	Primary Care Commissioning Committee self-assessment	Chair	Information
14.	Any Other Business (AOB)	Chair	

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

Date and time of next meeting: Thursday 30th March 2017 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 24th November 2016 in the Board Room, Sanger House, Gloucester GL3 4FE

Present:		
Alan Elkin	AE	Lay Member – Patient and Public Engagement (Committee Chair)
Marion Andrews-Evans	MAE	Executive Nurse and Quality Lead
Julie Clatworthy	JC	Registered Nurse
Joanna Davies	JD	Lay Member – Patient and Public Engagement
Colin Greaves	CG	Lay Member - Governance
Cath Leech	CL	Chief Finance Officer
Dr Andy Seymour	AS	Clinical Chair
Mary Hutton	MH	Accountable Officer
In attendance:		
Helen Goodey	HG	Director of Primary Care and Locality Development
Cllr Dorcas Binns	DB	Chair of the Health and Wellbeing Board
Andrew Hughes (Item 5)	AH	Locality Implementation Manager
Stephen Rudd	SR	Head of Locality and Primary Care Development
Claire Feehily	CF	Chair of Healthwatch Gloucestershire
Becky Parish	BP	Associate Director, Engagement and Experience
Alan Potter	AP	Associate Director of Corporate Governance
Fazila Tagari	FT	Board Administrator
There were 2 members of the public present.		

1 Apologies for Absence

1.1 There were no apologies received.

2 Declarations of Interest

2.1 AS declared a general interest as a GP member.

2.2 AE declared that the meeting was quorate and that he felt that AS should not be excluded from any discussions as there were no relevant and material conflicts of interests.

3 Minutes of the Meeting held on Thursday 29th September 2016

3.1 The minutes were approved subject to the amendment below:

- Section 5.11 to be amended to read: *'CF emphasised the importance of ensuring that the services were scoped around the local population and that the packaging was right to fit around the needs of the population whilst considering the national guidance during the* ***evaluation*** *process'.*

4 Matters Arising

4.1 28.01.2016 Item 9.1 – Any Other Business - AE advised that he had circulated a self-assessment questionnaire to members.

4.2 26.05.2016 Item 3.2 – Minutes of the Meeting held on Thursday 31st March 2016 – AH updated members regarding Stow Surgery and advised that the costs of the scheme had increased as the CCG was now requiring BREEAM excellent due to the scheme costing over £2m and was awaiting formal acceptance from the developer. The Committee accepted that not all public buildings could achieve the BREEAM approach.

4.3 28.07.2016 Item 8.13 - Sevenposts: Bishops Cleeve premises development – AH advised that the update was included in Agenda Item 5 (Premises Workstream Progress Report) and advised that the outcome from the planning application was still awaited.
Post Meeting Note: Planning permission was granted and it was anticipated that the developer would move as quickly as they could to progress to delivery.

4.4 29.09.2016 Item 7.13 - Smaller Improvement Grant Proposals – HG advised that the process was included in Agenda Item 5. **Item Closed.**

5 Premises Workstream Progress Report

5.1 AH presented the Premises Workstream Progress Report which outlined key progress for all areas of the premises workstream up to the 7th November 2016.

5.2 **Estates and Technology Transformation Fund (ETTF) –** AH advised that the CCG were informed that the Cheltenham Town Centre development would now proceed to business case and the due diligence process and had been awarded £2.9m funding. It was noted that other schemes that were awarded funding included Culverhay, Springbank and Cinderford Health Centre (for developing the business).

5.3 **New Churchdown Surgery** – AH advised that the scheme had now received formal planning approval and that it was progressing well.

5.4 **Kingsway** – AH advised that there had been some challenges in purchasing a new site. It was anticipated that a planning application would be submitted in the near future.

5.5 **Tewkesbury Primary Care Centre –** It was noted that handover was expected to be completed by the end of the week with the practices moving in during January 2017.

5.6 **Stoke Road –** AH advised members that work was progressing well against the plan. It was noted that the Clinical Chair and the local MP had visited the development to view progress.

5.7 **Longlevens –** Members noted that the handover process had already taken place and the property was awaiting a District Valuer assessment.

5.8 **Brockworth and Hucclecote** – AH advised that the joint proposal could only be developed when the Section 106 arrangements and greenfield site status were confirmed, which was subject to the outcomes of the Joint Core Strategy investigation. It was understood that the outcome of this would not be known until late 2017.

5.9 **Cheltenham Town Centre** – AH advised that work was progressing and that the five practices were working collaboratively to develop a business case.

5.10 **Cirencester –** Members were advised that the CCG and practices attended a workshop with Cotswold District Council departments and the developers of the Chesterton housing development to discuss NHS requirements.

5.11 **Gloucester City Health Centre** – AH advised that significant opportunity existed for a new surgery on the Quayside and Blackfriars regeneration site in Gloucester City Centre although the practices were concerned regarding the risks associated with a long term investment proposal. AH explained that the CCG were exploring an alternative long term solution for the local population.

5.12 **North West/ West Cheltenham –** The developer had submitted a planning application for housing development within the area. It was noted that an agreement of the process identifying which practice provides the services for this new population was required. The CCG was working closely with the developer and other agencies in order to procure a coordinated approach using the social sustainability model.

5.13 **West of Stonehouse** – AH advised that the CCG was reviewing a potential relocation of Regent Street surgery on the basis of a significant housing redevelopment West of Stonehouse. However, it was noted that the timeline for the development would be longer than anticipated.

5.14 **Beeches Green** – AH advised that this was a PropCo owned site and that the CCG was actively involved in the business case development process. It was noted that the CCG was in the process of procuring a professional to work with the practices to develop a full business case.

5.15 **Cinderford –** AH advised that the proposal should be fully aligned with the Forest of Dean community services review.

5.16 AE enquired into the rationale underpinning the ETTF process and how the decisions were made. AH felt that the process was quite AH

complex and that he had requested copies of the minutes of the meetings where the decisions were made in order to aid understanding of the rationale underpinning the decisions. AH also advised that the CCG had written to all practices informing them of the outcome of the process. MH suggested that further clarity on the ETTF process was sought from NHS England.

5.17 JC enquired if feedback had been sought on the schemes that had not been successful and was advised that this had also been queried. The Committee expressed disappointment on the level of funding that had been awarded in comparison to other regional areas. AE suggested that a review of the proposals submitted by other areas which was approved for the ETTF could also be undertaken.

5.18 AH drew attention to page 10 of the report, relating to the business case costs risk share proposal. It was noted that the CCG was discussing options with the practices and was keen to propose a 50% risk share with practices for business case support should the scheme not be approved or progress.

5.19 AH updated members on the small scale building improvement grant and advised that there was a strong indication that the funding from NHS England would not be available. AH explained that the CCG was asked to submit further capital proposal and that these were being worked through with the CCG Finance Team. AH advised that he had submitted a request for £4m improvement grant fund for the following year to NHS England as part of their operational planning process.

5.20 The Committee discussed the format of the report. JC felt that it would be helpful if further context to the schemes i.e. clarity on fees was included within the report.

5.21 CF questioned the process for managing expectations, particularly in terms of communicating the STP ambitions and the availability of any primary care funding for premises. MH advised that it is embedded within the STP and part of the wider picture and that timing was crucial to the development process. BP advised that the next PPG event would be focusing on the STP in order to allow a more facilitated discussion on these areas. AH also highlighted the potential additional risks that could arise in the future from not

addressing any premises issues

5.22 CG drew attention to Section 5.4 of the report relating to the arrangements with NHS England and PropCo for signing off the commissioner support letter. CG expressed his disappointment and requested that the process was modified and suggested that a letter was written highlighting that CCG had delegated authority for primary care. AH agreed that he would work this through with CL and HG. AH

5.23 <u>RESOLUTION:</u> The Committee noted the contents of the report.

6 General Practice Forward View update

6.1 SR provided a presentation relating to the General Practice Forward View (GPFV). The presentation covered

- what does GPFV want to achieve;
- latest guidance;
- general practice resilience programme;
- general practice development programme;
- transformational support;
- improving access;
- GPFV programme high level summary; and
- other schemes in GPFV.

6.2 JC enquired on the level of interest received from practices and was advised that practices were really keen and that the CCG was working with the Local Medical Committee and the Royal College of General Practitioners (RCGP) to develop the bids in order to accelerate the process further. JC suggested that this was linked with the Quality Academy.

6.3 DB enquired of the plans for communicating with the public and was advised that a communications plan had been developed. HG advised that funding had been allocated for communication in relation to this process. DB also enquired of the timeline of the consultation process and it was agreed that Anthony Dallimore, Associate Director of Communications, would share the communication plan with members at the January 2017 meeting. AD/ HG

6.4 JD queried if an impact evaluation had been undertaken. HG HG advised that this would be confirmed at the January 2017 meeting.

6.5 CF queried if there was an awareness of the risks associated with the funding processes and the possibility of the national objectives not aligning with local priorities and the project mapping of change. MH stated that the pace of change could be affected by national directives and that the CCG would like to accelerate changes quicker than the national timescales. MH advised that further work on understanding the relationship between the national and local responsibility was required.

6.6 DB requested six monthly updates on the progress of the national recruitment issues and the plans to address the GP shortage crisis. HG advised that the CCG had a workforce workstream which comprised of a workforce plan which was part of the overall strategy. HG advised that the plan included the development of the trainee retention scheme which was a key priority for this year and that a meeting with ST3s (Speciality Trainee, 3rd Year) was scheduled for the following week to discuss this. AS suggested that a further survey should be undertaken in order to review any recruitment issues. The Committee discussed how practices could use the opportunities to change the practice skill mix and staff roles to address workload issues. HG added that the development of training hubs to meet the educational needs of a multi-disciplinary primary care team was a key element of the workforce plan.

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

7 <u>Delegated Primary Care Commissioning Financial Report</u>

7.1 CL presented the report which outlined the financial position on delegated primary care co-commissioning budgets as at the end of October 2016.

7.2 CL advised that the CCG had reported an underspend against delegated budgets as at the end of October and anticipated that the CCG would be forecasting a breakeven position by the year end.

7.3 CL explained that the main reason for the year to date variance

was an underspend against the 2015/16 Quality Outcomes Framework (QOF) estimate.

7.4 Members noted funding had been reserved for increases to rent and rates for new developments as well as other rent increases that were expected during the year. These were assumed in the year to date position as fully spent but if there were any slippage, the overall underspend may increase.

7.5 CG enquired if there were any restrictions to the headroom fund and was advised that the headroom fund was not available to spend during the current financial year.

7.6 RESOLUTION: The Committee noted the report.

8 Primary Care Quality Report

8.1 MAE presented the Primary Care Quality Report which provided assurance to the Committee that quality and patient safety issues were given the appropriate priority and that there were clear actions to address them. MAE reminded members that the report had previously been presented to the October IGQC. The report was taken as read.

8.2 MAE advised that NHS England reviewed all GP Serious Incidents and that the CCG had not been alerted to any new such incidents from primary care.

8.3 Members noted that the responsibility for complaints and concerns in relation to primary care remained with NHS England. It was noted that the NHS England national complaints team had developed a Primary Care Complaints Dashboard although it was felt to provide limited information.

8.4 MAE advised that the CCG would be liaising with NHS England regarding the implementation of the whistleblowing arrangements for primary care. The CCG would be working with practices to review how this could be implemented more effectively.

8.5 Members noted the further work being undertaken to improve the response rates for the primary care Friends and Family Test (FFT).

8.6 BP provided an update on the key issues discussed at the Gloucestershire Patient Participation Group (PPG) Network meeting held in October 2016. BP advised that the key focus was on Mental Health and that a presentation was provided by the 2gether Trust. Other key issues discussed included Social Prescribing and embracing social media for communicating with the public. It was noted that the January 2017 meeting would include a focus on the STP.

8.7 BP also provided an update on the remaining practices that had not established a PPG and understood that some practices have established a PPG although some of these were virtual meetings. However, it was noted that the virtual meetings had not been effective and that discussions were being held regarding the process of establishing an effective PPG.

8.8 MAE updated members on the Care Quality Commission (CQC) inspections of Gloucestershire practices and noted that the dashboard of published CQC inspections reports was summarised in Appendix 1 of the report. It was noted that approximately 70 practices had received a CQC inspection and that most of the practices were rated as 'good' and that two practices were rated as 'outstanding'. It was noted that three practices required 'improvement' and that additional support would be provided to those practices. MAE highlighted an example of a practice who had been rated as 'good' but had been found to be in breach of registration requirements as the practice's procedure for storing prescription pads had been insecure. MAE also highlighted that all of the Gloucestershire practices were rated as 'good' or 'outstanding' for caring. HG advised that she had been liaising with one of the practices who had required 'improvement' and that they were disappointed with what they perceived as inconsistency of the inspection process. JC felt that the inspections were a good mechanism to act as a reflection and learning process.

8.9 DB enquired if there was a peer review programme available for practices. MAE felt that it could be useful tool and could be explored further.

8.10 MAE highlighted the increased focus on the medicines optimisation programme and the reduction in the number of antibiotics

prescribing was a high priority for the CCG. MAE recognised that a communication exercise should be undertaken to educate the public and managing expectations.

8.11 AE expressed concerns regarding where quality should be reported and the crossover between the roles of the PCCC and IGQC and in particular who was responsible for providing assurance to the Governing Body. AE highlighted that the Quality report presented that day had already been considered at the October IGQC meeting and felt that it was not an effective use of time and that a review should be undertaken to avoid any future duplications. CF highlighted that there were other sources of data available that could be obtained in order to review quality. MAE stated that the level of information available for primary care was limited compared to other providers. AS suggested optimising the use of the Quality Outcomes Framework (QOF) data was advised that the Primary Care team would be producing an annual report on QOF compliance which included details such as post payment verification and how many visits had been undertaken etc. MAE felt that there was a lack of outcome data which was required to measure quality. The Committee agreed that further discussions on how this would be managed going forward was required.

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

9 <u>Any Other Business</u>

9.1 CG requested an update on the progress of developing the short guide of the primary care strategy. SR advised that the guide had recently been finalised and would, subject to the comments of Committee members, be issued imminently.

10 The meeting closed at 12:45.

11 Date and Time of next meeting: Thursday 26th January 2017 in the Board Room at Sanger House.

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

Signed (Chair):_____ Date:_____

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Agenda Item 4

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

Item	Description	Response	Action with
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. *28/07/2016 Item to remain open as the Value for Money report had not been received as the scheme was being assessed by the BREEAM approach.*	**HG**
28/07/2016 Item 8.13	Sevenposts: Bishops Cleeve premises development	AH suggested that a regular progress report was presented to the Committee on a quarterly basis to update members on premises	**Andrew Hughes**
24/11/2016 Item 5.16	Premises Workstream Progress Report	MH suggested that further clarity on the ETTF process was sought from NHS England.	**Andrew Hughes**

Item	Description	Response	Action with
24/11/2016 Item 5.22	Premises Workstream Progress Report	CG drew attention to Section 5.4 of the report relating to the arrangements with NHS England and PropCo for signing off the commissioner support letter. CG expressed his disappointment and requested that the process was modified and suggested that a letter was written highlighting that CCG had delegated authority for primary care. AH agreed that he would work this through with CL and HG.	**HG/Andrew Hughes**
24/11/2016 Item 6.3	General Practice Forward View update	DB enquired of the plans for communicating with the public and was advised that a communications plan had been developed. HG advised that funding had been allocated for communication in relation to this process. DB also enquired of the timeline of the consultation process and it was agreed that Anthony Dallimore, Associate Director of Communications, would share the communication plan with members at the January 2017 meeting.	**HG/Anthony Dallimore**
24/11/2016 Item 6.4	General Practice Forward View update	JD queried if an impact evaluation had been undertaken. HG advised that this would be confirmed at the January 2017 meeting.	**HG**

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Agenda Item 6

Primary Care Commissioning Committee

Meeting Date	**Thursday 26th January 2017**
Title	**General Practice Forward View: Gloucestershire Update**
Executive Summary	The General Practice Forward View (GPFV) was published in April 2016 with the explicit aim of addressing the pressures being felt by GPs and their teams, such as reduced funding, increased workload and insufficient workforce. The timing was fortuitous, enabling GCCG to include the ambitions set out within the GPFV in our five-year Primary Care Strategy for Gloucestershire. Since publication, NHS England have released further guidance on implementation, principally within the NHS Operational Planning and Contracting Guidance, which required CCGs to submit a GPFV plan to NHS England by 23 December 2016. GCCG has already made good progress in implementing the GPFV and leading this on behalf of our members, with this paper providing updates against: • General Practice Resilience Programme • Practice Transformational Support • General Practice Development Programme: Releasing Time for Care • Local GPFV event
Risk Issues: **Original Risk** **Residual Risk**	Practices and clusters do not understand the many components of the GPFV and those with least time and therefore who most need support, are left behind. We are mitigating this

	through ensuring every practice is within a cluster, represented by a GP Provider Lead, with management support to clusters ensuring equity for all. In addition we are holding a GPFV event for all members in January 2017.
Financial Impact	GCCG are investing all funds received from NHS England for GPFV direct to practices and clusters. At the time of writing, for 16/17, this includes: • £132k: General Practice Resilience • £55k: Care Navigation and Clinical Correspondence In addition, we have made practice transformational funding available to our clusters in 16/17, earlier than the requirement of NHS England for 18/19, investing circa £400k this year and £1.2m next year.
Legal Issues (including NHS Constitution)	We are ensuring adherence to the NHS Operational Planning and Contracting Guidance 2017-2019 while also acting within the terms of the Delegated Agreement between NHS England and GCCG dated 26 March 2015.
Impact on Health Inequalities	Not applicable
Impact on Equality and Diversity	Not applicable
Impact on Quality and Sustainability	Not applicable
Patient and Public Involvement	Our Primary Care Strategy, which included how we planned to implement the GPFV, was informed by two rounds of engagement and feedback. For patients, this was focused through representative bodies, in particular Patient Participation Groups and Healthwatch Gloucestershire.

Recommendation	For information
Author	Stephen Rudd
Designation	Head of Locality and Primary Care Development
Sponsoring Director (if not author)	Helen Goodey, Director Locality Development and Primary Care

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 6

Primary Care Commissioning Committee

Thursday 26th January 2017

General Practice Forward View: Gloucestershire update

1. Introduction and Background

1.1 The General Practice Forward View (GPFV) was published on 21 April 2016 to reverse the trend of shrinking funding share allocations, increasing workload, ageing infrastructure and insufficient workforce. A funding increase of £2.4 billion a year by 2020/21, equating to a 14% real terms increase, created the headlines.

1.2 The Operational Planning and Contracting Guidance 2017-2019 provided more granular detail, including the responsibility of CCGs and what would remain the responsibilities of NHS England.

1.3 These CCG responsibilities can be summarised as:

- Practice Transformational Support
- General Practice Resilience Programme
- Care Navigation and Clinical Correspondence
- General Practice Development Programme
- Online Consultations
- Estates and Technology Transformation Fund
- Improving Access

1.4 CCGs were required to submit plans to NHS England detailing their approach to these responsibilities by 23 December 2016. Having a comprehensive Primary Care Strategy developed during 2016/17 which incorporates the General Practice Forward View ambitions, our plan was duly submitted by the deadline with a clear read-through from our Strategy.

This paper provides an update to PCCC across our current GPFV priorities:

- Practice Transformational Support

- General Practice Resilience Programme
- General Practice Development Programme: Releasing Time for Care
- Local GPFV event

2. Practice Transformational Support

2.1 The Operational Planning and Contracting Guidance specified that CCGs must spend £3 per head of population as a one-off non-recurrent investment over two years, either all in 17/18, or in 18/19, or split (e.g. £1.50 per head) across the two years. This funding must be found from within existing CCG allocations.

2.2 As previously reported to the PCCC, Gloucestershire CCG have brought this investment forward into 16/17 (pro-rata) and asked for bids from clusters of circa 30,000 for recurrent investment in order to support transformative schemes on a recurrent basis. This investment equates to £1.2m annually. This was warmly received and, with support from the CCG, has resulted in the development of 16 'clusters' across the county, with all practices now within a cluster.

Locality	Collaborations
Cheltenham (c. 50,000 patients each)	Three clusters based on geography
Forest of Dean (c. 60,000 patients)	All eleven practices in one cluster
Gloucester City (c.18,000 – 41,000 each)	Five clusters based on geography; two continue working together for their transformational support bid
North Cotswold (c. 29,000 patients)	All five practices in one cluster
South Cotswold (c. 58,000 patients)	All eight practices in one cluster
Stroud & Berkeley Vale (c. 18,000 – 39,000 patients)	Four clusters based on geography
Tewkesbury, Newent and Staunton (c. 43,000)	All four practices within one cluster
Total	**16 clusters encompassing all practices**

2.3 All clusters now have a transformational scheme, with the majority (11 of

the 15 schemes) based on employing clinical pharmacists, shared across their cluster. This will result in an additional 15 whole time equivalent (WTE) pharmacists working in general practice. Other transformational schemes include a repeat prescribing hub, an urgent visiting service, a frailty service, and mental health workers in primary care.

3. General Practice Resilience Programme

3.1 This programme is a follow-up to the initial Vulnerable Practice Programme offered by NHS England. While the Vulnerable scheme aimed to address those practices with the most pressing issues, particularly those rated as 'inadequate' or 'requiring improvement' by the CQC, the Resilience scheme sought to go further by building more longer-term sustainability too.

3.2 Gloucestershire were allocated £132k for 2016/17 for the Resilience Programme, which will reduce to circa £66k in each of 17/18 and 18/19. At the time of writing this paper, we understand further funding of circa £44k for 16/17 will follow from NHS England and are awaiting further details.

3.3 In order to ensure an equitable process for all, we twice invited all practices to consider requesting funding for building resilience, as well as working through our existing locality infrastructure to ensure everyone had the opportunity to consider applying for the funding.

3.4 We received responses covering more than 60 practices, with many being received at a cluster level requesting the support to start 'at-scale' initiatives, such as considering federation, merging, sharing back-office functions and sharing staff.

3.5 Working with the LMC and the RCGP GP Ambassador, these bids have been prioritised, with those seeking to work at scale to increase their resilience being prioritised. 12 of the 16 clusters have submitted bids and received confirmation of being supported through this scheme.

3.6 For the remaining 4 clusters, we are maintaining an open scheme and encouraging them to consider a resilience bid.

3.7 Through the Vulnerable Practice Programme, we have supported eight practices on an individual basis in accordance with that scheme, allocating £69k of the NHS England funding for this programme.

4. General Practice Development Programme: Releasing Time for Care

4.1 The General Practice Development Programme focuses on the ten high impact actions identified within the GPFV to release capacity. The programme's aim is to help practices lay the foundation for new models of care.

4.2 NHS England Ten High Impact Actions:

4.3 To support the implementation of these, NHS England has a £30m 'Releasing Time for Care Programme', making national resources and expertise available to Primary Care. This is led by the Sustainable Improvement Team at NHS England, working with its primary care improvement faculty, who are experts in improvement science.

4.4 Expressions of interest were opened for practices in July 2016, with a closing date of August 2018.

4.5 With the support of the LMC and the CCG GP Provider Leads, GCCG submitted a bid on behalf of all 81 practices in November. We set out the progress we've made in Gloucestershire so far and how we felt that

the national resource available could accelerate the momentum already gained within our clusters to begin implementing a programme designed around the needs of our practices.

4.6 We have now heard we have been successful and have a teleconference with the national team on 16 January to begin planning and designing the offer for Gloucestershire. We plan to use our upcoming event (see below) as a springboard to the programme, while also working with the LMC in the implementation.

5. Local General Practice Forward View event

5.1 In order to ensure all practices understand, and get benefit from, the GPFV schemes and initiatives, we have organised a local GPFV event on 24 January 2017.

5.2 We have invited one GP and Practice Manager from each practice and secured Dr Robert Varnam, a GP in Manchester and Head of Primary Care Development for NHS England, to be our key note speaker.

5.3 Dr Varnam will describe the reason for GPFV, the initiatives within it, and then do a session for all attendees on Quality Improvement, one of the ten high impact actions that underpin delivery of the other nine. During the afternoon, delegates have chosen two of three breakout sessions to attend that cover other, locally prioritised, high impact actions, with the opportunity for practices to hear from national and local speakers on how they have implemented them. A member of the Sustainable Improvement Team from NHS England will also be in attendance as part of our successful bid too.

5.4 We have also secured additional time at the end of the agenda to allow clusters the opportunity to meet, discuss and plan how they would like to implement the ideas heard during the day, with further support from CCG and national and local speakers in these smaller groups.

5.5 Our Accountable Officer will also be in attendance to set the context of Primary Care within the Gloucestershire Sustainability and Transformation Plan, while the event will be hosted by our Clinical Chair in what we hope will be a successful, and useful, event for all. At the time of writing we have over 160 confirmed attendees from our practices, making it the most well attended primary care event we've hosted. As noted above, we see this as the start of making the GPFV, and therefore our Primary Care Strategy, a reality for all members.

6. Recommendation

6.1 The Committee are asked to note this paper which is provided for information.

NHS
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Agenda Item 7

Primary Care Commissioning Committee

Meeting Date	**Thursday 26th January 2017**
Title	**GP Access Fund (GPAF) contract extension and next steps.**
Executive Summary	This paper gives an update on the delivery of the GPAF and asks the Primary Care Commissioning Committee to agree to a 12 month contract extension from April 2017 with GDOC to deliver against the national minimum core requirements for GPAF.
Key Issues	While the pilot has been a success in delivering Choice Plus across the county in 17 locations the distribution of these appointments has been mixed and further work has been required to ensure that the appropriate number of appointments are provided during evenings and weekends, particularly in areas of high patient need. Much of the difficulty in provision is due to the lack of availability of GPs.
Risk Issues: **Original Risk** **Residual Risk**	The CCG will need to ensure the minimum core requirements are achieved in order to secure the national funding.
Financial Impact	The national funding available for the GPAF is £6 per weighted head per annum from April 2017. This equates to around £3.68m for Gloucestershire.
Legal Issues (including NHS Constitution)	The procurement guidance from NHS England regarding new GPAF contracts from 2017/18 is that due to the Public Contracts Regulations they will need reassuring that the commissioners have tested the market to see if there are any other capable providers.

	NHS England have confirmed they are expecting CCGs to commission an integrated service going forward. Given the timeframes for the OOH and 111 procurement, initial procurement advice suggests a contract extension from April 2017 to April 2018 is necessary while a procurement is undertaken.
Impact on Health Inequalities	An equality impact assessment has not been undertaken at this stage as this is a contract extension that uses national funding to deliver against national criteria to improve access to GP appointments for patients. It is expected an impact assessment will be completed as part of the procurement for services in 2017/18.
Impact on Equality and Diversity	Not applicable at this stage
Impact on Sustainable Development	None
Patient and Public Involvement	As a series of pilots, these schemes consider patient feedback as part of the evaluation which will help inform any future commissioning decisions.
Recommendation	The PCCC is asked to consider to: 1) agree to a contract extension for 12 months from April 2017 to March 2018 within the available funding; 2) delegate the final agreement of the contract variation to the Chief Officer and Chief Finance Officer; and 3) note the scope of the options appraisal.
Author	Jo White
Designation	Programme Director, Primary Care
Sponsoring Director (if not author)	Helen Goodey, Director of Primary Care and Locality Development

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 7

Primary Care Commissioning Committee

Thursday 26th January 2017

GP Access Fund (GPAF) contract extension and next steps

1. Introduction

1.1 The purpose of this paper is to give an update on the delivery of the GP Access Fund (GPAF) and to ask the Primary Care Committee to agree to a 12 month contract extension from April 2017 with GDOC and agree next steps.

2. Background

2.1 In line with national guidance and following a decision made by the Gloucestershire CCG Primary Care Committee in November 2016 the CCG further extended the GPAF contract to March 2017 to continue delivery of the Primary Care Access Fund pilot. This included:

- Choice Plus appointments at 30minutes per 1000 to March 2017 and continue to work on improving utilisation and targeting need across the county to meet the national core requirements for evenings and weekends;
- Specialist Nursing – continue with this with a plan to shift the provision into general practice as part of cluster/locality working and new models of care;
- GP support to Rapid Response - as it is currently provided;
- Black Pear – implementation to allow information sharing;
- E-consult – continue supporting existing licences until expiry, no new licences; and
- Communications – working with the CCG to agree a communications and engagement plan.

3. National Core Criteria

3.1 To secure the funding for GP Access Fund schemes NHS England set out the criteria in a letter from Ros Roughton, Director of NHS Commissioning, NHS England, dated 23 September 2016, as follows:

Timing of appointments:

- commission weekday provision of access to pre-bookable and same day appointments to general practice services in evenings (after 6:30pm) – to provide an additional 1.5 hours a day;
- commission weekend provision of access to pre-bookable and same day appointments on both Saturdays and Sundays to meet local population needs;
- provide robust evidence, based on utilisation rates, for the proposed disposition of services throughout the week; and
- appointments can be provided on a hub basis with practices working at scale.

Capacity:

- commission a minimum additional 30 minutes consultation capacity per 1000 population, rising to 45 minutes per 1000 population.

Measurement:

- ensure usage of a nationally commissioned new tool to automatically measure appointment activity by all participating practices, both in-hours and in extended hours

Advertising and ease of access:

- ensure services are advertised to patients, including notification on practice websites, notices in local urgent care services and publicity that into the community, so that it is clear to patients how they can access these appointments and associated service;

- ensure ease of access for patients including:

  - all practice receptionists able to direct patients to the service and offer appointments to extended hours service on the same basis as appointments to non-extended hours services
  - patients should be offered a choice of evening or weekend appointments on an equal footing to core hours appointments.

Digital:

- use of digital approaches to support new models of care in general practice.

Inequalities:

- issues of inequalities in patients' experience of accessing general practice identified by local evidence and actions to resolve in place.

3.2 GPAF schemes are expected to fully comply with the requirements by no later than 31 January 2017. It has been clarified that the move to 45 minutes per 1000 patients will be based on population need, so for Gloucestershire it is likely this will only be in areas of high population density.

4. Current position

4.1 Timing and capacity of Choice Plus appointments

4.1.1 Choice Plus appointments are currently provided in excess of 30 minutes per 1000 patients and Choice Plus appointments that are provided in hours (8.00am to 6.30pm) continue to be popular with good utilisation rates. However in some areas such as Gloucester city and Cheltenham, while utilisation of the services is good, less sessions than the population need and demand require have been offered during evenings and weekends as it has been more difficult to find GPs to cover. Since it is evening and weekend provision that the scheme is measured on the CCG has been working with GDOC to ensure appointments are offered appropriately at these times and to meet each localities population requirements.

4.1.2 Progress is reviewed as part of the monthly Operational Review meeting and a plan is in place to increase the number of sessions provided in Gloucester and Cheltenham. Choice Plus appointment levels in Gloucester have now increased substantially and some Cheltenham practices have agreed to provide more appointments from the middle to the end of January. Choice Plus utilisation over Christmas and New Year was high with several days over 80%. This included many appointments used by the Out of Hours (OOH) service where GP cover was limited. Choice Plus appointments that have not been booked by practices at weekends are being released to OOH at the end of the week to ensure best use of resources.

4.1.3 The Specialised Nursing support remains successful, and a number of potentially vulnerable practices continue to receive nursing support to ensure continuity of care and patient access to services. Support to Rapid Response is continuing to midnight with 52 calls received in December. This service will be reviewed with the commissioning lead for Rapid Response to understand the impact it has had over winter.

4.1.4 Nationally the expectation is that the appointments can be used for routine and same day (urgent) appointments. To achieve this the interoperability of practice systems to allow record sharing is key. The Black Pear software solution proposed by GDOC will allow better sharing of information for urgent appointments but it is thought not enough for routine appointments which require investigations and referrals. This is being piloted from January in North Cotswolds.

4.2 Measurement

4.2.1 All practices in Gloucestershire, bar two, have the national GP Access software installed to collect appointment data. These two practices are being contacted by the CCG to ensure this is completed as it is a core requirement of the GPAF contract for 2016/17. One practice has technical issues which prevent installation and is being managed separately.

4.3 Advertising and ease of access

4.3.1 The Choice Plus appointments are advertised on practice websites and receptionists are able to book patients into appointments. The CCG Communications team has worked with GDOC to review communications and as a result Choice Plus has been added to the planned CCG ASAP pocket reminder leaflet to support winter pressures.

4.3.2 Once the distribution of appointments has been addressed it is expected further advertising of appointments will be undertaken to maximise utilisation.

4.4 Digital

4.4.1 The original proposal for November to March agreed by PCCC was not to renew e-consult software licences, for example for Ask My GP, which were expiring as there was very little usage. However some practices with licences that are ending before March wish to continue with them as the usage of them is now increasing. Since this will be funded as part of the GP Forward View all practices with licences are being surveyed to consider the cost of ensuring continuity of the software where patients are using the service.

4.5 Inequalities

4.5.1 Patient and practice feedback is being used to ensure there are no issues of inequalities in patients' experience of accessing general practice identified by local evidence. Two locations are now being offered rather than one in the Forest of Dean to improve access to Choice Plus appointments following feedback. It is expected that the increase in availability of appointments in areas like Gloucester and Cheltenham will also support better patient experience around access.

4.6 General Practice Forward View Plan

4.6.1 CCGs were asked to outline their approach as to how to improve access by 23 December 2016 and how they will secure these services following a procurement process as part of their General Practice Forward View Plan. The CCG is

undertaking an options appraisal to support this process.

5. Options appraisal

5.1 The scope of the options appraisal (Annex 1) has been agreed by the Core Leadership Group and includes a review of the current service provision and what is working well elsewhere. A set of questions is being sent to Gloucestershire practices, GP provider and cluster leads and GP locality commissioning leads to gather their feedback as to what works well, what does not work well and what could be improved.

5.2 The options appraisal will include a review of the non-registered patient element of the Gloucestershire Health Access Centre (GHAC) to understand opportunities for alignment with extended access through the GPAF. The non-registered element provides access to additional GP capacity from 8am to 8pm, 7 days a week including bank holidays, for patients that are registered with other GPs across the county or those that are not currently registered with a GP.

5.3 The options appraisal is scheduled for completion at the end of February.

6. Procurement

6.1 The national guidance states that from 2017/18, CCGs will need to put contracts in place as General Practice Access Fund (GPAF) schemes move to mainstream and become part of an integrated model of service delivery in primary care. The procurement guidance from NHS England regarding new GPAF contracts from 2017/18 is that due to the Public Contracts Regulations they will need reassuring that the commissioners have tested the market to see if there are any other capable providers. NHS England has confirmed they are expecting CCGs to commission an integrated service going forward.

6.2 NHS England also expressed there will be some flexibility allowing for the extension to the existing contract. It is understood that in many areas an additional 12 month extension was given in October 2016 to take contracts up to

April 2018 giving time for CCGs to agree an approach and align the specification with other services.

6.3 It will be important to ensure any provider solution is closely aligned with general practice to support the integration of Primary Care services including urgent care, OOH and 111. Further advice will be taken in the next year.

7. Contract extension 2017/18

7.1 In order to secure the funding available for 2017/18 to continue extended access arrangements in Gloucestershire a contract extension with GDOC is proposed for 12 months to April 2018. The rationale for 12 months rather than a shorter period is to allow time for the scheme to establish the appropriate appointment levels for evenings and weekends depending on the population need for each locality and then the time to go out to procurement. This timescale would provide plenty of notice to the current provider to manage a transition and it would bring the service re-provision timescale into close alignment with the GHAC APMS contract renewal (May 2018) and the OOH and 111 procurement, and potentially the mobilisation of the urgent care centre proposals. Any procurement would begin Summer 2017 and will require further detailed planning over the next two months.

7.2 The outcomes of the options appraisal will support the development of an appropriate local model for procurement to deliver the national core criteria.

7.3 The contract variation will need to be agreed by March 2017 and it is proposed that PCCC delegate agreement of the detail of this to the CCG Chief Officer and Chief Financial Officer.

8. Financial

8.1 In early January NHS England confirmed the funding of £1.59m for November 2016 to March 2017. The contract extension funded GDOC for £1.32m for this period. GDOC have received payment for November and December 2016 and have been asked to provide a forecast and year to date

position to allow for a reconciliation to take place before any payment is made in January.

8.2 In order to build the availability of appointments GDOC are performing at over 30 minutes per 1000 patients and are currently absorbing this cost. If a move towards 45 minutes per 1000 is agreed in some locations then this would need additional funding from the remaining £264,000 held by the CCG to support the development of the placed based model with clusters of practices.

8.3 For 2017/18 the CCG will receive £6 per head on a weighted population basis. This is less than the actual registered population and is line with the GMS/PMS/APMS funding arrangements. It will equate to around £3.68m.

9. Recommendations

The PCCC is asked to:

1) agree to a contract extension for 12 months from April 2017 to March 2018 within the available funding;
2) delegate the final agreement of the contract variation to the Accountable Officer and Chief Finance Officer; and
3) note the scope of the options appraisal.

10. Appendices

Appendix 1 – Options Appraisal scoping document

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Appendix 1

GP Access Fund (GPAF) contract extension and next steps

Choice Plus - the proposed scope for an Options appraisal

1. Purpose

The purpose of this paper is to propose the scope of an options appraisal to consider options and best approach for the future of 7 day working against local objectives, patient experience and the cost to deliver the national criteria.

2. Background

The Prime Ministers Challenge Fund (PMCF) was designed to pilot different schemes to help improve access to general practice and increase innovation in primary care. The latest guidance from NHSE (September 2016) sets out a minimum core requirement to provide 30 minutes of appointments per 1000 patients by January 2017 with a rise to 45 minutes per 1000in line with population demand.

From 2017/18, CCGs will need to put contracts in place as General Practice Access Fund (GPAF) schemes move to mainstream and become part of an integrated model of service delivery. The aim is to extend access to general practice services in the evenings and at weekends in line with the national core requirements. CCGs were expected to outline their approach as to how to improve access by 23 December 2016 and how they will secure these services following procurement guidance as part of their General Practice Forward View Plan. NHS England has expressed there will be some flexibility allowing for the extension to the existing contract while a process to develop and procure an appropriate model of care is undertaken.

3. Local Context

There are 81 GP practices in Gloucestershire serving 635,000 patients within seven localities providing general medical services to their registered population list. Sustainability in primary care is an important

factor of the STP with many practices unable to fill GP and nursing vacancies at a time when there are more GPs leaving general practice. Many practices are looking at ways of working more closely together in their clusters, streamlining back office functions and discussing federating or merging. In some cases this includes reviewing how they manage patient flow and in particular urgent care in primary care to better manage demand. In line with the GP Forward view practices are also employing other healthcare professionals as part of the primary care team, for example, pharmacists and paramedics. Within the Stroud and Berkeley and Gloucester City localities practices are also working in clusters towards a placed based approach to provide integrated primary and community care with other system providers.

The CCG is currently developing an approach to integrate primary and community urgent care in line with national urgent care guidance. The focus is on face-to face provision and how the services that already exist work better together to meet key outcomes and benefits for patients, staff, organisations and the wider health, social care and wellbeing systems and meet national requirements. The CCG model sees the Urgent Care Centre as a place where a number of services collocate with each other. An amount of Choice Plus provision has been assumed as part of the modelling for the Urgent Care Centres although at this stage it is unclear how much extended access will be delivered at a cluster level or at which locations.

Procurement is underway for NHS 111 and Out of Hours provision across the county from 2018. Out of Hours is extremely busy and increasingly there is a lack of GPs available to fill shifts at peak times.

4. Proposed scope of the options appraisal

The options appraisal will need to review a number of elements. In broad terms we need to understand what we can learn from the local pilot and other PCAF pilots i.e. what works well, what are the issues and what are the options to deliver it differently. We also need to be clear on the national direction and expectation i.e. the level to which this funding is seen as being an integral part of primary care delivered alongside primary care medical services contracts. It is critical this does not destabilise general practice and it will be important to take into account the workforce issues and the different delivery models that have been piloted nationally utilising a different skill mix. Lastly we need to consider duplication with other services and how closely aligned services work

together, for example GHAC unregistered appointments that are contracted for up until May 2018.

To understand what is and isn't working locally we propose asking for feedback from practices, cluster leads and provider leads.

4.1 What is in scope?

a) Seeking and analysing feedback of the current local extended access model (Choice Plus) looking at utilisation and demand
b) Patient feedback from users of the service
c) Reviewing what extended access arrangements are working elsewhere
d) Services to unregistered patients - currently part of the GHAC APMS contract
e) Consideration of and linking with the local community and primary urgent care review
f) Consideration of and linking with the Procurement of OOH and 111
g) Consideration of sustainability and resilience in general practice
h) Analysis of extended hours provided through the DES
i) Analysis of OOH capacity and provision
j) Reviewing local population health needs and system demand to support the distribution of appointments
k) Reviewing the specialist nursing element of the pilot
l) Reviewing local workforce issues and skill mix opportunities
m) Financial review of current model and funding available from 2017-18
n) Procurement guidance, including contract extension option
o) Appropriate performance measures and outcomes

4.2 What is out of scope?

a) Procurement including consultation process and patient and public engagement, advertising of appointments, Equality Impact Assessment
b) Evaluation of other pilots as part of the GDOC PCAF contract, specifically Black Pear, e-consult, GP support to Rapid Response
c) Financial review of the lifecycle of the GDOC contract?

4.3 Proposed outputs

a) Analysis of current model
b) Delivery Model options for extended access (Choice Plus)
c) Delivery Model options for GHAC unregistered (walk-in) patients

d) Analysis of population need and demand (mapping population need against provision and the use of services)
e) Procurement options and advice
f) High level service specification
g) Service positioning and signposting in relation to other primary care and urgent care services – how the service fits and works with other services
h) Recommendation for the future provision of Choice Plus and GHAC unregistered patients

4.4 Stakeholders

a) GP Practices
b) GP cluster provider leads
c) GP locality leads
d) GDOC Ltd
e) GHAC Ltd
f) LMC
g) Urgent Care commissioners
h) Primary Care team
i) NHS England

5. Resources Required

a) Procurement
b) Finance
c) Project support
d) Information support
e) Contract holder data – GDOC and GHAC

6. Timeline

The options appraisal has a target to be completed by the end of February 2017. It is proposed a report is taken to the Primary Care Commissioning Committee in March 2017.

7. Engagement and feedback with GP practices, cluster leads and locality leads.

In order to understand what is working well and what could be done differently it is proposed we approach GPs, Cluster leads and Locality leads to get their views. While extended access does not have to be only provided by GPs it will be important local GPs engage in the provision of

extended access at a cluster level either directly or through a subcontracting arrangement to make best use of resources and the joining up of services.

The following questions are proposed for each audience to be sent with a letter giving the context of the local pilot and the national agenda.

A. Proposed questions for practices (GPs and PMs?)

1. Utilisation - Do you book regularly Choice Plus appointments for your patients?

If so, when - daytime, evenings, weekends?

2. Location - what are your thoughts on the current location of appointments and what recommendations would you have to improve this?

3. Criteria for patients being seen by Choice Plus – is this appropriate or does it need changing? If so, how should it change?

4. Skill mix –the service is currently delivered by GPs. In your view is this appropriate or could it be provided by a MDT approach? If so, who could that be?

5. Sustainability and resilience in general practice - does the current model of provision for Choice Plus support this? If not, in what way does it not support resilience of general practice? How could this be improved going forward?

6. Patient experience– what feedback have you received from your patients about using Choice Plus appointments?

7. Clinical effectiveness - do you feel that Choice Plus deals with the patient need or does it often require further follow up from GPs?

8. Capacity - do you think there is sufficient clinical capacity to provide extended access evenings and weekends (i.e. Choice Plus appointments)?

9. Future provision - going forward how do you think the £6 per head could be used to deliver 7 day services for patients and improve resilience and sustainability of general practice.

a. No change to current model

b. Recommended changes and why

10. Is there anything else you would like us to tell us?

B. Questions for GP cluster provider leads – please answer the questions below to the best of your knowledge

As above

C. Questions for GP commissioning locality leads

1. What do you think are the strengths and weaknesses of the current model to deliver extended access?

2. What do you see as the direction of travel for extended access in general practice, currently the GPAF? (Who is best to provide it, how would it work, how would it integrate with other services)

3. How do you think we can make this an affordable model that supports the sustainability of general practice and managing increasing demand?

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Agenda Item 8

Primary Care Commissioning Committee

Meeting Date	**Thursday 26th January 2017**
Title	**NHS England (NHSE) Commissioner Guidelines for responding to requests from practices to temporarily suspend patient registration**
Executive Summary	NHSE published guidance in December 2016 to assist commissioners in responding to practices wanting to suspend patient registration on a temporary basis. The guidance recognises the duty on commissioners to secure services for patients as well as the pressure on practices in providing services inking with support arrangements described in the General Practice Forward View. Requests for temporary suspension of patient registration is likely to be a symptom of rising pressure in primary care which creates a risk to patients, neighbouring practices and the CCG as delegated commissioner. This latest NHSE guidance describes the circumstances where a temporary suspension may be appropriate.
Risk Issues: **Original Risk** **Residual Risk**	Temporary suspension of patient registration creates a risk to patients, neighbouring practices and the CCG as delegated commissioner. However there is also risk to patients being registered with an oversubscribed practice. Requests from practices should be seen as a trigger for support and help to help minimise risk to patients, the practice and neighbouring practices.

Financial Impact	Support for practices from practice resilience programme funding or use of section 96 discretion.
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	NHSE guidance referred to in this paper has given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.
Impact on Equality and Diversity	NHSE guidance referred to in this paper has given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity and to foster good relations between people who share a relevant protected characteristic.
Impact on Sustainable Development	Any action considered by the CCG should be in the context of the General Practice Forward View and our commitment to supporting practices in difficulty.
Patient and Public Involvement	Not applicable
Recommendation	The PCCC is asked to: • note this guidance • agree to delegate approval of requests from a practice to temporarily suspend patient registration to the Chair of the PCCC and the Accountable Officer.
Author	Jeanette Giles
Designation	Head of Primary Care Contracting
Sponsoring Director (if not author)	Helen Goodey Director of Locality Development and Engagement

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 8

Primary Care Commissioning Committee

Thursday 26th January 2017

Commissioner guidelines for responding to requests from practices to temporarily suspend patient registration

1. Introduction

NHSE published guidance in December 2016 (see Appendix 1) to assist commissioners in responding to practices wanting to suspend patient registration on a temporary basis.

The guidance describes the circumstances where a temporary suspension by the contractor of patient registration may be appropriate and the conditions that should govern that decision such that the roles and responsibilities of both parties are not compromised.

2. Facts/Principles

The guidance outlines the facts/principles the CCG should adopt when responding to practices seeking to 'temporarily' suspend patient registration. This should be in the context of the General Practice Forward View and a commitment to supporting practices in difficulty.

3. Issues to be taken into consideration

The guidance does not prescribe what length of time an approval of a temporary list suspension is appropriate as this will vary depending on the circumstances. However the situation the practice finds itself in should be unpredictable and/or short term. The guidance has been drafted in recognition of the immediate pressures some practices will face, e.g. an immediate and unpredicted shortfall in the availability of staff, an unexpected event affecting a practice's ability in the short term to provide a full range of services

normally available, e.g. flood or a fire.

Where the circumstance is one of a known history of difficulty, or the circumstances affecting the practice could be predicted to last longer than 3 months then it is clear that a formal list closure should be encouraged.

4. Process

The guidance outlines the process to be adopted with practices contacting their commissioner at the earliest possible opportunity so that the provider and CCG can work together to agree what support is required over an agreed period. At this point the CCG should engage the LMC and agree what action needs to take place by the practice and/or CCG for the list to be re-opened. The CCG should consider support under the practice resilience programme or use of Section 96.

As this process recognises the immediate pressures facing some practices, the CCG will need to respond quickly and therefore we would propose that the decision to approve any requests to temporarily suspend patient registration is delegated from the PCCC to its Chair and the Accountable Officer.

If despite support to deliver an action plan over an agreed period, the practice continues to feel compromised, the CCG should consider an application from the practice for formal list closure in line with GMS and PMS contracts (paragraph 29 of Schedule 6, Part 2 of the NHS (GMS Contracts) Regulations (as amended). This will require wider consultation and if approved the requirement is to close between three and twelve months.

5. Recommendation

The PCCC is asked to:

- note this latest guidance and;
- agree to delegate approval of requests from a practice to temporarily suspend patient registration to the Chair of the

PCCC and the Accountable Officer.

6. Appendices

- Appendix 1 – NHSE publication – Commissioner Guidelines for Responding to Requests from Practices to Temporarily Suspend Patient Registration

suspend-pat-reg-res pns-guid.pdf

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Agenda Item 9

Primary Care Commissioning Committee

Meeting Date	**Thursday 26th January 2017**
Title	**Update on Primary Care Support England**
Executive Summary	On 1 September 2015, Primary Care Support England (PCSE) took on responsibility for the delivery of NHS England's primary care support services. PCSE's priority was to continue to deliver the support services provided to GP practices and in addition introduce new arrangements to help create national, consistent services, which replaced a range of diverse current local arrangements. Services provided by PCSE include: • Medical records movement • NHSE supplies ordering and delivery • Administration of the Performer's List process • Administration of payments to GPs • Administration of some screening programmes.
Risk Issues: **Original Risk** **Residual Risk**	There is a risk to patients if movement of medical records is considerably delayed and patients are treated without full medical history. Contractual risk if CCG is not fully aware of performer list changes. The CCG are requesting information with regard to practice issues/concerns so we can be aware of potential contracting issues.
Financial Impact	None to the CCG. Practices are forecasting financial pressure as a

	result of the requirement to process a backlog of medical records which will need to be processed as soon as possible.
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. Contract documents need to include up to date signatories.
Impact on Health Inequalities	There are no direct health and equality implications contained within this report.
Impact on Equality and Diversity	There are no direct equality and diversity implications contained within this report.
Impact on Sustainable Development	There are no direct sustainability implications contained within this report.
Patient and Public Involvement	Not applicable
Recommendation	The PCCC is asked to note the contents of this paper.
Author	Jeanette Giles
Designation	Head of Primary Care Contracting
Sponsoring Director (if not author)	Helen Goodey Director of Locality Development and Engagement

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 9

Primary Care Commissioning Committee

Thursday 26th January 2017

Update on Primary Care Support England (Delivered on behalf of NHS England by Capita)

1. Introduction

1.1 On 1 September 2015, Primary Care Support England (PCSE) took on responsibility for the delivery of NHSE England's primary care support services.

PCSE's priority was to continue to deliver the support services provided to GP practices and in addition introduce new arrangements to help create national, consistent services, which replaced a range of diverse current local arrangements.

Services provided by PCSE include:

- Medical records movement
- NHSE supplies ordering and delivery
- Administration of the Performer's List process
- Administration of payments to GPs
- Administration of some screening programmes

1.2 Medical Records

Local courier arrangements were ceased and a new nationwide courier service, delivered by CitySprint was set up from 4 April 2016.

Practices reported issues with the pick-up and drop off of medical records especially the significant delay in service delivery and processing of medical records.

1.3 New supplies portal

With effect from 29 March 2016, PCSE set up a new portal for GP practices to order and track supplies of medical supplies

and stationery from a controlled catalogue.

It became clear very quickly that there was a national shortage of needles and syringes and as a delegated CCG we permitted practices to order supplies from other sources as an interim solution to ensure direct patient care was not affected.

1.4 A national customer support centre was set up to deal with queries relating to medical records and supplies.

The call centre has not been able to cope with the number of calls and emails it has been receiving from practices. Practices are frustrated as their only contact with PCSE is via a generic email address and telephone number. Practices also reported that those responding to emails and telephone numbers do not possess the experience of SBS staff who previously handled queries and therefore confidence in the new system was low.

1.5 The local office for performer's list services which was staffed by experienced personnel with local knowledge and located at Sanger House was closed in July 2016. GP practices were subsequently referred to the PCSE customer support centre.

Once the service had been transferred concerns were expressed especially with delays in processing requests from practices.

2. Action taken by CCG to mitigate risk to local GP practices

The Primary Care Development & Engagement Manager is the dedicated CCG lead in this area. She is working closely with our local NHS England colleagues and proactively escalates practice issues for resolution, contacting nominated PCSE contacts as required.

2.1 <u>Meetings with NHSE Area Team and Capita</u>

The CCG lead has met with members of the Local NHS England team and held teleconferences with members of PCSE/Capita transition team so that ongoing issues can be worked through and addressed.

2.3 In September 2016 a letter was sent to the national NHSE lead on behalf of the CCGs from the local NHSE office, outlining risk and concerns along with lack of assurance/response on matters escalated to Capita.

In particular the following was outlined:

- Delays in medical records collection/delivery
- Collection of medical records from branch surgeries
- Urgent direct telephone numbers for PCSE transition team leaders
- Performers list applications
- Payments to training practices
- PCSE support centre – length of time for a response on phone and email
- An issue with GMS payment run in August
- Patient registration backlog

3. Update provided by Primary Care Support England in December 2016

3.1 Medical Records

PCSE are reporting service improvements in relation to CitySprint routes and distribution of medical records envelopes for first time registrations which may result in practices seeing a temporary increase in records delivered. On average the current record move time is three to six weeks. This is from the time CitySprint collects a record (i.e. the point it is released by the current practice or from a storage facility) to the time it is delivered to the receiving practice.

There are currently two main reasons why some records requested are taking longer to arrive:

- Records in storage – the majority of archived medical records (for those patients not previously registered with a GP) are currently kept in NHSE's third party storage facilities. PCSE and NHSE are working together to improve access and the time to locate and pick the records out for onward distribution.

- Medical Record Envelopes for first time registrations (i.e. babies and new entrants to the NHS) for patients registered between March and November 2016 these will be delivered to practices between November and January 2017 in a single drop off.

From week commencing 14 November 2016, practices started receiving new medical record envelopes for patients registered since 2 November 2016 on a regular basis as part of their weekly CitySprint records collection and delivery.

3.2 Temporary resident forms

These forms can currently be scanned and uploaded to the records section of the PCSE portal or posted to Darlington.

For governance reasons, NHSE requires these are sent securely via Royal Mail special or recorded delivery.

PCSE are working on a solution that will enable practices to request a label for temporary resident forms through the PCSE portal and send the forms on in shipping bags.

3.3 GP registrar payments

PCSE are only reporting delays in payment where they are missing information to process. Registrar payment issues are being prioritised for review and a simpler, standardised approach for registrar payments has been agreed with NHSE ahead of the February Registrar in-take.

3.4 National Performers List

NHSE is seeking an amendment to legislation that will change the way GP registrars are included on the performers list in future. In the meantime, GP registrars joining the performers list from August 2016 onwards will not need to complete an application form, attend face-to-face ID verification interviews or be subject to background checks by PCSE. These checks will already have been completed by Health Education England as part of the recruitment process.

In the meantime GP registrars who applied to join the list prior to August 2016 or applying to join the list between August 2016 and January 2017 should have received an email/letter from PCSE confirming NHSE's decision to include them on the national performers list.

3.5 PCSE have increased their staff numbers in the Support Centre and invested further training for call handlers, to ensure they respond to queries effectively. All calls are now allocated a case number so queries can be tracked and updated on progress.

Urgent queries which are prioritised are:

- Issues relating to performers lists applications for existing practitioners and any removals or suspensions
- Issues relating to information and recorded access requests to identify safe-guarding issues, clinically urgent requests, coroner requests and issues related to homicide reviews
- Payment issues which could affect the financial stability of a business or increased financial hardship for an individual performer
- Urgent supply needs

3.6 Whilst some improvements are evident, the primary care contracting team is still concerned with regard to notifications from PCSE about changes to our performers list and potential impact on contract signatories.

4. Actions to be taken by primary care contracting team to mitigate risk to CCG

4.1 Practices will need to ensure they inform primary care contracting team of any changes to their partnership which would necessitate a contract variation, e.g. resignation/addition of partners to ensure contracts are kept up to date.

4.2 We continue to escalate any outstanding queries from practices to NHSE team who then take it up with PCSE team at a senior level. As a result of this process we do seem to be

getting some items/elements resolved.

4.3 The Primary Care contracting team ensure they continue to be aware of ongoing issues by regular communication to practice managers to understand current issues (old and new).

5. Recommendation

The Committee is asked to note the contents of this paper.

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 10

Primary Care Commissioning Committee

Meeting Date	**Thursday 26th January 2017**
Title	**Delegated Primary Care Commissioning financial report as at 31st December 2016**
Executive Summary	At the end of December 2016, the CCG's delegated primary care co-commissioning budgets reported an underspend of £60k 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

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 10

Primary Care Commissioning Committee

Thursday 26th January 2017

Delegated Primary Care Commissioning financial report as at 31st December 2016

1. Introduction

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

2. Financial Position

2.1 The CCG reported an underspend of £60k against delegated budgets at the end of December (see table below).

2.2 This represents a reduction of £15k on the underspend reported in October.

2.3 The reason for the year to date variance is:

- an underspend against the 2015/16 Quality and Outcomes Framework (QOF) estimate has been reported previously but it is reported that other costs (such as language and translation costs and a commitment for a potential recharge of Primary Care information governance and smartcards from the CSU) have offset this gain in the year to date.

2.4 The CCG continues to forecast a breakeven position for 2016/17 and has assessed all known commitments for the remaining months of the financial year. This includes a non-recurrent amount for the 2016/17 for setting up of the cluster schemes relating to the GP Forward View which comes into effect in 2017/18 (funded from non-delegated budgets on an ongoing basis). It is important that additional spend approved in 2016/17 does not lead to any recurring commitments in future years.

3. Recommendation(s)

3.1 The PCOG are asked to:

Note the contents of the paper

2016/17 Delegated Primary Care Co-Commissioning budget

December 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	3,895,535	3,895,535	0	35,059,885	35,059,885	0	
	Contract Payments - PMS	3,356,147	279,674	279,674	0	2,517,073	2,517,073	0	
	Contract Payments - APMS	1,379,509	114,958	114,958	0	1,034,624	1,034,624	0	
	Enhanced Services	4,216,184	351,207	351,207	0	3,161,026	3,161,026	0	
	Other GP Services	2,174,661	184,892	184,892	0	1,618,887	1,618,887	0	
	Premises	8,147,486	678,791	678,791	0	6,109,305	6,109,305	0	
	Dispensing/Prescribing	3,125,231	411,599	411,599	0	2,298,762	2,298,762	0	
	QOF	8,198,783	683,159	683,159	0	6,148,516	6,088,516	(60,000)	
	TOTAL	**77,345,155**	**6,599,815**	**6,599,815**	**0**	**57,948,078**	**57,888,078**	**(60,000)**	**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
- Other general supplies & services
- Doctors retainer scheme
- Locum/adoption/maternity/paternity payments

NHS
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Clinical Commissioning Group

Agenda Item 11

Primary Care Commissioning Committee

Meeting Date	**Thursday 26th January 2017**
Title	**2017/18 Budget Proposals**
Executive Summary	The paper provides an overview of the Gloucestershire Clinical Commissioning Group draft budget proposals for delegated co-commissioning in advance of the 2017/18 financial year.
Risk Issues: **Original Risk** **Residual Risk**	None
Financial Impact	The position has been included within the CCG's overall financial plan for 2017/18.
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

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 11

Primary Care Commissioning Committee

Thursday 26th January 2017

Delegated Primary Care Commissioning 2017/18 Budget Proposals

1. Introduction

1.1 This paper gives details of the draft 2017/18 budget proposals for delegated co-commissioning for Gloucestershire CCG. Budgets have been prepared in accordance with the NHS England business rules.

2. Allocations

2.1 The CCG has received its Primary Care allocation for 2017/18 in January 2016, this has subsequently been updated and the budget for 2017/18 set on the updated allocation. The total allocation for 2017/18 is £79.968m, an increase of £1.445m.

3. NHS England Business Rules

NHS England's national business rules state that:

- 1% of the allocation should be used to create a reserve for non recurrent spend with 50% of this reserve to be uncommitted and held as a risk reserve and 50% available for the CCG to spend non recurrently to support transformation and change.
- 0.5% of the allocation should be provided as a contingency to manage risks within the in-year financial position.

The Primary Care budget includes the following:

- 1% non-recurrent reserve of £0.8m

- 0.5% contingency reserve of £0.4m

4. Budget Setting Methodology

Detailed budget setting is underway on a practice basis. The budget setting methodology uses both historical and known new commitments together with national guidance; guidance being sought from NHSE in specific areas. The detail is still to be finalised but it is anticipated that the budget will breakeven.

5. Contract Payments

Continued reinvestment of changes in Seniority and MPIG have been assumed.

Minimum Practice Income Guarantee (MPIG) payments have been reduced by 1/7 during the year, in accordance with national policy to eliminate MPIG payments by 2021.

A pay uplift of 1.07% has been included together with a 0.51% uplift relating to indemnity fees.

When all factors above are taken into account, it has been assumed that the global sum uplift will be equivalent to 3% in 2017/18. (This is in line with NHSE local assumptions).

In addition, a demographic increase over the year of 0.72% has been assumed, which is broadly in line with the assumptions used nationally in setting the CCG's allocation.

PMS contract prices have taken account of the PMS review reductions, bringing those practices more in line with GMS practices; the funding released being offset against increases in business rates, water rates and trade waste for PMS practices.

5.1 Enhanced Services (ES)

All current schemes have been rolled forward for 2017/18 and assumes those practices currently signed up continue to claim at the current rate based on the first nine months of the current financial year.

5.2 Other GP Services

This includes expenditure on items such as legal fees, GP Retainer schemes, adoption/maternity/paternity cover, seniority and additional staff payments.

Seniority payments, which are due to be phased out by the end of 2019/20, have been reduced in line with NHSE local assumptions.

The proposed budget has been based on historical recurrent spend and uplifted where appropriate. It is, however, recognised that in some instances (e.g. maternity cover) that the cost may lie with different practices in the new financial year.

Current GP Retainer payments are budgeted to their individual planned end dates. However, this budget assumes that four additional retainers will be funded for the full year.
The CCG has included a planned spend relating to a potential recharge of primary care information governance and smartcards from the CSU. This cost was initially highlighted by NHSE in 2016/17 but has yet to be incurred.

5.3 Premises

The baseline for these costs has been founded on the forecast expenditure incurred in 2016/17. However, further adjustments have been assumed for:

- Inflationary increases

- The estimated impact of rent reviews where appropriate
- The impact of new developments (both those due to newly open in 2017/18 and for those already opened part way through 2016/17).

The latter item has added potential additional costs of £459k in 2017/18; £328k being for rent and £131k for rates.

5.4 Dispensing/Prescribing

Proposed budget based on spend incurred in 2016/17 and then uplifted for inflation.

5.5 QOF

Achievement element of 30% has been uplifted in line with demographic growth.

Aspiration element of 70% has been based on 2015/16 outturn (as this is the last full year available) and uplifted in line with demographic growth.

6. Recommendation(s)

PCCC are asked to:

- Note the contents of the paper

Proposed 2017/18 Primary Care Co-Commissioning budgets

	Area	2017/18 £000
FUNDING	Allocation	79,968.0
	Less :- nationally mandated adjustments	
	1% headroom	(799.7)
	0.5% contingency	(399.8)
		78,768.5
SPEND	Contract payments	52,698.2
	Enhanced services	4,163.7
	Other GP services**	1,729.0
	Premises	8,754.5
	Dispensing/prescribing	3,155.4
	QOF	8,267.8
	TOTAL	**78,768.5**
	SURPLUS/DEFICIT	0.0

** Other GP services includes:- legal fees, GP retainer scheme, adoption/maternity/paternity cover, seniority and additional staff payments.

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 12

Primary Care Commissioning Committee

Meeting Date	**Thursday 26th January 2017**
Report Title	**Primary Care Quality Report**
Executive Summary	This report provides assurance to the Committee that quality and patient safety issues are given the appropriate priority and that there are clear actions to address them.
Key Issues	Failure to secure quality, safe services for the population of Gloucestershire.
Risk Issues: **Original Risk (CxL)** **Residual Risk (CxL)**	Failure to secure quality, safe services for the population of Gloucestershire.
Management of Conflicts of Interest	Not applicable
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)	Not applicable

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 12

Primary Care Commissioning Committee

Thursday 26th January 2017

Primary Care Quality Report

1. Introduction

1.1 At the request of the Committee (PCCC) 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 In November 2016 the Committee discussed the evolution of reporting Quality matters to the Committee. The Quality Team and the Primary Care team will prepare a revised report in the new year, drawing upon the CCG Primary Care quality assurance framework.

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. At present, NHS England have agreed to continue to review all GP Serious Incidents. This may change in the future though. To date we have not been alerted to any new serious incidents in primary care, although some GP's have used the NRLS to report other incidents Quality Alerts.

3. Complaints and Concerns

3.1 Responsibility for complaints and concerns in relation to primary care remains with NHS England. Following requests for information on complaints, NHS England invited us to be part of a trial of a new Primary Care Complaints Dashbaord.

3.2 NHS England have delayed further iterations of their Primary Care complaints dashboard following poor feedback from participating

CCGS. Version two was due to be sent in November, but this has now been pushed back to December.

4. Safeguarding

4.1 Appointment of Named GP for Safeguarding

4.1.1 The Named GP for Safeguarding Adults and Children has been in post since June 2016, working alongside other Designated and Named Professionals in Gloucestershire.

4.1.2 The Named GP will be co-facilitating the new Adult Safeguarding forum for Gloucestershire GPs. This forum is intended to be a regular event (2/3 per year) supporting aspects of Primary Care training needs as well as clarification of legislation, policies and guidance through partnership working.

4.1.3 Other activities that have been undertaken by the Named GP include:

- Direct work in relation to completing Individual Management Reviews for Safeguarding Adult Reviews
- Participation in one current Domestic Homicide Review
- Supportive discussions and supervisory work for GP Practice (both Adult and Child Safeguarding)
- Member of the Child Death Overview Panel
- Attendance at GSCB executive meeting and planned attendance at GSAB Board.
- Member of MARAC Steering Group
- Participation at Primary Care Safeguarding Forums (Child and Dental).

4.1.4 GCCG has increased the number of sessions for the Named GP to 3 per week (12 hours). This has enabled greater flexibility and commitment to attend the variety of network meetings for the whole Safeguarding team. Awareness of the Named GP role is increasing through strengthened Primary Care links and work with other GP colleagues in the CCG.

4.2 Safeguarding Adult Review

"Ted", 72 year old gentleman admitted acute hospital late August with kidney problems, discharged late September with a re enablement package and catheter in situ. This package of care at the end of

October. Ted was last seen mid-January and was found dead in his flat approximately 7 weeks later after concerns were raised by a neighbour.

- Discharge letters from hospital to GP should include more detail
- Re-enablement Service should provide GP's with a report when the service ends.
- GPs should consider how they identify those who have not accessed repeat prescriptions for some time.
- The process for making referral to District nursing Service should not rely on an answer phone

"KH" admitted to acute hospital with grade 4 maggot infested pressure ulcers. Self-neglect and non-attendance/contact with District nursing Service. GP good practice noted for exploring ways in which adult safeguarding could be better highlighted in its system.

The named GP will continue to raise awareness of signs of neglect both in adults and children.

5. Primary Care Clinical Quality Review Group (CQRG)

5.1 Unfortunately, due to the number of apologies received, the November session of the Primary Care CQRG was cancelled. The next session will be in January 2017.

5.2 Quality Assurance Framework

Since the establishment of the Primary Care CQRG the oversight the primary care quality and safety has been undertaken using a Quality Assurance Framework (see **Appendix 1** attached). This framework focuses on 3 areas Planning for Quality, Quality improvement and Quality Assurance. This is a unique approach which has been devised by the CCG. It is anticipated this will be eventually used to examine Quality at CCG, locality and practice level.

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.

More information will be presented in the Experience presentation.

6.1.2 The Primary Care Contracts Team have reminded practices of the deadline for submitting FFT data and that it is a contractual requirement. 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.

6.1.3 Patient Participation Groups have been reminded at their Network meeting in October 2016 of the value of encouraging practices to participate in the FFT process.

6.2 Patient Participation Groups (PPG)

6.2.1 GCCG has established a Gloucestershire Patient Participation Group (PPG) Network.

6.2.2 The focus of the event in October 2016 was: reducing stigma in mental health, patient facing website and social prescribing and working with the community and voluntary sector.

6.2.3 The next PPG Network meeting will focus on the STP and PPG members will work in 'localities' with colleagues from the CCG Locality Team.

6.2.4 Members of the CCG Engagement Team continue to support individual practices and PPGs providing advice and guidance as requested.

7. CQC Inspections

7.1 A dashboard of completed and published CQC Inspections Reports is attached at **Appendix 2** for information. The majority of practice reported by CQC as 'Good' with 3 practices reported as 'Requiring Improvement' and 2 practices reported as "Outstanding".

7.2 6 Practices are still awaiting inspection under the new CQC

inspection regime.

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 The 3 main themes from practices who are considered to 'Require Improvement' include:

- Medicine management

Unsafe storage of medicines
Blank prescriptions not being stored securely

- Training

Evidence of induction and training not available
No appraisals for staff
No evidence of prevention of infection control training
GPs not completed safeguarding adults training.

- Infection control and prevention

No Infection control audits had been carried out
No evidence of prevention of infection control training
Unclean treatment rooms
No cleaning schedules

8. Medicines Optimisation

8.1 <u>Quality Premium (QP) Antimicrobial Resistance (AMR)</u>

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 continues to work with practices to reduce these rates.

The total percentage of prescribed antibiotics from Cephalosporin, Quinolone and co-amoxiclav class antibiotics has reduced from 10.42% April 2016 to 10.24% June 2016.

8.2 A Medicines Optimisation Programme Group has been established, and meets monthly. There are 8 strands to the work of this group, GHT, 2gether, Dietetics, Prescribing Improvement Plan, Traffic light list, Non-generic ED drugs, Localities and Enablers. Each work stream has several projects including:

Reduction in SIP feeds
Branded generic switches
Lower cost over active bladder drugs
North Cotswolds clinical pharmacist

8.3 Reducing Clinical Variation

8.3.1 In line with the Gloucestershire Sustainability and Transformation Plan (STP) work programmes have been established to reduce Clinical Variation to achieve maximum effective use of resources, including medicines, ensuring that the right patients get the right choice of intervention, at the right time. This helps patients to improve their outcomes; take their medicines correctly; avoid taking unnecessary medicines; reduce wastage of medicines; and improve medicines safety.

The current key programme areas are highlighted below.

8.3.2 Gluten Free Prescribing

Cessation of gluten-free prescribing began 1st December 2016. GCCG have engaged 2 Primary Care support Dieticians (1 in post, 1 starting beginning of January 2017) to ensure continuing support is provided to GPs and patients.

An IFR process which includes the support of dietitians has been introduced.

8.3.3 SIP Feeds

Following the successful work undertaken by Swindon CCG, GCCG will be working with practices to ensure appropriate prescribing of SIP feeds with follow-up support. The 2 Dieticians employed by GCCG will be also providing support to this work programme which will commence in January 2017.

8.3.4 Gloucestershire Pain Transformation Pathway

One of the first year priorities identified in the STP will be to develop a new and innovative medicines optimisation approach for patients living with pain, considering the role of pharmaceutical interventions, the pathway of care and new ways to provide alternative and holistic

support to this often complex group of people.

9. Workforce

9.1 Appointment of Practice Nurse Facilitators

9.1.1 The Practice Nurse Facilitators are currently undertaking a workforce profiling audit to gain a full understanding of the profile of practice nurses and health care assistants working across the county. This will assist in planning future education and training strategies.

9.1.2 Working with the University of West of England and practices the number of placements for nursing students has increased from 6 to 11.

9.1.3 Practice nurses continue to be supported regarding Nursing and Midwifery Council new revalidation requirements.

10. Appendices

Appendix 1 - Dashboard of completed and published Gloucestershire GP CQC inspection reports

Appendix 1

Quality Framework for General Practice: Domain: Planning for Quality

	Activity Description	Responsible Group	Lead	Current Position	Risk Matrix	Future Actions Required
1	Workforce Planning	Primary Care workforce and education planning group	Marion Andrews Evans	Annual template included in Primary care workforce and education planning		
2	Training and Development Plans	Primary Care workforce and education planning group	Karyn Probert	Annual template included in Primary care workforce and education planning		
3	Premises Development Plans	Primary Care Estates workstream	Helen Goodey	AH written estate strategy plan and progressing links to STP		
4	Financial Planning	PCCC	Helen Goodey	Part of Primary Care annual template		Links with Business Intelligence at CCG/Oracle system
5	Care Pathways and Referral Criteria	CQRG	Kathryn Hall, CPGs	G Care, Prescribing formulary compliance, Practice variation reports		
6	Practice/population needs assessment	LA PH	Sola Aruna	Ad hoc PH needs assessments undertaken by LA PH team		
7	Risk Stratification	Variance group	Bronwen Barnes	Variance report		
8	Inter practice Partnership Working	PCOG	Helen Goodey	Clusters developing		Developing partnerships ref to STP

Appendix 1

Quality Framework for General Practice: Quality Improvement

	Activity Description	Responsible group	Lead	Current Position	Risk Matrix	Future Actions Required
1	Productive General Practice used	CQRG	Marion Andrews Evans	Detail of individual practices take up.		Early Dec will have further details
2	Use of NICE Guidelines and Care Pathways	CQRG	Terersa Middleton	Clinical effectiveness group monitoring/CQC visit/Use of G Care		
3	Policies / Procedures / Protocols available, in use and updated. e.g. Safeguarding, infection control, drugs formulary	CQRG	Terersa Middleton	Picked up via CQC visit		QOF achievement as a proxy. PN facilitators to support practices with policies/procedures/protocols
4	Patient safety programme – 'Sign up for Safety'	CQRG	Kay Haughton	One practice to date		Increase number of practices
5	Use of assessment tools: RCA, Clinical Audit, significant event reviews	CQRG	Terersa Middleton	Picked up via CQC visit		
6	Service activity and performance data collected, reviewed and benchmarked	CQRG	Sara Riordan-Jones	Primary care audit plan/programme.		Availlable on CCG portal. Some payments related to scrutiny by practice
7	GP, Nurse and Staff appraisals undertaken	CQRG	Marion Andrews Evans	Primary care workforce and education and planning group. GP NHSE. CQC visit. PN facilitators support		
10	Customer care training undertaken for staff	CQRG	Bronwen Barnes/Karyn	Primary care workforce and education and planning group. CQC visit.		
8	Quality Improvement, leadership and service innovation training	CQRG	Bronwen Barnes/Karyn Probert	Primary care workforce and education and planning group.		Forms part of STP
9	Skills based training undertaken by clinical staff e.g. infection control, safeguarding	CCG	Bronwen Barnes/Karyn	Primary care workforce and education and planning group. CQC visit. PN facilitator data. Bluestream offered to practices.		
11	Peer Review undertaken	CQRG		CQC visit		
12	Medicine management patient reviews regularly undertaken	CCG	Terersa Middleton	Eclipse database		
13	Active Patient Participation Groups working in practices	CCG	Becky Parish	Pt Engagement team		PPG network. 2 practices not engaged
14	Monitoring and learning from complaints	NHSE	Rob Mauler	NHSE		NHSE and CCG liase to share meaningful data
15	FFT	CQRG	Rob Mauler	HSCIB portal		
16	Practice environment audits undertaken	CQRG	Andrew Hughes	Estate strategy pan and links to STP. Locality team		

Appendix 1

Quality Framework for General Practice: Quality Assurance

	Activity Description	Responsible Group	Lead	Current Position	Risk Matrix	Future Actions Required
1	CQC Inspections	CQRG	CQC	CQC Website. CCG support plan		
2	Practice Visits	CCG	Andy Seymour	Primary care and Quality team co visit practices		
3	QOF Scores	CQRG	Jeanette Giles	CQRS Website		Feedback from Primary Care contracting
4	Payment Verification	Primary Care	Jeanette Giles	Finance. Data base available		Feedback from Primary Care contracting
5	Analysis of practice Variance and performance information	CQRG	Helen Goodey/Bronwyn Barnes	Primary Care offer		
6	Revalidation of Doctors and Nurses	NHSE	Marion Andrews-Evans	NHSE Doctors ? Nurses CCG provided revalidation workshops. PN faciliators to support PNs		
7	Legal Compliance – H&S, E&D	NHSE	NHSE	Picked up at CQC visit		
8	NRLS Reports	NHSE	Rob Mauler	Reported to CQRG		NHSE and CCG re meaningful data
9	SIs reports	NHSE	Rob Mauler	Reported to CQRG		NHSE and CCG re meaningful data
10	Practice training activities and participation in training events outside of practice	Workforce and training	Marion Andrews-Evans	CQC. Primary care data		
11	Practice staffing levels and recruitment	Workforce and training	Helen Goodey	NHSE annual report re workforce, CCG data		

Green: Low; Yellow: Moderate; Amber: Significant; Red: High

		Consequence				
		1	**2**	**3**	**4**	**5**
Likelihood	**1**	1	2	3	4	5
	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25