NHS
Blackburn with Darwen
Clinical Commissioning Group

General Practice Quality and Outcomes Enhanced Services Transformation (QOEST)

-DRAFT-

2016/17

Contents

1.0 Introduction

The vision for NHS Blackburn with Darwen Clinical Commissioning Group (BwDCCG) is to deliver accessible, safe, high quality care for the entire local population, including children, young people, hard to reach and vulnerable groups. To achieve this in an environment of increasing demand for care, yet within constrained financial resources, services will need significant transformation in how they perform, particularly in terms of quality, outcomes and access. The Quality and Outcomes Enhanced Services Transformation (QOEST) scheme is designed to support Primary Care to transform into a sustainable, high quality provider that delivers better outcomes and improved access for patients and manages more people outside of a traditional hospital setting.

2.0 Strategic Rationale

The CCG has engaged with the public, practices, Senate, other CCGs, Local Authority, NHS England and and the Local Medical Committee. It has also consulted national authoritative reports from NHS England, King's Fund and others to understand the evidence in order to develop this scheme (see appendix F for further details).

The QOEST scheme will be a phased scheme running over at least the next 5 years. The aim is to improve the quality of care across the health and care system. Co-commissioning of Primary Care enables the CCG to facilitate changes in General Practice by commissioning services differently. The CCG must ensure that the services it commissions deliver its strategic objectives. Development of QOEST is in line with the CCGs existing strategies and plans, notably BwD CCG's Primary Care Strategy 2014.

In order to deliver its strategic objectives, the CCG must facilitate shifting the delivery of care from a hospital to a community setting, whilst ensuring that the resource to deliver this care is also transferred. The CCG aims to increase the funding of General Practice in line with the Royal College of General Practitioners advice from 8.4% to 11% of total NHS spend (equates to an extra £6 million into General Practice in Blackburn with Darwen).

Primary Care providers must decide how the CCG's commissioning objectives can be delivered most effectively and efficiently.

3.0 Funding

The NHS is facing unprecedented financial challenge due to the combination of increasing demand and financial constraints. Remuneration of the QOEST scheme will be financed by current Local Improvement Scheme monies plus any Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) monies that are made available to the CCG. In year 1, an additional £200k will be included, making a total resource of £1,086,000 available for the scheme. This equates to approximately £6.40 per head of population.

There may be funding freed up from APMS contracts but this will only be available from 2017. From year 2 additional funding is likely to have to be generated from savings accrued by moving care out of hospital. Practices may also release resources if they develop more effective organisational delivery models.

A full breakdown of the resources available is shown in appendix B.

4.0 Phases

The QOEST scheme will be phased over the next 5 years

4.1 Phase 1

For the Phase 1 there will be two parts to the scheme.

1. **Rationalisation and streamlining of existing local improvement schemes.**

   There are a number of existing Local Improvement Schemes (LIS) that are disparate in terms of duration, claiming procedures and how they operate. This variation causes an increase in bureaucracy and does not allow practices to plan efficiently for the future, particularly regarding cash flow and the employment of staff. These existing schemes will be combined into a more coherent set with a unified claiming process and a guarantee of remuneration going forward - provided relevant targets and end points are achieved. The payment approach will reflect the Quality and Outcomes Framework remuneration, in that there will be a significant proportion of funding upfront (70%), with the rest paid on achievement. The individual components will vary as the scheme progresses, depending on need or changes in demand.

2. **Improving Quality and Reducing Unwarranted Variation through development of improvement plans**

   In order to facilitate primary care to become a high quality, sustainable provider, the CCG would like to commission General Practice based on outcomes, quality and access - measured by improved mortality and morbidity and patient experience. In this first phase, the additional investment in General Practice through QOEST will enable practices to:

   - Access and understand the available data and information regarding General Practice performance in terms of quality, access, outcomes and variation.
   - Develop plans on a Locality, Practice and Blackburn with Darwen level (as appropriate) as to how they will;
     - improve quality and outcomes and reduce unwarranted variation. (Locality and Practice plan)

- improve access for patients in line with public need and expectations. (Locality and Practice plan)
- develop a high quality, sustainable General Practice service for Blackburn with Darwen residents. This should include how General Practice will be part of a sustainable health and care system and how reliance on secondary care will be reduced. (Blackburn with Darwen plan with reference to what will happen at Locality and Practice level).

4.2 Phase 2

Phase 2 is envisaged to have 3 components depending on outcomes of phase 1:

1. **As per phase 1 – Delivery of rationalised Local Improvement Schemes**

   The combined LIS's will continue. These may be subject to change depending on CCG strategic plans, population need and the plans developed by General Practice. Ultimately the CCG expects that Local Improvement Schemes will cease to be commissioned as Practices and Localities will develop their own improvement plans.

2. **Plan Implementation**

- Plans developed in phase 1 should now start being implemented.
- Improvements should be evident in quality, reduced variation and improved access
- General Practice must provide regular quarterly and annual reports to the CCG regarding performance against Key Performance Indicators (KPIs), with exception reports and recovery plans where services are not delivering or KPIs not being achieved.

3. **Further plan development**

- General Practice (at locality level and for Blackburn with Darwen) will develop further plans which will, over the next 4 years, release the extra funding required to achieve the target of 11% of NHS spend being in primary care. There should be a year on year trajectory in terms of services provided and resources freed up.

4.3 Subsequent Phases

The work which began in the first 2 phases will be further developed. By year 5, 11% of NHS spend should occur in General Practice. Patients will receive a high quality service with appropriate access to General Practice and utilise hospital services less.

5.0 Inclusion criteria.

The QOEST scheme will only be available to those providers:

- currently offering essential primary medical services to a list of patients under either a General Medical Services Contract (GMS), Personal Medical Services Agreement (PMS) or Alternative Provider Medical Services (APMS). The service will be for all registered and temporary registered NHS patients without exclusion.
- already providing the full range of core and additional services (albeit they can subcontract with other practices to deliver any of its components). The CCG would like all practices to sign up to the scheme so that all patients have access to the full range of services commissioned by the CCG. If any practice declines to sign up to the scheme, they will only be commissioned to provide General Medical Services, Additional Services, Directed Enhanced Services and the Quality and Outcomes Framework (QoF).
- achieving 90% of QoF points
- complying with CCG policies eg interventions of limited clinical value.
- opening from 8am until 6.30 pm Monday to Friday. This means open door and telephone access. Clinical services do not have to be provided for all of this time, though there will have to be adequate cover for emergencies. This is in addition to the improved access developmental requirement as this can be done across a locality or Blackburn with Darwen footprint.

6.0 General Principles

To implement the scheme, Blackburn with Darwen CCG will apply the following core principles:

- Patient safety should not be compromised
- Patients should continue to receive clinical care, specific to their individual needs
- The incentives should not encourage a uniform or blanket approach to all patients with the same condition.
- GPs should continue to have the necessary flexibility to meet the individual needs of their patients
- Incentives should be paid in relation to outcomes

7.0 Business Continuity

The practice shall include this scheme within its business continuity plan. The practice will provide, if requested, details and plans for continuity of service arrangements, including staff shortages, facilities and system failures which may affect service delivery.

8.0 Key Performance Indicators

Practices will be expected to comply with all the Key Performance Indicators (KPIs) within the QOEST scheme. If practices are not meeting the KPIs they will be asked to document why and produce an action plan to demonstrate remedial action. Financial clawbacks may be applied if practices do not achieve the KPIs.

8.1 Part 1 - Amalgamated LIS's

All the key performance indicators in the current LIS's will be carried forward although there will be some streamlining of reporting and monitoring processes. The scheme will be monitored by the CCG.

8.2 Part 2 - Quality and Improvement Plans

Practices and localities will gather and analyse data in relation to prescribing, referrals, procedures of limited clinical value, A&E attendances, unplanned admissions, patient experience, access and any locality agreed quality improvement areas. This list is not exhaustive.

Practices will work within localities to develop systems and processes to understand quality, performance and outcomes. Patient experience will be a key performance metric. Localities and practices will be required to produce 3 improvement plans:

Improvement Plans

Plans will be produced at Practice, Locality and/or Blackburn with Darwen level as follows;

1. A plan to improve quality and reduce variation in services provided, particularly with regard to prescribing, A&E attendances, unplanned admissions and referrals.
   (1 Locality plan and 1 Practice plan – it will be acceptable for the practice plans to be part of or appended to the Locality plan).
2. A plan to deliver improved access to General Practice, reflecting the publics needs and expectations. The aim should be to reduce the number of patients accessing A&E due to being unable to get a GP appointment. Patient experience of access should also be measured.
   (1 Locality plan and 1 Practice plan – it will be acceptable for the practice plans to be part of or appended to the Locality plan).
3. A plan of how General Practice in Blackburn with Darwen will be developed into a sustainable, high quality service fit for the future that is attractive for staff to work in and provides an excellent service for patients. This plan must describe how:
   i. General Practice will work more effectively and efficiently together,
   ii. General Practice will achieve better outcomes and reduce reliance on secondary care
   iii. Prevention, patient education and self care will be improved

iv. General Practice will utilise new technology to improve effectiveness, patient care and experience
v. Functional and/or organisational form may need to change to deliver these improvements.

(a single plan covering all Blackburn with Darwen practices which references developments at Locality and Practice level).

The plans will be submitted according to an agreed timetable and will be reviewed by a CCG panel to ensure that they are robust, ambitious and likely to achieve their aim. Plans that are not at the required standard will be resubmitted following feedback and guidance from the panel. Once plans are approved, payments will be authorised.

9.0 Engagement

Patients are key to service changes and practices must involve them in planning. Practices must undertake patient engagement in a variety of ways eg through PPG groups (practice and Locality based) and other patient groups such as Healthwatch. Practices will be expected to work with the CCG to develop further focus groups and electronic methods of gathering patient views.

In developing this scheme the CCG has utilised national feedback from patients engagement of wave 1 Prime Ministers Challenge Fund (PMCF) sites in terms of service quality and access. Information from the national GP Patient survey has also been used. The CCG has also used local evidence from patient views gathered by East Lancashire CCG and through Blackburn with Darwen Healthwatch (see appendix F).

10.0 CCG Role

The CCG will:

- facilitate General Practice development through its co-commissioning role - particularly with new contractual and funding models - and with its relationships and interactions with other providers
- review, evaluate and approve submitted plans
- monitor outcomes, quality, finance and patient experience to ensure delivery of high quality, cost effective services within budgetary constraints.
- review achievement at year end and make any financial adjustments necessary.

11.0 Payment System

The QOEST scheme is designed to simplify the claiming process for Local Improvement Schemes and allow General Practice to plan for improved quality, access and sustainability

by spreading payments evenly across the year. The total possible payment per practice will be estimated and 70% paid up front in equal twelfths every month. A review and reconciliation process will take place at year end to determine achievement and further payments due (up to a further 30%). If practices do not achieve the KPI's, payment for the following financial year may be adjusted to recover any overpayment made in the previous year.

Funding arrangements for the quality improvement plans are as above, with 70% of payment made up front and the final 30% paid when all plans have been submitted and agreed by the CCG. To be entitled to the full amount, all three plans must be approved by the CCG.

For 2016/17, practices are expected to continue submitting activity information for Near Patient Testing, Clinical Haematology and Health Checks, and final payment will continue to be based on activity. Practices are asked to submit activity information to Midlands and Lancashire Commissioning Support Unit on the claim form.

A breakdown of the funding sources for QOEST is included at Appendix B together with an example of a practice summary payment structure. An individualised version of this payment structure will be issued to each practice separately.

Note – it is the localities and practices' responsibility to monitor their own progress throughout the year to ensure they are on track to achieve KPI's.

Any Enhanced Services or Improvement Schemes not included within QOEST must be claimed for separately.

12.0 Validation and Reconciliation Process

The CCG will monitor the scheme and receive plans and claims. At the end of the year a panel will be convened to review practice achievement, rule on appeals or errors and agree balancing payments or overpayments. This process will be overseen by the Primary Care Commissioning Committee.

13.0 QOEST COMPONENTS - PHASE 1

Part 1 – Amalgamation of existing schemes

Component 1	**Medicines Optimisation** **Draft outline of scheme**
Rationale	The utilisation of medicines is one of the key interventions that a primary care health professional can make. There is a finite resource attached to this intervention and every decision to prescribe carries a clinical risk. Review of clinical risk and outcomes of prescribing are essential for cost effective prescribing (Maughan & Ansell, 2014, Webb, 2014). The GP element of the prescribing budget accounts for approximately £26million, with expected growth each year in the region of 5%. This presents a significant risk if appropriate financial stewardship measures are not adopted. As such, cost effective, evidence based prescribing, both for improving health outcomes and financial management, is a priority for BwD CCG. Benefits • improve prescribing quality and patient safety • reduce risk from medication errors • reduce waste • support prescribing spend within budget
Delivery:	Practices must: End the year not more than 1% over their prescribing budget. Meet with their Medicines Management Team on 2 occasions to agree areas of improvement and, if necessary, cost improvement plans. Use Eclipse Live to review patients with 'Red' (all) and 'Amber' (2 patients per 1000 practice population) alerts monthly Undertake medication reviews of potentially inappropriate prescriptions in selected cohorts of persons over 65 years. Use TARGET resources within practice to support local antimicrobial stewardship program & undertake an annual antibiotic audit. Agree an individualised QIPP plan for specified prescribing indicators.
Key Performance	• The provider shall deliver improvements or maintain agreed performance against defined prescribing indicators over the duration

indicators	of the scheme. • Providers already achieving the target for individual indicators within the defined areas shall maintain the achievement throughout the duration of the scheme. • The provider will meet the agreed annual prescribing budget. • Baseline data from the current QIPP reports will be used in defining performance required in the indicators for the forthcoming year. For any new indicators the most current data will be used as a baseline. • The practice-prescribing budget will be issued monthly and shall be frequently monitored by the provider and commissioner. Forecast over spend will be reviewed as appropriate. • Metrics for other work identified will be agreed annually**.**

Component 2	Cancer Draft outline of scheme
Rationale	**1. Agreement to adhere to best practice advice on investigations and referrals for suspected cancer.** New NICE guidance for suspect cancer came out in 2015. To help support practices implement these guidelines we have developed "best practice advice". This followed a consultation process with G.P.s, cancer consultants, commissioners and hospital cancer managers. It is designed as a practical help guide for G.P.s, practice nurses and their staff. The aim is to ensure safe, effective, and efficient processes that enhance the early diagnosis of cancer. The main themes include • Procedures in practice that ensure acting on practice initiated test result than highlight the suspicion of cancer • The inclusion of safety netting in clinical situations where patients are given specific advice of when to return. • The utilisation of standardised referral proformas (2WR 2016) and the inclusion of all relevant demographic and clinical data. **2. Putting patients at the centre of care pathways for suspected cancer.** This element of the LIS focuses on trying to improve patient understanding, engagement and satisfaction. In parallel to work within primary care there will be patient participation groups collaboratively developing patient information leaflets and offering feedback on the best ways of G.P.s communicating the need for investigation or referral for suspected cancer (using "MINDSPACE" principles). This will also be backed up with a marketing campaign of encouraging patients to attend appointments. In addition ELHT (supported by a cancer CQIN) will be expected to improve the process of making an offer to patients of appointment for suspected cancer. The primary care elements of the LIS include • Informing patients they are on a suspected cancer pathway. • Accessing and supplying patient information which enhances patient understanding and engagement. • Making specific steps to support vulnerable patients to engage with the process (e.g. checking on attendance of patients with learning difficulties) • Communicating with ELHT about patients who have expressed

concerns about the timeliness of their follow up.

- Analysing the practice specific information for patient cancellations and DNA for suspected cancer appointments.

3. Cancer prevention for patients referred who were found not to have cancer.

91% of 2week wait (WW) referrals turn out not to have cancer. These patients have presented to a G.P. with a symptom or sign that could indicate cancer and have been referred on a cancer suspicion pathway. There is a potential opportunity to offer cancer prevention advice to these patients. The cancer LIS will involve:

- Practices coding and tracking all 2ww referrals.
- Contacting patients once cancer has been excluded (likely 1-2 months after referral)
- Sending a standardised letter ("…good news you do not have cancer but to keep healthy…")
- CRUK leaflet about the best ways to prevent cancer
- Links to local cancer prevention therapies (smoking cessations)

4. Enhanced Cancer Care reviews of new diagnosis of cancer

Patients diagnosed with cancer (9% of all referrals) are currently offered a basic cancer care review as part of the QoF process. In Pennine Lancashire we have developed this system by training practice nurses to provide a more holistic review using the Macmillan Cancer Care Review Template and offering signposting to other services (e.g. Macmillan Cancer Information Post). As part of the cancer LIS:

- Practice nurses will be offered training in communication skills for cancer and holistic needs assessment of patients.
- The practice will offer patients newly diagnosed an extended practice nurse appointment.
- The practice nurse will perform and enhanced cancer care review
- In addition the nurse will undertake a brief satisfaction survey exploring the quality of communication they have received and capturing patient suggestions on improving patient experience and engagement.

5. Audit and Significant Event Analysis of Cancer Cases.

- The practice will be asked to choose cases (approximately 1 per

3000 registered patients) for SEA.

- There will be steered towards a case that initially presented with "vague symptoms" e.g. weight loss or abdominal pain.
- There will complete a SEA using the standardised RCGP format and be expected to undertake an in house clinical discussion of learning and action planning.
- Furthermore the SEA reviewer will consider the impact that new NICE guidance could or would have made on this retrospective case. The aim is to stimulate problem based learning and assess the change that NICE recommended.
- Each practice will bring their one or more SEAs to a locality meeting for a peer based review exploring the merits of new NICE guidance and considering recommendations that could be made to commissions (e.g. access to urgent diagnostic)
- We will analyse the themes and consider outcomes that can improve future patient care.

This project is subject to a CRUK ACE development bid. If successful we will employ the services of academics from UCLAN to independently evaluate results.

6. Improve Uptake in Screening for Bowel Cancer

The cancer LIS 2014/15 involved a successful scheme to improve bowel screening. The overwhelming recommendation from G.P.s was to try to set up a system where they could opportunistically order a test kit for a patient in surgery who had recently been invited but not participated. We have been working on this recommendation with the ambition of including it in the next LIS:

- All practices record none participation of bowel screening in a standardised way
- Practice set up a screen alert pop up "did not participate in bowel screening"
- When the patient is with then in surgery the G.P. will opportunistically advocate participation and encourage the patient to complete a kit.
- If the patient agrees and does not still have a kit, the G.P. will order this kit directly for the patients (perhaps through the EMIS system or via E mail to the bowel screening Hub)

Please note due to a number of factors outside our control (IT solutions, capacity within the bowel screening Hub etc.) we currently cannot be certain

	that this project can definitely go ahead in full. It is likely that some part of it will happen. However it may not cover the whole of Pennine Lancashire or be delivered in exactly the way described above.
Key Performance indicators	• As part of the sign up process to the cancer LIS, practices would be expected to maintain their team of cancer champions (G.P. , practice nurse and administrator) who would take responsibility for sharing and instigating best practice advice • Creating an individualised practice plan for reducing patient DNA rates 9practices with a high DNA rate will be offered extra support from a CRUK facilitator) • Practices will audit the number of 2ww referrals and number of patients contacted (In addition we will explore the potential of smoking cessation service involvement) • Practices will audit the number of new diagnoses of cancer and the number of cancer care reviews. • Patient satisfaction will be analysed by the CCG to capture evidence of patient engagement and communication • Each practice will be asked to audit all new cancer cases in the preceding year, exploring tumour type and route to diagnosis • Practices will be expected to audit the numbers of patient with whom they have had the conversation, numbers of new kits ordered and of these the numbers of completed kits.

Component 3	Membership Engagement and Involvement
Rationale	NHS Blackburn with Darwen Clinical Commissioning Group (CCG) is a membership organisation, incorporating 27 GP Practices. The CCG has a formal constitution which lays down a clear governance structure, demonstrating how the CCG will exercise its functions effectively, efficiently, economically and in accordance with accepted, good governance principles. To effectively deliver clinical commissioning it is recognised that there will be certain requirements from General Practice which are over and above the usual remit of roles, and outside of the expectations associated with membership of the CCG.
Delivery:	To deliver this component you will be expected to: Engage in all elements as detailed below: 1. Clinical Senate Each practice is required to have a named GP representative who will attend each Clinical Senate. They will be expected to contribute to discussions and vote on schemes or initiatives when requested, on behalf of their practice. The Senate representative should be able to evidence that they have fed back to their practice following the meeting. 2. Locality Meetings Each practice is required to have a named GP representative in attendance at each locality meeting. The Locality representative will be expected to contribute to the leadership and development of the Integrated Locality Teams, expressing opinions on behalf of their practice. The Locality representative will encourage participation from their respective practices to ensure joint working across localities. The Locality representative should be able to evidence that they have fed back to their practice following the meeting. Each practice is required to have a named Practice Manager in attendance at each locality meeting. The Practice Manager representative will be expected to contribute to the leadership and development of the Integrated Locality Teams, expressing opinions on behalf of their practice. The Practice Manager representative will encourage participation from their respective practices to ensure joint working across localities. 3. Practice Manager Forum Practices are expected to release Practice Managers to attend the Practice Manager Forum. Programmes for Practice Manager Forums will be formed through collaborative working with the CCG and professional development will be evident.

	4. Surveys and Additional Meetings Practices are expected to participate in surveys and, within reason, additional ad-hoc meetings as outlined below: • Participation in a minimum of four CCG Survey Monkey surveys annually • Participation in ad-hoc surveys throughout the year including 360° Stakeholder Surveys • Participation in ad-hoc meetings scheduled by the CCG as appropriate. Examples of this type of meeting include the QOF development and locality service change events.
Key Performance indicators	Payment will be made based on compliance with the following key performance indicators: 1. Clinical Senate Payment is based on 100% participation from the practice. Practices will be expected to release one GP to attend Clinical Senate unless there are extenuating circumstances and an agreement has been made with the CCG. 2. Locality Meetings GPs: Payment is based on 100% participation from the practice; the same representative should attend the meetings wherever possible. Practices will be expected to release one GP to attend these meetings unless there are extenuating circumstances and an agreement has been made with the CCG. Practice Managers: Payment is based on a minimum 75% attendance rate over all Locality Meetings annually (allowing for annual leave and absence). 3. Practice Manager Forum Payment is based on a minimum 75% attendance rate over all Practice Manager Forums annually (allowing for annual leave and absence). 4. Surveys and Additional Meetings Communication from the CCG regarding surveys or additional meetings will clearly define whether the survey or meeting is included in the Clinical Commissioning Involvement Scheme.

Component 4	Near Patient Testing & Clinical Haematology
Rationale	To improve the patient experience by providing monitoring and review appointments in convenient locations, streamlining the patient journey and providing more local access to services. The provision of near patient testing and clinical haematology by GPs is designed to be one in which: • The service to the patient is convenient whilst remaining clinically safe • All clinicians involved are confident in accepting the legal and clinical responsibility associated with the prescribing of these medicines or monitoring of these conditions • Maintenance of patients first stabilised in the secondary care setting should be properly controlled • Monitoring of patients therapy is managed through their GP practice, standardising the provision and use of blood test monitoring • The need for continuation of therapy is reviewed regularly by the specialist • The therapy is discontinued when appropriate • The use of resources by the National Health Services is efficient
Delivery	Practices will monitor and review patients on the following Amber light medicines and medical conditions: • penicillamine • auranofin • sulphasalazine • methotrexate • sodium aurothiomalate • Auranofin (oral gold) • Azathioprine • Ciclosporin • Leflunomide • Mycophenolate mofetil

	• Mycophenolate sodium • Penicillamine • Sodium aurothiomalate (IM Gold) • Tacrolimus • Mercaptopurine • Sirolimus • Mild thrombocytopaenia due to chronic ITP • Chronic Lymphocytic Leaukaemia • Mild Neutropenia • Monoclonal Gammathapy of undetermined significance (MGUS Practices will be expected to adhere to the whole list. Prescribing by a primary care clinician of a listed drug should be carried out in accordance with the guidance provided in the East Lancashire Monitoring Guidelines and/or the shared-care protocol (where available) for that drug. However, on occasions, specialists and GPs may agree to work outside of these guidelines for that drug if circumstances make this appropriate. East Lancashire Monitoring Guidelines for AMBER drugs can be found on line at www.elmmb.nhs.uk and provide best practice guidance for monitoring these drugs with information accrued from a variety of sources. Adherence to the guidelines will not ensure a successful outcome in every case. The ultimate judgement regarding a particular clinical result must be made by the doctor in light of the clinical data presented by the patient and the diagnostic and treatment options available. Monitoring of any of the identified conditions by a primary care contractor should be carried out in accordance with the guidance provided by the ELHT haematology department and with the algorithms and follow up chart established by the department in line with the British Society for Haematology Guidelines and the information provided as part of the patients discharge papers. Reference information on Amber drugs is available on the website of East Lancashire Medicines Management Board, available on www.elmmb.nhs.uk This agreement will be reviewed and if required updated annually for example as drugs / conditions are added to or removed for the list.
Key Performance	1. Practices will be required to submit activity for the following:

Indicators	• Number of blood samples taken by treatment room • Number of blood samples taken by the practice Final payment will be made based on actual activity performed during 2015/16. 2. Maintain an up-to-date register of all patients receiving a listed medicine or with one of the listed conditions, indicating patient name, date of birth and the initiation and duration of treatment, including the last hospital appointment. Ensure that systematic call and recall of patients on this practice register is taking place. 3. 100% of newly diagnosed/treated patients receive education on the management of, and prevention of, secondary complications of their condition.

Component 5.	NHS Health Checks
Rationale	Together diabetes, heart disease, kidney disease and stroke make up a third of the difference in life expectancy between the most deprived areas and the rest of the country. Additionally, the cost of social and health care from the rise in levels of obesity, type 2 diabetes and dementia makes the prevention and risk reduction of these conditions key drivers of the programme. The NHS Health Check programme aims to prevent diabetes, heart and kidney disease and stroke, and raise awareness of dementia both across the population and within high risk and vulnerable groups. The NHS Health Check is made up of three components: risk assessment, risk communication and risk management. During risk assessment standardised tests are used to measure key risk factors and establish the person's risk of developing CVD or diabetes. The outcome of the assessment is then communicated in a way that the person understands and raises awareness of risk factors, as well as inform a discussion on, and agreement of, the lifestyle and medical approaches best suited to managing the individual's health risk. NHS Health Checks have the potential to reduce health inequalities. The greatest benefit will ensue by targeting those already known to have risk factors for CVD, those living in more deprived areas, and those at highest pre-calculated risk of diabetes (e.g. using the Leicester practice risk score tool which will identify patients who should be offered HbA1c blood test).
Delivery	Practices will be expected to deliver the following objectives: Identify their total eligible population aged 35-74yrs (i.e. not excluded due to presence of CVD[1], diabetes, >20% 10 year risk of CVD, or taking a statin). Offer an NHS Health Check to a sufficient number of eligible patients who have not had an NHS Health Check in the last 5 years, in order to achieve the target number of NHS Health Checks agreed with each practice. The target number of NHS Health Checks across the whole CCG for 2016/17 is 3,000, approximately 7% of the estimated eligible cohort. (See KPI section for further information on targets) Practices should send out invitations by letter from the GP in the first instance. The evidence suggests that a systematic approach will have the greatest impact. Fixed appointments are encouraged as they are more successful than asking patients to call to make an appointment. Risk Assessment includes

[1] CVD includes CHD, CKD stages 3-5, hypertension, AF, Stroke/TIA, Heart Failure, Peripheral Vascular Disease

	• Family history of CHD in a first degree relative under age 60 • Ethnicity • Height • Weight • BMI • Smoking status • Physical activity (using GPAC) • Diet • Blood pressure • Manual pulse check for rate and rhythm • Alcohol consumption (using AUDIT-C) • Blood tests for cholesterol, U&E, LFT A validated risk assessment tool to quantify risk of type 2 diabetes should be used to identify those at moderate risk of diabetes or greater, who should also be offered HbA1c blood test. Use the QRISK2 tool to estimate 10 year CVD risk. **Risk Communication** Everyone who attends for an NHS Health Check must be told their CVD risk score and other results. People aged 65 to 74 must be given information at the time of the risk assessment and face to face interview to raise their awareness about the signs and symptoms of dementia, the possible link to CVD risk factors, and sign post to memory services if appropriate. **Risk Management** Low risk = <10% 10 year CVD risk - include encouragement to continue good health behaviours, maintain a healthy lifestyle, and a healthy weight, as well as any other appropriate health advice. At risk = Between 10% – 20% 10 year CVD risk – refer to Wellbeing Service, consider statins High risk = >20% 10 year CVD risk - refer to Wellbeing Service, and commence on statins. For individuals with HbA1c 42-47mmol/l (6.0-6.4%) – refer to Wellbeing

	Service and code as non-diabetic hyperglycaemia. If HbA1c 48mmol/l (6.5%) and over, investigate for diabetes – if excluded, manage as non-diabetic hyperglycaemia above. Practices are expected to provide appropriate follow up and care for any patient who has a health problem identified through the NHS Health Check. Submit data about the practice registered population, broken down in 5-year age bands, by gender, to the CCG as follows: Within the first month of the financial year – Size of total 35-74 year age cohort Size of cohort eligible for an NHS Health Check Number in eligible cohort who have not had an NHS Health Check in the last 5 years (from which the practice target number of NHS Health Checks for the year will be calculated and agreed) Monthly - Number of patients offered an NHS Health Check and number of NHS Health Checks completed in the preceding month Year end summary – To be confirmed with practices by end of 2nd Quarter and delivered by end of the first month of the following financial year. Training - All staff delivering NHS Health Checks must be able to demonstrate that they are working towards or meet the NHS Health Check Competency Framework and the Dementia training tool, both developed by Public Health England.
Key Performance Indicators	At the start of the year every practice will be required to submit an analysis of their patients who are eligible for an NHS Health Check and have not had one in the last 5 years. Each practice will then be set a target for the number of NHS Health Checks to be completed during the year, based on this analysis. Practices will earn an average payment per NHS Health Check of £30 if they meet the following three KPIs :- 1. Achievement of their annual target number of NHS Health Checks 2. After an NHS Health Check, all patients are given appropriate health improvement advice 3. Provision of Year end summary containing all the specified data. Until a practice achieves all three KPIs, each completed NHS Health Check will be valued at £26.25. Practices therefore need to achieve 80% of their annual target number of NHS Health Checks, in order to avoid pro-rata claw-back the following year.

	Practices will also be paid £1 per eligible patient offered an NHS Health Check, for which they submit an appropriate claim.
References	NHS Health Check Best Practice Guidance; PHE, Feb 2015 NICE PH 38 Preventing Type 2 diabetes: risk identification and intervention for individuals at high risk, July 2012 NICE Clinical Guideline CG181 Lipid modification, July 2014

Component 6.	Long Term Conditions
Rationale	Diabetes prevalence is high and increasing in Blackburn with Darwen. Locally we are experiencing increasing obesity figures, and a moderately higher proportion of our community from a South Asian heritage (both of which increase the risk of diabetes) compared to the England average for council demographics. It has been recognised since the Wanless report, Securing Our Future Health: Taking a Long-Term View April 2002, that promoting self-care successfully was the most cost-effective way to improve health and the only way that the NHS could afford to continue as a publicly funded body. Respiratory disease is very common and is a major cause of disability and premature mortality. After circulatory disease and cancer, respiratory disease is the third leading cause of death in England. It is also one of the principal reasons for acute admissions to hospitals and, as a result, it accounts for a substantial proportion of NHS expenditure. The Department of Health published a Chronic Obstructive Pulmonary Disease and Asthma outcomes strategy in 2011, which encompasses 6 objectives focusing on equity, prevention, early identification and management of respiratory disorders. The respiratory element of the Long Term Conditions LIS aims to address these objectives both from a patient and health professional viewpoint.
Delivery	To improve access for patients in General Practice by: • Building upon and sharing best practice wherever possible • Improving access to primary medical care • Reducing demand on urgent care • Reducing out of practice activity • Increasing capacity in primary medical care in order to meet the needs of the registered population • Supporting GP practices to identify areas for improvement in their existing systems by understanding how to base improvement on recognised quality models • Support practices to effectively manage future demand • Improve patient experience of accessing primary medical care To improve quality across all domains of the NHS Outcomes Framework by: • Reducing variation

	• Improving patient safety • Improving patient outcomes • Improving patient experience Service description This scheme has been developed in order to: 1. Case find an increased number of patients in primary care and; 2. Reduce unplanned and emergency hospital admissions. Phase 1 – Now completed Phase 2 – Planning Now Completed Phase 3 – Implementation • Practices will be responsible for ensuring their action plans are implemented. • Practices will be asked to plot their own trajectory in line with their own understanding of their own resources and capabilities as to the outcomes they expect to achieve. • To monitor progress the CCG will periodically update practices of their outcomes to date and practices will be asked to adjust their trajectories accordingly. Phase 4 - Outcomes • Practices will need to demonstrate an improved quality outcome for patients against their baseline. Outcome reports will need to include any evidence that demonstrates what practices and localities have implemented to achieve outcomes, as well as a measured final improvement. • Each locality will be requested to present a chosen area of best practice to share across the CCG. This will ensure at least one idea from each locality is shared to enable other practices to learn new potential ways of working that may benefit their patients.
Key Performance Indicators	As the Long Term Condition Enhanced Services is a two year scheme running over 2015/16 and 2016/17, for the purposes of QOEST, the second year of the scheme has been included. Practices will therefore be required to complete the Implementation phase and the Outcomes phase of the Long Term Conditions Enhanced Services in 2016/17 to receive the full pa**y**ment.

Part 2 - Quality Improvement, Access and Sustainability Plans (Phase 1)

Analysing Quality and Performance and Planning for the Future

A major component of the QOEST scheme is the development of quality and performance analysis capability by localities and practices and the subsequent use of this intelligence to plan for the future. The plans produced will be practice and locality based but reflective of individual quality and performance. These will cover;

1. Quality improvement and reduction in unwarranted variation between practices
2. Improved Access
3. Organisational sustainability

Given that additional funding into primary care will be generated by shifting resources from secondary care, particular consideration must to be given to;

- Unplanned admissions
- Prescribing
- Emergency Department attendences
- Referrals
- Procedures of limited clinical value
- Use of alternative services to secondary care eg GPwSI, AQP and other available services including the voluntary sector.

Improvement Plans

In designing the improvement plans it will be important to engage with colleagues, practice staff and patients both in practice and localities. Engagement is a key part of the planning process particularly when services are to be changed. In developing these plans it is important that systems and processes are in place to monitor the KPIs and produce exception reports and recovery plans when appropriate.

All plans will be submitted to the CCG where a panel will review to ensure they meet the requirements of the QOEST particularly that they have sufficent content, ambition, KPIs, performance monitoring processes etc. Plans that are not fit for purpose will be returned for revision.

Plan 1 - Improving Quality and Reducing Unwarranted Variation

Once the practice and locality have reviewed their quality and performance data, then a number of improvement areas should be chosen. It is suggested that approximately 10 elements are considered. These should be a mixture of clinical and non clinical areas, for example Atrial Fibrillation could be chosen with prevalence and anticoagulation rates compared with evidence based practice and local and national benchmarks. Exception reporting (within QoF) is generally varied so a KPI is chosen to reduce the exception reporting rate. Ideally, any improvement should be at least to the national average.

Plan 2 - Improving Access

Appropriate access to GP practice is defined as “no patient feels the need to attend the Accident and Emergency Department because they cannot get an appointment at their own General Practice or within a locality service”. The quality of out of hours access to primary care should also be considered. In order to develop this plan it is expected that localities and/or practices, survey their patients to understand what their needs and preferences are. Services can then be developed to meet these requirements. Localities and practices will need to undertake a demand and capacity review as part of this plan to understand when and how many appointments are needed. There should also be a review of skill mix within the practice. Practices/Localities should create methods to demonstrate the effectiveness of their plans eg - attendances at A+E and patient experience.

Once information has been acquired, a plan to improve access should be developed. This needs to be at both locality and practice level. The locality level plan is particularly important since practices could work with each other to develop solutions, share resources etc. Solutions may be around expanded access, altering clinic times, use of telephone triage, email, Skype or use of other modern digital technologies. Practices and localities should decide what solution best meets their requirements. The outcomes will be monitored and if not achieved an exception report must be generated and recovery plan developed.

Plan 3 - Sustainability into the Future

Blackburn with Darwen practices together as a whole must consider how the General Practice system can be improved to offer an organisational solution fit for the future. A number of factors should be considered eg; appropriate remuneration and work life balance, self monitoring and continuous improvement, access that works for patients and the system, improved outcomes eg in cancer and cardiovascular disease, and affordability for the commissioners. It must also deliver a service that can manage more care out of hospital yet retain the best of General Practice.

The CCG expects a rational **“**case for change” be produced which informs the plans. It is important that public and staff are engaged in the planning process, and that continuity and holistic care from prevention through to end of life are considered. Workforce development should be a key part of the plans particularly looking at training, education and appropriate skill mix. Systems, processes and finance will also be important aspects of the plans.

The plans will then be submitted to the CCG. The Blackburn with Darwen plan should be an amalgam of all the practice plans and should describe the future role of practices and localities (and indeed other services on a Blackburn with Darwen basis). (see Appendix C for plan structure).

APPENDIX A

Practice Declaration for Delivering the General Practice Quality and Outcomes Enhanced Services Transformation Scheme (QOEST)

This document constitutes the agreement between the practice and the CCG in regards to the QOEST scheme.

I can confirm that the terms of this scheme have been read and understood and that on the agreement of NHS Blackburn with Darwen CCG the Practice will deliver the components and phases as detailed in this scheme.

By signing this agreement with the CCG the practice agrees to comply with and deliver all the requirements, components and phases of the QOEST scheme. Also the practice agrees to produce and deliver any required recovery plan as requested by the CCG.

Practice……

Name……

Signature:……..……

Date:……..

On behalf of Blackburn with Darwen CCG

Name……

Signature:……..……

Date:……

APPENDIX B

Breakdown of Funding Source - Year 1 and subsequent years funding

Description		Current resource	Public Health	Total	
Improving Access to General Practice					
Medicines Optimisation		200,000		200,000	
Cancer		98,000		98,000	
Membership Engagement and Involvement		105,000		105,000	
Near Patient Testing		55,000		55,000	
Health Checks (funding tbc)			90,000	90,000	
Long Term Conditions		150,000		150,000	
		608,000	**90,000**	**698,000**	
additional £200k 2016/17 non recurrent funding				200,000	
PMS Review money (less MPIG pressure) reinvested				188,000	
Total year 1				**1,086,000****	**2016/17**
additional £200k 2017/18 non recurrent funding*				200,000	
PMS Review money (less MPIG pressure) reinvested				188,000	
Potential total year 2				**1,474,000****	**2017/18**
additional £200k 2018/19 non recurrent funding*				200,000	
PMS Review money (less MPIG pressure) reinvested				188,000	
Potential total year 3				**1,862,000****	**2018/19**
additional £200k 2019/20 non recurrent funding*				200,000	
PMS Review money (less MPIG pressure) reinvested				153,000	
Potential total year 4				**2,215,000****	**2019/20**

*** From 2017 onwards the additional £200k may not be available from the CCG and so will have to be generated by efficiency gains through shifting care closer to home**
**** APMS monies available not yet known**

APPENDIX B Example of Payment Checklist

					Practice Practice Code List Size at 1/10/15		P810000 10,257
	Target Areas	Payment Methodology	Completed Y/N	Maximum payment available	100% Funding available	70% paid on 1/12th basis	30% paid on achievement
Medicines Optimisation	Eclipse Live - Review patients with 'Red' (all) and 'Amber' (2 patients per 1000 patients practice population) alerts monthly from July 1st 2015 – 30th June 2016.	24 pence per registered patient		£2,462			
	Review the prescribing of New Oral Anticoagulants (NOAC) and Low Molecular Weight Heparin to ensure adherence to local and National guidelines	18 pence per registered patient		£1,846			
	Medication reviews. Undertake review of potentially inappropriate prescriptions in persons over 65 years.	24 pence per registered patient		£2,462	£12,308	£8,616	£3,693
	Review prescribing of antibiotics to reduce overall antibiotic prescribing by 1% and prescribing of antibiotics linked to C.Difficile infection (the '4C's') to below national average.	24 pence per registered patient		£2,462			
	Individualised QIPP plan for practices to be completed by MMT. A list of QIPP projects is available in Appendix 2. Practices will be advised of the QIPP projects that will be worked on at the initial practice visit	30 pence per registered patient		£3,077			
Cancer	2016/17 scheme tbc	2015/16 £561 per 1000 patients (tbc)			£5,754	£4,028	£1,726
Clinical Engagement	Clinical Senate	Payment is based on 100% participation from the practice. Practices will be expected to release one GP to attend Clinical Senate unless there are extenuating circumstances and an agreement has been made with the CCG.		£3,750 per practice			
	Locality Meetings	GPs: Payment is based on 100% participation from the practice; the same representative should attend the meetings wherever possible. Practices will be expected to release one GP to attend these meetings unless there are extenuating circumstances and an agreement has been made with the CCG.			£3,750	£2,625	£1,125
	Locality Meetings	Practice Managers: Payment is based on a minimum 75% attendance rate over all Locality Meetings annually (allowing for annual leave and absence).					
	Practice Manager Forum	Payment is based on a minimum 75% attendance rate over all Practice Manager Forums annually (allowing for annual leave and absence).					
	Surveys and Additional meetings	Communication from the CCG regarding surveys or additional meetings will clearly define whether the survey or meeting is included in the Clinical Commissioning Involvement Scheme.					
Near Patient Testing	Treatment room takes the blood sample	based on 2014/15 activity		£22.99 per blood sample	£460	£322	£138
	Practice takes the blood sample	based on 2014/15 activity		£25.43 per blood sample	£509	£356	£153
Health Checks	Target number of health check for 2016/17 = 180	Number of health check offered to eligible patients		£1 per invitation sent out	£200	£140	£60
		Number of health checks performed		Average £26.25 per health check if less than 80% of target number achieved	£3,780	£2,646	£1,134
				If number of healthchecks achived is over 80% and up to 100%, then an additional £3.75 will be paid per health check			
				£15 per health check will be paid for each health check carried out over 100% of the target number			
Clinical Haematology	Patients being monitored in practice	based on 2014/15 activity		£25 per patient	125	£88	£38
	Domiciliary visit	based on 2014/15 activity		£4 per visit	£8	£6	£2
Long Term Conditions	Implementation	Practice- to complete two interim reports		£700 per plan (up to 5,000 patients)	£3,900	£2,730	£1,170
		Locality- to complete 1 interim report		£1000 per plan (5,000 to 10,000 patients			
		Attendance by the three named champions at the Diabetes educational event		£1,300 per plan (over 10,000 patients			
	Outcomes	Practice to complete two outcomes reports (one per practice improvement plan)		£1500 per outcome report	£3,000	£2,100	£900
		Locality to submit one outcome report		£1500 per outcome report	£1,500	£1,050	£450
		Prepare and submit 'sharing best practice' powerpoint presentation			£500	£350	£150
Plans	Plan 1			£0.77 per plan per registered population (tbc)	£23,694	£16,586	£7,108
	Plan 2						
	Plan 3						
	TOTAL				£55,708	£38,995	£16,712

APPENDIX C

Plan Structure

Practices should submit 3 plans (variation, access and sustainability). For the plans pertaining to variation and access, a locality plan should first be produced with that practice's individual action plan appended. For the plan pertaining to sustainability, the practice individual action plan should be appended to an overarching Blackburn with Darwen plan.

Plans should be well structured and address key elements, these being;

- The case for change (why is change required, any evidence to back this up?)
- What are the key areas to be covered by the plan, considering the different aspects of Quality, Access and Sustainability.
- How has the practice /locality engaged with patients and stakeholders?
- The overall plan itself (what are the components of the plan)
- How will outcomes be measured? Particularly how will things be better for patients and staff?
- Project plan/timetable
- Resources required including workforce / place of service delivery
- Sign up and commitment to delivery

The plan will need to be structured to ensure all elements are covered. See example below:

Title Page

- Title of the Plan
- Author's name and contact details
- Date

Executive Summary (this summarises the plan so readers can understand its rationale and key components)

- Reason for the plan/case for change
- Evidence and data used
- Key components
- How will services improve for patients
- Key Performance Indicators and Outcomes

Contents List

- Section/Chapter headings
- Page or section numbers

Introduction

- What the plan is about and the context.
- Terms of reference,scope and constraints of the plan

Main section of the plan

- Case for Change
- Results of the evidence gathering, data review, patient engagement
- Key areas that the plan covers
- What the plan is going to do
- What are the Key Performance Indicators and how these will be measured (including mitigation and recovery if targets are not being met)
- The project plan and timetable
- Resources and workforce implications (including savings)
- How and when the plan will be reviewed and improved if necessary

Conclusions

- Summary of the plan and the Authors' expectations.

Appendices

- Supplementary information and or evidence which would obstruct the reading of the plan ie project time table / mobilisation plan and any relevant data.

APPENDIX D

Response Outcomes Timetable – Key Dates

All participating practices sign up by date	February 28th 2016
Start date including delivering standard requirements	April 1st 2016
New payment system implemented	April 1st 2016
Commence delivering Components Including continuation of previous LIS's	April 1st 2016
Submission of all plans	October 31st 2016
CCG – Final approval of plans	February 28th 2017
Localities / Practices commence implementation of plans	April 1st 2017

APPENDIX E

Understanding and utilising data regarding quality and performance

There are numerous sources of data available for practices to use to understand their individual and practice performance and quality. The expectation is that practices will investigate the various tools and sources of information to see which gives the most useful information such that they understand how they are performing both absolutely and in comparison to peers.

Peer comparisons could be with other practices in Blackburn with Darwen or with CCG, regional or national level data. Many tools already give benchmarked information on a range of clinical and non clinical information and reports can be generated or data exported from them. Practices will need to group together to develop these reports in localities or even across Blackburn with Darwen.

The CCG will require data gathered and reports generated to be at individual, practice and locality level and be benchmarked to allow comparison. Listed below are some suggested websites and tools that localities and practices may consider using. This is not exhaustive and there may be other sources of information.

The practice EMIS system also has useful information that can be searched for eg QoF, referrals, admissions, disease prevalence and management.

- Primary Care Web Tool https://www.primarycare.nhs.uk/
- NHS Choices http://www.nhs.uk/
- National General Practice Profiles http://fingertips.phe.org.uk/profile/general-practice
- Quality and Outcomes Framework via the EMIS practice system, also http://www.hscic.gov.uk/qof
- CQC for those practices inspected http://www.cqc.org.uk/content/doctorsgps
- Aristotle – for admissions/attendances/referrals (log in required)
- Prescribing data – ePACT (log in required)
- Eclipse software now installed on practice computers
- Cancer Profiles http://www.ncin.org.uk/cancer_information_tools/profiles/gp_profiles
- Individual Practice and Locality Patient Surveys.

APPENDIX F

This is a synopsis of some of the engagement activity undertaken in the development of the QOEST scheme together with local and national evidence of the challenges facing General Practice with hyperlinks to original documents.

Engagement Activity

Local Engagement

The draft QOEST scheme has been presented to Senate, Local Medical Committee and relevant clinical leads. All have welcomed and been supportive of the plan and its objectives. Extracts of relevant minutes below:

Clinical Senate, 13th October 2015:

Dr Ridgway provided details around the rationale for the QOEST scheme, highlighting that QOEST aims to combine enhanced services whilst addressing financial challenges in a transformational way. Dr Ridgway clarified that QOEST aims to preserve the best of General Practice whilst focusing on quality improvement, reduced variation, improved cost effectiveness, improved access and out of hospital care wherever possible; it was confirmed that QOEST is coherent with the CCG's Primary Care Strategy and the CCG's vision.

Dr Ridgway explained that QOEST will be executed in phases as it is a long term scheme, he highlighted that due to its length, it is expected the scheme will naturally evolve over time dependent on the needs of the population and commissioning plans. Phase 1 was described as plan development and work carried out during this phase is focusing on quality improvement, reducing unwarranted variation, organisational sustainability and improving access to General Practice, with the aim that no patient attends A&E because they are unable to attain a GP appointment. Phase 2 was described as the phase in which the phase 1 plans will be implemented by practices. Dr Ridgway described how developing the infrastructure will deliver the CCG's CIs, provide performance, exception and outcome reports, and recovery plans when targets are not met.

Dr Ridgway presented members with a breakdown of the QOEST funding, highlighting the focus on equality of funding across all practices, bringing GMS funding up to current PMS funding. Dr Ridgway confirmed that the CCG's aim is fund General Practice with 11% of the overall NHS spend within the next 5 to 10 years.

Dr Ridgway concluded the presentation by highlighting to members that QOEST is an "add on" to a contract and not a full contract in itself. He advised members of the next stages prior to the launch, including engagement and approval processes and then the period following April 2016 when the scheme will be reviewed and refined and future phases developed.

Healthwatch has undertaken local surveys – key findings were; Patients generally satisfied with care given by GP practices but dissatisfied with appointment systems.

http://www.healthwatchblackburnwithdarwen.co.uk/sites/default/files/uploads/daisyfield.pdf

LMC meeting - Matters arising

Update - BwD Quality & Outcomes Enhanced Services Transformation (QOEST)

Dr Ridgway reported on developments around QOEST since the last liaison meeting and advised that the direction of travel will be explored further at the CCG Senate meetingthe follwing week.

Year one of QOEST was outlined as an amalgamation of the current schemes available to practices, along with an incentive for practices to review/analyse performance data and develop quality improvement plans. Practices would also be expected to be involved with development of plans around seven day access and working up a sustainable model of primary care. This would involve working with colleagues in localities and across BwD. The principles of the CCG direction of travel were supported by LMC, noting that the detail around QOEST proposal requires much more discussion prior to LMC agreement.

East Lancashire CCG Survey

East Lancashire CCG undertook a survey of their population in terms of GP service provision (reproduced with permission). The East Lancashire population, in part, closely reflects that of Blackburn with Darwen. – brief findings were that patients want appointment systems improving including using digital systems. Hours of opening to be longer early mornings and evenings, Saturday mornings but not Sundays, however did want to access services if required on Sundays if urgent. Services to be within the local community as much as possible and reduce any waiting times for procedures and diagnostics.

Summary of Primary Care Access analysis.

APPENDIX G

National Evidence and Reports

Report - Department of Health and NHS England Stocktake of access to general practice in England November 2015

https://www.nao.org.uk/wp-content/uploads/2015/11/Stocktake-of-access-to-general-practice-in-England-Summary.pdf

Extracts from above Regarding Availability of appointments;

- "The proportion of patients reporting they were able to get an appointment fell from 91% in 2011-12 to 89% in 2014-15. Patient satisfaction with the process of making appointments has declined each year since 2011-12. For example, in 2014-15, 27% of patients reported it was not easy to get through to the GP practice on the telephone, compared with 19% in 2011-12 (paragraphs 4.5 and 4.7)."

- "Good access to general practice reduces pressure on other parts of the NHS, particularly hospital accident and emergency (A&E) departments. This helps the health system to make the best use of its resources. Research has estimated that in 2012-13, 5.8 million patients attended A&E or walk-in centres because they were unable to get an appointment or a convenient appointment in general practice. We estimated that a typical consultation in general practice costs £21, whereas hospitals are paid £124 for a visit to A&E."

- "Improving access to general practice is a priority for the government. It has committed to recruiting 5,000 extra doctors working in general practice, and to ensuring that people have access to general practice from 8 am to 8 pm, 7 days per week, by 2020. The Department and NHS England have a range of initiatives to improve access. These include a workforce action plan and the Prime Minister's GP Access Fund, which has been piloting different approaches, including extended opening hours."

- "A fifth of patients report that opening hours are not convenient, and meeting the government's commitment on extending access to general practice will require significant change. The percentage of patients reporting that opening times are not convenient increased from 17% in 2011-12 to 20% in 2014-15."

- "GP practices' working arrangements affect the proportion of patients who can get appointments. The availability of appointments varies significantly between different practices – the proportion of patients unable to get an appointment ranged from 0% to 52% in 2014-15. We found that much of this variation could not be explained by demographic factors, practice characteristics or supply of general practice staff. This suggests that the way practices work is an important factor."

Report - Improving General Practice – a Call to Action(NHS England August 2014) https://www.england.nhs.uk/wp-content/uploads/2013/09/igp-cta-evid.pdf

- In Blackburn with Darwen, on average,22% of people report it not easy to get through to the practice on the telephone. (Data source/s: 2012/13 GP Patient Survey Results)

(http://www.gp-patient.co.uk/results/)

- Blackburn with Darwen has high rates (top quartile) of unplanned hospitalisation for chronic ambulatory care sensitive conditions (Data source/s: HSCIC Indicator Portal, 2003/04 to 2011/12)

Demand and Workforce Challenges

- Growing population with more complex needs.
- Increasing prevalence of long term conditions, but often under-recorded.
- Increasing demands on general practice services.
- Overall satisfaction with services remains high, but growing challenges in relation to patient experience of access.
- Growth in general practice workforce, particularly up to 2005/06, but slower growth since.
- Inequity in distribution of workforce.

Report - Improving the quality of care in general practice Report of an independent inquiry commissioned by The King's Fund (2011)

http://www.kingsfund.org.uk/sites/files/kf/improving-quality-of-care-general-practice-independent-inquiry-report-kings-fund-march-2011_0.pdf

The current state of quality in English general practice - Core services provided within general practice

This report discusses the variation in quality across all practices with some comments as to how reliable the findings are and what interpretation can be made.

Diagnosis

- A variety of factors can lead to delays and errors in diagnosis, but there is not enough evidence to ascertain the scale of such problems in general practice.

- Retrospective audit and significant event audit is essential in order to assess and improve the quality of diagnosis.

Referral

There are wide variations in the rate of referrals between practices. The evidence suggests that a significant proportion of referrals made in general practice may not be clinically necessary. However, the appropriateness of a referral is specific to the context, and it may be difficult to decrease unnecessary referrals without also decreasing necessary referrals. There is scope for improvement in the quality of other aspects of referral:

- ensuring that timely referrals are made (especially in cancer care)
- the quality of referral letters
- getting patients to the right destination
- involving patients in decisions about referral options.

Prescribing

Variation in the level of prescribing between general practices is common and widely reported. Much of the practice-level variation in prescribing results from differences in the clinical case-mix of patients and socio-economic factors. There are opportunities for quality improvement to address inefficient or inappropriate prescribing – for example, through reducing medication errors improving adherence to what is prescribed standardising prescribing practices for certain treatments, such as the prescription of low-cost statins, potentially saving the NHS £200 million.

Acute illness

Appropriate and effective diagnosis and management of acute illnesses form a key aspect of high-quality care. The evidence suggests that GPs are more likely to make a misdiagnosis of acute illness compared to non-acute illness. More needs to be done to monitor the quality of acute care – for example, through peer reviewed audit of referral letters and case notes, and to reach out to those patients whose acute illness is not being managed.

Long-term conditions

Improvements in care for patients with long-term conditions have been made over the years, particularly for those with diabetes, but the evidence suggests that recommended care is not reliably delivered to all patients – especially to those with multiple long-term conditions. There is significant scope for primary and community care providers to undertake more proactive preventative activities that can lead to earlier diagnosis and treatment, and the prevention of unscheduled hospital admissions.

Health promotion

There is a need to target childhood immunisations at those groups where uptake is low. Most general practices meet targets related to smoking cessation advice, but there is evidence that a more proactive approach to supporting patients may help people to quit smoking. Approaches to the management of people with obesity are inconsistent, and obesity is often seen as a lifestyle issue rather than as a priority for general practice. More evidence is needed for appropriate interventions in general practice.

Report - RCGP Position Paper on 7 Day Access

(http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/RCGP-Position-statement-7-day-access.ashx

The Government's priority has to be to shore up existing five day and urgent out of hours services over the course of this Parliament. In particular:

- There is currently a major workforce crisis in general practice with an expected shortfall of 8,000 GPs in England by 2020. The current number of GPs and practice staff is not sufficient to cope with the roll out of seven day GP services. GPs are already over-stretched simply providing five day routine access for patients, with many working unsustainably long hours just to keep existing services up and running.

- Years of underinvestment in general practice. General practice deals with 90% of all patient contacts – yet the proportion of NHS spending allocated to GP services in England fell to a historic low of 8.4% in 2012/13 – leaving practices struggling to meet the growing needs of patients.

- Increasing problems getting a GP appointment. According to RCGP analysis, patients in England will have to wait a week or more to see a GP or practice nurse on an estimated 67 million occasions in 2015.