DUDLEY CLINICAL COMMISSIONING GROUP  
PRIMARY CARE COMMISSIONING COMMITTEE  

HELD IN PUBLIC SESSION ON  
FRIDAY 22 FEBRUARY 2019 1:00pm – 3:00pm  
T051, 3RD FLOOR, BRIERLEY HILL HEALTH & SOCIAL CARE CENTRE, VENTURE WAY, BRIERLEY HILL, DY5 1RU  

QUORACY  
A meeting of the Committee will be quorate provided that at least 4 members are present of which:  
• one must be either the Chair or Vice-Chair of the Committee  
• one must be the Chief Finance Officer/Deputy Chief Finance Officer or Chief Nursing Officer/Head of Quality Assurance or nominated deputies

**PUBLIC AGENDA**

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Attachment</th>
<th>Presented by</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:00pm</td>
<td>1 Apologies</td>
<td></td>
<td>Mr S Wellings</td>
</tr>
<tr>
<td></td>
<td>2 Declarations of Interest</td>
<td></td>
<td>Mr S Wellings</td>
</tr>
<tr>
<td></td>
<td>2.1 To request members to disclose any interest they have, direct or</td>
<td></td>
<td>Mr S Wellings</td>
</tr>
<tr>
<td></td>
<td>indirect, in any items to be considered during the course of the</td>
<td></td>
<td>Mr S Wellings</td>
</tr>
<tr>
<td></td>
<td>meeting and to note that those members declaring an interest will</td>
<td></td>
<td>Mr S Wellings</td>
</tr>
<tr>
<td></td>
<td>not be allowed to take part in the consideration or discussion or</td>
<td></td>
<td>Mr S Wellings</td>
</tr>
<tr>
<td></td>
<td>vote on any questions relating to that item.</td>
<td></td>
<td>Mr S Wellings</td>
</tr>
<tr>
<td></td>
<td>2.2 This meeting is being held in public and is being recorded</td>
<td></td>
<td>Mr S Wellings</td>
</tr>
<tr>
<td></td>
<td>purely to assist in the accurate production of minutes, decisions</td>
<td></td>
<td>Mr S Wellings</td>
</tr>
<tr>
<td></td>
<td>and actions. Once the minutes have been approved the recording will</td>
<td></td>
<td>Mr S Wellings</td>
</tr>
<tr>
<td></td>
<td>be destroyed. All care is taken to maintain your privacy; however,</td>
<td></td>
<td>Mr S Wellings</td>
</tr>
<tr>
<td></td>
<td>as a visitor in the public gallery, your presence may be recorded.</td>
<td></td>
<td>Mr S Wellings</td>
</tr>
<tr>
<td></td>
<td>Should you contribute to the meeting during questions from the public,</td>
<td></td>
<td>Mr S Wellings</td>
</tr>
<tr>
<td></td>
<td>you agree to being recorded.</td>
<td></td>
<td>Mr S Wellings</td>
</tr>
<tr>
<td>1:00pm</td>
<td>3 Questions from the Public</td>
<td></td>
<td>Mr S Wellings</td>
</tr>
<tr>
<td>1:10pm</td>
<td>4 Minutes of last meeting held on Friday 18 January 2019</td>
<td>Enclosed</td>
<td>Mr S Wellings</td>
</tr>
<tr>
<td>1:20pm</td>
<td>5 Matters Arising/Action Log</td>
<td>Enclosed</td>
<td>Mr S Wellings</td>
</tr>
<tr>
<td>1:30pm</td>
<td>6 Report from the Primary Care Operational Group</td>
<td>Enclosed</td>
<td>Mrs J Robinson</td>
</tr>
<tr>
<td>1:40pm</td>
<td>7 Risk Register</td>
<td>Enclosed</td>
<td>Mr D King</td>
</tr>
<tr>
<td>1:50pm</td>
<td>8 Quality &amp; Safety Report</td>
<td>Enclosed</td>
<td>Mrs C Brunt</td>
</tr>
<tr>
<td>2:00pm</td>
<td>9 Finance Report</td>
<td>Enclosed</td>
<td>Mrs S Johnson</td>
</tr>
<tr>
<td>2:15pm</td>
<td>10 Terms of Reference for the Primary Care Development Group, GPFV</td>
<td>Enclosed</td>
<td>Mrs J Taylor</td>
</tr>
<tr>
<td></td>
<td>Workforce Sub-group and changes to the Primary Care Reporting</td>
<td></td>
<td>Mrs J Taylor</td>
</tr>
<tr>
<td></td>
<td>Structure</td>
<td></td>
<td>Mrs J Taylor</td>
</tr>
<tr>
<td>2:30pm</td>
<td>11 Update from the Primary Care Development Group &amp; GPFV Workforce</td>
<td>Enclosed</td>
<td>Mrs J Taylor</td>
</tr>
<tr>
<td></td>
<td>sub-group – GPFV work programme</td>
<td></td>
<td>Mrs J Taylor</td>
</tr>
<tr>
<td>2:40pm</td>
<td>12 STP - General Practice Forward View Planning Proposals</td>
<td>Enclosed</td>
<td>Mr D King</td>
</tr>
<tr>
<td>2:50pm</td>
<td>13 Primary Care Operational Plan and GP Contract 2019/20</td>
<td>Enclosed</td>
<td>Mr D King</td>
</tr>
<tr>
<td>3:00pm</td>
<td>14 Glossary</td>
<td>Enclosed</td>
<td>For Information</td>
</tr>
<tr>
<td></td>
<td>Date and Time of Next Meeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>15th March 2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1:00-3:00pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Board Room Brierley Hill Health &amp; Social Care Centre</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Venture Way, Brierley Hill, West Midlands DY5 1RU</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>First Name</td>
<td>Surname</td>
<td>Job Title</td>
</tr>
<tr>
<td>--------</td>
<td>------------</td>
<td>--------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Mrs</td>
<td>Caroline</td>
<td>Brunt</td>
<td>Chief Nurse</td>
</tr>
<tr>
<td>Mr</td>
<td>Philip</td>
<td>Cowley</td>
<td>Senior Finance Manager – Primary Care</td>
</tr>
<tr>
<td>Mrs</td>
<td>Andrea</td>
<td>Crew</td>
<td>Chief Officer of Dudley Healthwatch</td>
</tr>
<tr>
<td>Mr</td>
<td>Bal</td>
<td>Dhami</td>
<td>Senior Contract Manager - NHS England (West Midlands)</td>
</tr>
<tr>
<td>Dr</td>
<td>Christopher</td>
<td>Handy</td>
<td>Lay Member for Quality &amp; Safety</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr</td>
<td>Matthew</td>
<td>Hartland</td>
<td>Chief Operating &amp; Finance Officer</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr</td>
<td>Tim</td>
<td>Horsburgh</td>
<td>Clinical Executive for Primary Care &amp; LMC Representative</td>
</tr>
<tr>
<td>Mr</td>
<td>Alan</td>
<td>Johnson</td>
<td>Secondary Care Clinician</td>
</tr>
<tr>
<td>Ms</td>
<td>Sue</td>
<td>Johnson</td>
<td>Deputy Chief Finance officer</td>
</tr>
<tr>
<td>Mr</td>
<td>Daniel</td>
<td>King</td>
<td>Head of Membership Development &amp; Primary Care</td>
</tr>
<tr>
<td>Mrs</td>
<td>Helen</td>
<td>Mosley</td>
<td>Lay Member – Patient &amp; Public Involvement</td>
</tr>
<tr>
<td>Mrs</td>
<td>Anna</td>
<td>Nicholls</td>
<td>Interim Deputy Head of Commissioning (Primary Care)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NHS England (West Midlands)</td>
</tr>
<tr>
<td></td>
<td>Name</td>
<td>Position</td>
<td>Additional Information</td>
</tr>
<tr>
<td>-----</td>
<td>----------</td>
<td>-----------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Dr</td>
<td>David</td>
<td>Pitches</td>
<td>Public Health Representative - Primary Care Commissioning Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Primary Care Commissioning Committee Member at Dudley CCG</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Consultant in Public Health Medicine, Dudley MBC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Wife is a Consultant Obstetrician at Heart of England Foundation Trust</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Occasional Church organist fees received for giving recitals or playing for services</td>
</tr>
<tr>
<td>Mrs</td>
<td>Julie</td>
<td>Robinson</td>
<td>Primary Care Contracts Manager</td>
</tr>
<tr>
<td>Mr</td>
<td>David</td>
<td>Stenson</td>
<td>Patient Opportunity Panel Representative</td>
</tr>
<tr>
<td>Mrs</td>
<td>Joanne</td>
<td>Taylor</td>
<td>Primary Care Commissioning Manager</td>
</tr>
<tr>
<td>Mr</td>
<td>Thomas</td>
<td>Thomik</td>
<td>Dudley Local Pharmaceutical Committee Representative</td>
</tr>
<tr>
<td>Mr</td>
<td>Steve</td>
<td>Wellings</td>
<td>Lay Member - Governance</td>
</tr>
<tr>
<td>Mr</td>
<td>James</td>
<td>Young</td>
<td>Head of Quality Assurance</td>
</tr>
</tbody>
</table>
DUDLEY CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE

MINUTES OF THE MEETING HELD IN PUBLIC ON
FRIDAY 18 JANUARY 2019
THE BOARD ROOM, 3RD FLOOR, BRIERLEY HILL HEALTH AND SOCIAL CARE CENTRE,
VENTURE WAY, BRIERLEY HILL, DY5 1RU

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

ATTENDEES:

Voting Members
Mr S Wellings Non-Executive Director for Governance, Dudley CCG (Chair)
Mrs C Brunt Chief Nurse, Dudley CCG
Dr C Handy Non-Executive Director, Quality and Safety, Dudley CCG (Vice Chair)
Mrs J Jasper Non-Executive Director for Patient and Public Involvement, Dudley CCG
Mr A Johnson Secondary Care Clinician, Dudley CCG
Ms S Johnson Deputy Chief Finance Officer, Dudley CCG
Mrs H Mosley Non-Executive Director for Patient and Public Involvement, Dudley CCG

Non-Voting Members
Dr T Horsburgh Clinical Executive for Primary Care, Dudley CCG/LMC Representative
Mr D King Head of Membership Development & Primary Care, Dudley CCG
Mr T Thomik Dudley LPC Representative

In Attendance
Mr P Cowley Senior Finance Manager, Dudley CCG
Mr B Dhami Senior Contracts Manager (Primary Care), NHS England (West Midlands)
Mrs J Robinson Primary Care Contracts Manager, Dudley CCG
Mr D Stenson Patient Opportunity Panel Representative
Mrs J Taylor Primary Care Commissioning Manager, Dudley CCG

Minute Taker:
Mrs F Jolly PA to the Director of Commissioning, Dudley CCG

1.0 APOLOGIES FOR ABSENCE

Apologies were received from

Voting Members
Dr D Pitches Consultant in Public Health, Dudley MBC

Non-Voting Members
Mrs A Crew Chief Officer, Healthwatch Dudley

2.0 DECLARATIONS OF INTEREST

To request members to disclose any interest they have, direct or indirect, in any items to be considered during the course of the meeting and to note that those members declaring an interest would not be allowed to take part in the consideration or discussion or vote on any questions relating to that item.
Resolved:
No changes were made to those listed.

3.0 QUESTIONS FROM THE PUBLIC

Mr Wellings noted that there were no questions submitted to Committee prior to the meeting.

Resolved:
1) Committee noted that there were no questions submitted prior to the meeting.

4.0 MINUTES OF THE LAST MEETING

The notes of the last meeting held on 21 December 2018 were submitted to Committee and were agreed as an accurate record of the meeting.

Resolved:
1) That the minutes of the meeting held on the 21 December 2018 were agreed as an accurate record of the meeting.

5.0 MATTERS ARISING/ACTION LOG

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

PCCC/APR/2017/13.0   Supporting Professional Decisions
Although the Committee noted the deadline for this was February 2019. The Committee agreed that a progress report be submitted to the Committee meeting in March 2019. Further issues to include would be regarding the rising costs of drugs linked with Brexit and the potential supply problem, excluded and difficult to manage patients.

Discussions took place regarding cost of certain drugs linked with Brexit and it was reported to committee that there were some community pharmacists saying to GP’s that was due to the change in price and not being able to stock items. It was confirmed by the CCG’s Pharmaceutical Public Health Team this is not correct and have advised GP’s to resist any pressure like that. It was noted that the BMA do produce a monthly letter which flags up recognised shortages and wider issues. Mr Thomik advised Committee that, some pharmacies will only use one wholesaler due to the nature of business or that the wholesalers aren’t able to supply.

Mr Johnson joined the meeting.

Committee noted that community pharmacy are caught in the middle of this and this issue was raised at Commissioning Development Committee as a risk. It was suggested that the Medicines Management team discuss the possibility that drugs are being brought in bulk. Concerns were raised if wholesalers are “working the system” then this needs to be addressed on a STP or West Midlands footprint. To investigate this would also require national leadership.

Mrs Jasper advised that Directors of the CCG governing body were made aware of the issues relating to the obtaining of medication.

PCCC/AUG/2018/5.0   Moss Grove Kingswinford & Kinver
There has been no further update for this item.
The deadline for this action to be extended until February 2019.
PCCC/DEC/2018/7.0  Finance - Interconnectivity with WMAS
Mr Cowley has raised this to be included on the non-recurrent expenditure items.
**Action closed.**

The following updates were given on actions which were closed at a previous Committee meeting.

PCCC/NOV/2018/11.0  GP Patient Survey (GPPS)
Mr Stenson advised Committee that there is a further discussion to be had at the February 2019 POP’s.
**Action to remain closed.**

PCCC/NOV/2017/8.0  Chaperoning Policy
The policy has been to the LMC and a GP education event. It has also been considered by the Quality and Safety Committee who have requested changes and suggestions around training. Committee were advised that this is now a formally adopted policy. It is expected that Ms Patel within the Quality & Safety team will be involved in the training.

It was raised during these discussions whether this will incur any cost implications for practices. Committee recognised there was a cost implication to this but this was the right thing to do.
**Action to remain closed.**

Mr Wellings noted the formal appointments of Dr Horsburgh & Dr S Mann to the MCP as Clinical Leads

---

### 6.0 REPORT FROM THE PRIMARY CARE OPERATIONAL GROUP

Mrs Robinson spoke to this item to update Committee following the Primary Care Operational Group (PCOG) meeting held on 9 January 2019.

Primary Care Operational Group provided Committee with assurance that there were no contractual breaches to be issued for any Dudley practice and there were no applications for variations to any GMS contract received.

The Committee noted the DQOFH performance monitoring report in relation to exception reporting.

It was highlighted that 25 practices have been identified as having high levels of exception reporting (over the 5% tolerance) across multiple indicators and/or very high levels of reception reporting (over 20%) in particular indicators. The practices that were identified was given the opportunity to describe the rationale for the decision and the practice policy for undertaking exception reporting which was then reviewed and validated by a clinician.

Out of the 25 practices identified; 11 will be receiving a visit; 10 practices require further discussion; and 4 were able to evidence their decision making with no further action being taken.

The Primary Care Operational Group agreed;
- That the process applied was robust and would be formally written up for approval at the next PCOG for ratification by Committee;
- That a GP from the Quality and Safety team be added to clinical review process;
- That a summary of the DQOFH performance including upper and lower quartile exception reporting be brought to each PCOG meeting
- That future exception reporting into PCOG set out the reasons why no further action be taken was recommended.

Committee were advised that high levels of exception reporting had been predominately due to either coding
errors or patients declining a care plan. Committee were assured that there were robust processes in place to monitor in the future and that any key themes highlighted would inform the next iteration of the DQOFH template.

The planned reforms to the National Quality Outcomes Framework as part of NHS Long Term Plan will potentially have a significant impact and will need reflecting in the DQOFH once the National contract has been released.

Committee noted that with regard to the Special Allocation Scheme (SAS) previously known as the Violent or Excluded Patient Scheme that the small task and finish group at their meeting had agreed in principle the revised service specification, the review process and the local guidance for GP practices. The document would be presented to Committee for ratification in February 2019.

The Committee noted that PCOG would be reviewing the Risk Register which would be presented to the February Committee for ratification. PCOG assigned operational lead to each of risks and those will be responsible for updating their risks. This would include any risks associated with the Long Term Plan.

Resolved:

1. Committee noted the report for assurance.

7.0 INTEGRATED ASSESSMENT FRAMEWORK

The follow item was discussed but was not a scheduled agenda item.

Mrs Taylor spoke to this tem to update Committee in regards to the Integrated Assessment Framework

Dudley CCG has received a letter from the national team at NHS England regarding the CCG’s achievement for 2017-18 and informing the CCG that the reported position for Learning Disabilities (LD) is inadequate. However following further investigation it was noted that the figures being used by NHSE had been extracted from CQRS rather than the local data set within Dudley Quality Outcomes for Health. Despite the CCG receiving a prerelease notification and the national team being informed that the figures were incorrect the information was still published.

The CCG will continue to work closely with NHSE to ensure this is rectified in the future but gave assurance to Committee that the reported position of 16% achievement was actually 63% (without exception reporting and 83% with exception reporting) achievement from the local data set.

Committee noted there disappointment that NHSE had published the data.

Resolved:

1. The Committee noted the item.

8.0 OPERATIONAL PLAN

The follow item was discussed but was not a scheduled agenda item.

The Long NHS Term Plan has been launched and there will be significant impact on Primary Care with the introduction of the Primary Care Networks. The Framework for GP contract reform will be considered by a number of groups e.g. Primary Care Development Group & GPFV Workforce Sub Group etc. due to changes within their work plans.

Committee were informed that the CCG would need to produce a first draft Operational Plan to be submitted to NHSE by the 4 February 2019, this deadline does not allow time for the draft to be considered by Committee. The draft plan will be brought to Committee, at this point both the CCG and Committee will be given the opportunity to make amendments. It was noted that this item was discussed at a GP Members Event & Primary Care Development Group. It was agreed that Mr. King would circulate the presentation given
Concerns were raised in relation to the risk to Primary Care and the changing structure of the GMS contract. In the Long Term Plan it notes that some resources will be taken from the GP contract and given to Primary Care Networks, there is a potential to destabilise general practice however there is greater detail to be released.

Resolved:
1. The Committee noted the item.

### 7.0 QUALITY AND SAFETY REPORT

Mrs Brunt spoke to this item to provide on-going assurance to Committee regarding quality and safety in accordance with the CCG’s statutory duties.

Committee noted that since the last meeting there had been a CQC report published. The Committee was pleased to note that the Waterfront Surgery had been rated as good overall across all domains following a previous rating of requires improvement. The improved rating is a result of improved leadership within the practice and support of the CCG Quality & Safety & Primary Care teams.

The Quality & Safety Team have sight of a risk that has been identified in terms of quality and safety for practices who are not compliant in Health and Safety procedures, this issue was considered in item 10.0.

Committee noted that the local immunisation group met on the 9 January 2019 and identified potential improvements for next year, these would be raised with NHSE for consideration.

Resolved:
1. That the Committee noted the report for assurance.

### 8.0 FINANCE REPORT

Mr Cowley spoke to this item to provide an overview of financial performance against budgets delegated to Committee for Month 9 2018/19.

There has been one change to the budget reported to Committee in November, an allocation of £21,000 received into the Core CCG budget in respect of diabetes transformation. Committee noted that the money allocated for diabetes was not substantial however assurances were given that this was only for one quarter for structured education and funding for an additional diabetes inpatient surgical nurse. Discussions then turned to how this will be monitored it was noted that the CCG are heavily scrutinised and expected to submit data on quarterly basis.

A small underspend was forecast in respect of budgets reported to the Committee, with a break-even position being reported against co-commissioned primary care services, together with an underspend in respect of Core commissioning budgets offsetting an overspend in respect of GP Forward View allocations.

Committee were advised that as part of the Long Term Plan investment there will be a recurrent payment of £1.50 per patient to be allocated to Primary Care Networks. Mr Cowley has been asked to work on the financial plan to accompany this, however it was noted that the CCG would not receive any additional funding as it is a continuation of the funding the CCG were expected to “ring-fence” from the previous financial year. Concerns were raised in relation to the schemes that were funded within Primary Care since the termination of the Vanguard scheme e.g. Integrated Plus. Committee were advised that the CCG are awaiting further detail from NHS England regarding funding and development.

Resolved:
1. Committee accepted the Finance report
2. Committee noted the Finance Report for assurance.
Mrs Taylor spoke to this item to present to Committee the process for monitoring the ‘Dudley Quality Outcomes for Health’ (DQOFH) contract 2018/19 and 2019/20 for ratification.

The Committee recalled in November 2019 that the review process was presented to Committee for ratification. The report outlined the process for contractual monitoring for the 2018/19 and 2019/20 contract.

The DQOFH framework is derived of four key sections:
- Access including working at scale
- Continuity of care for long-term conditions management
- Co-ordination of care for people with complex comorbidities
- Audit

There are a total number of 60 indicators within these sections. These are split into 3 areas as follows:
- Primary Prevention – 9 indicators
- Secondary Prevention (Generic indicators) – 9 indicators
- Clinical (long-term conditions) – 42 indicators

Practices will receive payment based on their percentage achievement within the target range set for each individual indicator.

Participation in the DQOFH framework is undertaken on an annual voluntary basis by consenting to opt out of QOF, DES and LIS schemes amalgamated within DQOFH for that financial year, however practices must be able to meet all Access requirements in order to participate in the DQOFH framework.

It was noted that practices continue to be provided with a dedicated DQOFH dashboard which is updated on a monthly basis to monitor progress and practices receive predicted end of year financial schedules. Committee were advised that if practices are identified as having difficulties part through the financial year then support visits would be offered.

**DQOFH Contract Monitoring**

During the year the CCG will monitor practices against the requirements within the DQOFH contract which will include:
- Monthly / quarterly data extracts or submissions of appointment data
- Monthly data extracts of Continuity and Co-ordination indicators
- End of year submissions of Audit requirements
- Self-declaration and spot-checking of Access requirements
- Practices within the lowest quartile will be offered supportive visits part way through a contractual year
- End of year contractual visits based on a set criteria (approximately 25% of practices on an annual basis)

**Access**

Committee were informed that the CCG had previously experienced difficulties in extracting appointment data from the EMIS system. The IT and Primary Care team has been exploring if a proxy estimation could be established to ensure that practices are meeting the required 75 contacts per 1000 population per week, with an expectation that practices who are not meeting those requirements will be asked to submit a more detailed appointment report as supplementary evidence.

Committee was advised that by 2019/20 the CCG will have developed an appointment search for practices to run on a regular basis, practices will then be required to submit an appointment report to the CCG on a quarterly basis.
Contract Visits

A final year-end report will be produced in regards to contract visits based on the following criteria:

- Practices who are unable to demonstrate they are meeting the necessary Access and audit requirements
- High levels of exception reporting without clear rationale
- Practices who demonstrate continued poor performance against indicators

Practices who require a visit will be expected to demonstrate compliance against each requirement within the visit template and provide supporting evidence accordingly.

If during the visit, the CCG Visit Team identifies an area of exception or a matter of concern which signifies non-compliance to the DQOFH framework, the CCG visit team may take one or more of the following actions:

- Make a recommendation for action by the practice stating the timeframes in which it needs to be compliant.
- Report back to PCOG for discussion before deciding on the actions that will be taken should the findings be significant or the practice have failed to meet the timeframes for action/response and make a recommendation to PCCC for decision.

Resolved:
1) Committee made a recommendation to approve the process for contractual monitoring of the Dudley Quality Outcomes for Health contact 2018/19 and 2019/20.

10.0 PRIMARE CARE PREMISES COMPLIANCE REPORT

Mr Cowley spoke to this item to update Committee on the compliance of Primary Care Premises with Statutory safety standards.

Committee were advised that a detailed review of all within Dudley was considered at Committee in June 2018 whereby primary care premises were assessed in relation to their condition, functional suitability and compliance with statutory standards. The review identified a number of breaches of statutory standards in respect of premises, including the absence of key risk assessments, and proposed remedial actions to be taken to rectify these issues.

Following this report, practices have been given an opportunity to submit further documentation to the CCG and a more detailed assessment has been undertaken into Statutory Compliance, with a classification of each site as high, medium or low risk based upon the outstanding items.

There has been significant improvements in compliance since the initial report, and it was noted that this audit has been carried out in other areas were more significant issues have been discovered however Committee were advised that 8 practices are still rated as red due to:

- Lack of fire or water risk assessments in place
- Gas certificates not in place
- Fix Electrical testing have not been completed

However since writing the report this has reduced to 7 practices. The areas outstanding still represent a potential high risk to patients and staff.

The report submitted to Committee detailed an approach where it was proposed that the CCG write to the responsible practice to inform them of the areas in which action is necessary, requiring a response by 31st January 2019 providing:

- For risk assessments, evidence that these have been carried out, or where they have not been, confirmed dates for contractors to carry them out prior to 28th February 2019
- For outstanding high priority actions and other outstanding high priority matters, an action plan to ensure that these are in place by 31st March 2019 at the latest.
It was further recommended that the communication gives practices notice that if a response is not received by 31st January, or if the deadlines for action are not met, remedial breach notices will be issued in respect of these failures.

It was noted, further to the report submitted to Committee this item was discussed in detail at the Estates Operational Group which includes provider representation. The providers share the CCG’s concerns and it was noted that where actions remain outstanding past the 31 January 2019 consideration will be given to remove their services from the practices in question due to concerns for the health & safety of its staff.

Committee were advised that a wider report on Premises Compliance to include non GP services will be considered at the Quality & Safety Committee. It is expected that actions plans will be in place for all practices at this point.

The report also notes additional training requirements for practices in terms of their statutory compliance responsibilities.

Discussions turned to including into the draft letter to the practices that the CCG have the right, if not rectified to stop premises reimbursement, however Committee felt strongly that reimbursements should be withdrawn until the actions were rectified as there was a duty to protect the public and there will be consequences if not taking action.

Committee highlighted the risk for patients if providers withdrew their service, and were advised that midwifery, phlebotomy, physio-therapy and counselling services would be effected, and this raised significant concerns.

It was proposed that a letter should be drafted and signed by Mr Wellings as chair of this Committee to practices who have been identified as having an overall red rating, noting the serious concerns of this Committee of this issue and highlighting practices statutory obligation to be comply with the law and that failing could incur a breach notice. Practices would then be expected to rectify the issues within 28 days or reimbursements could be withheld. The letter should be shared with the members of the Estates Operational Group as the CCG has taken some challenge from the providers to say the CCG has double standards.  

**Action: Mr Cowley**

Given the seriousness of the matter Committee agreed that giving practices 28 days was an unreasonable length of time and suggested a shorter timescale of 7 days, Committee were advised that some of the practices with the red RAG rating have highlighted that they have set dates for work to be completed within the next 14 days.

After further discussions and agreement by the LMC representative, Committee agreed that remedial breach notices would be issued to the 7 practices identified within the report if the required evidence was not received within the next 7 days.

**Resolved:**

1) Committee noted the latest position in respect of statutory compliance of GP premises.
2) Committee approved the proposed approach to red-rated practices, including the issuance of remedial breach notices to all practices not complying with the deadlines for rectification.

**11.0 AOB**

**Farewell to Julie Jasper**.

Committee noted that Mrs Jasper would be standing down as Non-Executive Director for Patient and Public Involvement and thank her for all of the work she has done on public and patient engagement, Patient Opportunity Panel and her support to the Committee. Committee wished her luck for the future.
11.0 DATE AND TIME OF THE NEXT MEETING

Friday 22 February 2019
1:00-3.00pm
The Board Room Brierley Hill Health & Social Care Centre
Venture Way, Brierley Hill, West Midlands DY5 1RU

MINUTES ACCEPTED AS A TRUE AND CORRECT RECORD

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signed</td>
<td>Date</td>
</tr>
</tbody>
</table>
### PRIMARY CARE COMMISSIONING COMMITTEE

#### OUTSTANDING ACTION LIST – 22 February 2019

<table>
<thead>
<tr>
<th>MEETING REFERENCE</th>
<th>ACTION</th>
<th>LEAD</th>
<th>STATUS</th>
<th>DEADLINE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCCC/APR/2017/13.0</td>
<td>Supporting Professional Decisions&lt;br&gt;The Committee requested further detail around the membership of the panel and how that would work.</td>
<td>Dr Horsburgh</td>
<td>In progress</td>
<td>March 2019</td>
</tr>
<tr>
<td>PCCC/AUG/2018/5.0</td>
<td>Moss Grove Kingswinford &amp; Kinver&lt;br&gt;A standing item on the action log for regular updates.</td>
<td>Mrs Brunt</td>
<td>On-going</td>
<td>February 2019</td>
</tr>
<tr>
<td>PCCC/JAN/2019/8.0</td>
<td>Operational Plan&lt;br&gt;The presentation made at a GP Members Event in relation to the operational Plan to be shared with Committee.</td>
<td>Mr King</td>
<td>In progress</td>
<td>February 2019</td>
</tr>
<tr>
<td>PCCC/JAN/2019/10.0</td>
<td>Primary Care Premises Compliance&lt;br&gt;A letter to be drafted and sent to practices who have been identified as having an overall red rating noting the serious concerns of Committee. Practices will be expected to rectify the issues within 7 days or reimbursements could be withheld and remedial breach notices issued. The letter is also to be shared with the members of the Estates Operational Group as the CCG has taken some challenge from the providers.</td>
<td>Mr Cowley</td>
<td>In progress</td>
<td>February 2019</td>
</tr>
</tbody>
</table>
DUDLEY CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE

Date of Committee: 22 February 2019
Report: Update from the Primary Care Operational Group
Agenda Item: 6.0

TITLE OF REPORT: Update from the Primary Care Operational Group

PURPOSE OF REPORT: To update Committee following the Primary Care Operational Group meeting held on 6 February 2019

AUTHOR OF REPORT: Mrs J Robinson, Primary Care Contracts Manager

MANAGEMENT LEAD: Mrs C Brunt, Chief Nurse

CLINICAL LEAD: Dr T Horsburgh, Clinical Executive for Primary Care

KEY POINTS:
The Primary Care Operational Group:
- Received a report regarding Primary Medical Services contract monitoring for 2018/19 and provides assurance to Committee that there are no contractual breaches to be issued for any Dudley practice.
- Agreed the revised GMS contract monitoring process for ratification by Committee
- Considered and recommends the contractual changes set out below in the recommendations
- Received the latest position in relation to statutory premises compliance and agreed that sufficient assurance had been provided by those practices identified in the report and that remedial breaches should not be issued
- Noted that the Wollaston branch surgery of Three Villages Medical Practice will close on 12 April 2019
- Receive a report detailing minor surgery provided in primary care delivered under the GMS Contract and the Local Improvement Scheme (LIS) and agreed communication to practices
- Received the quality and safety matters that are set out in the quality and safety report.
- Reviewed the Committee risk register and make recommendations under agenda item 7

RECOMMENDATION:
Committee is asked to:
- Note the actions of the Primary Care Operational Group for assurance
- Approve V2 of the Primary Medical Services contract monitoring process
- Approve the contractual changes recommended by the group as follows:
  - Removal of 1 partner from The Waterfront Surgery

FINANCIAL IMPLICATIONS: Not applicable
| WHAT ENGAGEMENT HAS TAKEN PLACE: | Not applicable |
| ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE: | No conflicts of interest were declared in advance. |
| ACTION REQUIRED: | ✓ Decision Assurance |
1.0 INTRODUCTION

1.1 This report provides an update from the Primary Care Operational Group (PCOG) following its meeting held on 6 February 2019.

2.0 CONTRACTUAL

Contract Variations

2.1 The group considered and supported the following partnership change for approval by Committee:

| The Waterfront Surgery | Removal of 1 partner | Effective 1 May 2019 |

The group was assured that adequate steps had been taken to replace the sessions provided by the outgoing doctor to ensure that the provision of primary medical services would not be affected.

Primary Medical Services contract monitoring 2018/19

2.2 At the Primary Care Commissioning Committee held in November 2017, Committee members ratified the 2018/19 contract monitoring process. Three methods of monitoring were agreed that included face to face visits, remote monitoring and e-declaration.

It was agreed that visits would continue to those practices where there was cause for concern such as inadequate CQC rating.

Committee asked that training be added to the monitoring schedule and in specific this related to Practice Nurses and protected learning time. It was agreed that this would be managed by The Primary Care Development Group, outside of the 18/19 contract monitoring exercise.

Face to face visits

Face to face visits were carried out for the nine practices previously visited by NHS England, prior to the CCG being fully delegated.

- Lapal Medical Practice
- Links Medical Practice
- Netherton Health Centre
- Coseley Medical Centre
- Meadowbrook Surgery
- The Greens Health Centre
- Central Clinic
- Chapel Street Surgery
- Stourside Medical Practice

Stepping Stones Medical Practice was added to the schedule of face to face visits following a cold chain incident, highlighted during the remote monitoring process, which was subsequently reported to Public Health England.

Remote monitoring

Desk based monitoring for all Dudley practices was completed for the agreed areas that included:

- New contractual clauses for 2018/19
GP Earnings (raised by Governing Body)
CQC registered manager (raised by CQC)
Practice leaflet (theme from previous monitoring)
Cold chain processes (suggested by NHS England)
Submissions and extractions to NHSE & NHS digital

**e-Declaration**

All practices are also required to complete an e-Declaration against a wide range of GMS contract clauses, there was 100% compliance.

2.3 PCOG received the full report regarding primary medical services contract monitoring for 2018/19 and provides assurance to Committee that there are no contractual breaches to be issued for any Dudley practice.

2.4 The contact monitoring process has been revised to reflect changes in both internal arrangements and NHS England, Primary Care Medical Services Policy and version 2 was approved by the group for ratification by Committee (appendix A).

2.5Clauses to be monitored during 2019/20 will be considered by PCOG when further guidance is received and the implications are understood following the release of the five year framework for GP contract reform on 31 January 2019.

**Primary Care Premises Statutory Compliance**

2.6 PCOG received the report relating to practices compliance with statutory standards that was presented to Committee at the January meeting.

2.7 The group noted that Committee had considered the safety related elements relating to fire and legionella risk assessments, and the regular inspection and certification of gas and fixed electrical equipment and the decision of Committee to issue remedial breach notices if the required evidence was not received by Tuesday 29 January.

2.8 The group received the latest position and agreed that sufficient assurance had been provided by those practices identified in the report within the deadline and therefore remedial breach notices should not be issued.

**Three Villages Medical Practice – closure of the Wollaston branch surgery**

2.9 The group noted that the Wollaston branch surgery of Three Villages Medical Practice will close on 12 April 2019.

2.10 The contract variation was approved by Committee on 19 October 2018. The practice has been provided with a closure project plan and NHS England, the CCG and the Practice are working together to ensure actions are taken in a timely manner.

**3.0 PRIMARY CARE COMMISSIONING**

**Minor Surgery**

3.1 The group receive a report detailing minor surgery provided in primary care delivered under the GMS Contract and the Local Improvement Scheme (LIS).
3.2 The group was assured that the LIS has been reviewed to ensure that there are no procedures that were being commissioned that are set out in the Procedures of Limited Clinical Value or Aesthetics Policies.

3.3 PCOG agreed with the recommendation made in the report to communicate with practices in order to clarify the commissioning arrangements for minor surgery under both the GMS Contract and the LIS. This will be done through a simple table outlining the services to be provided under both contractual routes to include the options for opting out, sub-contracting and referral along with the financial consequences.

4.0 PRIMARY CARE QUALITY & SAFETY

4.1 PCOG received the primary care quality and safety matters that are set out in detail in the quality and safety report to Committee.

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

5.0 RISK REGISTER

5.1 PCOG reviewed the Committee risk register and make recommendations set out under agenda item 7.

6.0 RECOMMENDATION

Committee is asked to:

- Note the actions of the Primary Care Operational Group for assurance;
- Approved V2 of the Primary Medical Services contract monitoring process;
- Approve the contractual changes recommended by the group as follows:
  - Removal of 1 partner from The Waterfront Surgery
Primary Medical Services Contract
Compliance Monitoring Process
DUDLEY CCG CONTRACT COMPLIANCE MONITORING PROCESS

1. INTRODUCTION

Under fully delegated co-commissioning arrangements, Dudley CCG has to discharge its responsibility of seeking and confirming contractual compliance of all primary medical contracts that fall under its governance. In order to fulfil this responsibility the CCG will undertake contract monitoring visits to practices and or remote monitoring. The monitoring template attached at appendix 1 will be used for practice visits and will be updated annually to reflect any national variations to the contract. It is intended that this process will maintain high trust, fairness and equitability.

Various data sets are used to oversee the delivery of GMS services. Complying with the core contractual obligations provides only one part of a large picture. Compliance with the contractual clauses must be used alongside other intelligence to gain a full understanding of any potential risk to delivery of Primary Medical Services, quality and patient safety.

Accurate records of all contract monitoring will be maintained and may be required to demonstrate if requested, evidence of compliance. This may be for example be via the NHS England Primary Care Activity Report (PCAR) or internal and external audit functions.

2.0 PRACTICE VISITS

2.1 Structure

All GMS and APMS visits will be carried out by the Primary Care Contracts Manager and or the Primary Care Contracts Support Officer. The visit is expected to last approximately 2 hours and the visiting team will need intermittent access to individual practice staff throughout the visit. The practice manager will be required throughout the process. Where clinical or quality and safety issues have been identified prior to the visit, a Clinician or CCG Quality and Safety Manager may form part of the visiting team.

APMS practices will also have an assessment carried out on their specific additional agreement targets/objectives.
2.1 Criteria for Choosing GP practices for visits
The CCG will arrange the schedule of visits by a combination of targeted and random selection. Example of where a targeted visit may be identified may include:

- Primary Care Analysis Tool (PCAT)
- Informed Local intelligence (complaints, NHS choices etc, Friends and Family, GP Patient survey, infection control audits);
- The annual GP Practice electronic self-declaration (eDec) submission;
- Information from external and internal stakeholders;
- Where the CQC inspection report raises issues of non-compliance;
- Where issues of contractual nature have been raised; and
- Performer performance/concerns (if appropriate)

2.3 Frequency of Visits
It is intended that the contract compliance visits will be carried out throughout the year, maintaining a three year rolling programme. The timing is crucial for practices in terms of being able to manage their workload. To align with the commitment to reduce burden and bureaucracy, consideration should be given whether other practice visits may be planned or recently undertaken to avoid unnecessary duplication.

2.4 Notification of the Visit
The visit will be arranged at least 4 weeks in advance. The date and time will be mutually agreed - early communication is key to a successful visit. The Practice will be notified of the named member(s) of the team and confirmation of the dates will be followed up in writing.

2.5 Before the visit
Before visiting the practice, the contract monitoring template will be shared with the practice for pre-population where appropriate, and will be returned to the CCG with supporting evidence at least 2 weeks prior to the agreed visiting date. The template will be pre-populated by the CCG with any of the relevant information already known.

2.6 Outcome and reporting
2.6.1 No Concerns and Issues
Draft report will be sent to practice for comment and return to the CCG within 2 weeks of the visit.

2.6.2 **Minor Concerns and Issues** (For example: no dates on policies, missing information, documents to follow etc)

- Practice to rectify within 2 weeks or an action plan drawn up to conclude any outstanding issues which should be rectified within 28 days or an agreed timescale.

2.6.3 **Serious Concerns**

- Each event will be considered on a case by case basis
- The concern will be immediately escalated to the CCG Head of Primary Care and The Clinical Executive for Primary Care. Immediate action may be taken which may include, for example, immediate suspension of specific service(s).
- The concerns will be reported to the Primary Care Operational Group and Primary Care Commissioning Committee who may discharge their delegated powers to apply a sanction, breach or remedial notice against the contract.
- An action plan will be developed which may include information sharing with external stakeholders such as NHS England or CQC.
- The CCG should encourage practices in these circumstances to make contact with their LMC as early as possible to ensure they have access to expert help and advice (see section 3)

2.7 **Reporting**

Reports will be produced as set out in 2.6 and an annual report of GMS contract compliance will be presented to the Primary Care Operational Group as soon as practically possible after the monitoring exercises are completed. The report will include a summary of practice visits and any remote monitoring undertaken.

3.0 **THE LOCAL MEDICAL COMMITTEE (LMC)**

In accordance with NHS England, Primary Care Medical Services Policy, If the CCG is undertaking a targeted visit relating to concerns raised or known contractual
underperformance, which may result in actions being imposed or considered, then it shall, whenever it is reasonably practical to do so, consult the Local Medical Committee.

The LMC has a role in supporting practices facing remedial, breach and termination notices or those undergoing performance investigations. The LMC can advise practices on how to complete actions required by remedial notices, how to address issues in order to avoid further contract breaches and how to appeal against termination notices if appropriate. The LMC can signpost practices to experts who can help, e.g. the practices’ Medical Defence Organisation or consultants who can advise on practical issues such as practice policies, etc. For those practices undergoing performance investigations, the LMC can support practices in preparatory meetings with the investigating officers and the commissioners, assist with drafting terms of reference, guide practices through the investigation process and sit in on interviews with clinicians and staff to ensure that due process is followed.
REGULATIONS AND NHS ENGLAND POLICY THAT APPLY

The NHS (General Medical Services Contracts) Regulations 2004 as amended

The delegation agreement between NHS England and Dudley Clinical Commissioning Group

Schedule 2 – Delegated Functions
Part 1: Delegated Functions: Specific Obligations
1.0 Primary Medical Services Contract Management

NHS England - Primary Medical Care Policy and Guidance Manual (PGM)
Published 12 January 2016 (as Policy Book for Primary Medical Services),
Updated: 9 November 2017
## CONTRACT MONITORING 2018-2019

<table>
<thead>
<tr>
<th>Practice</th>
<th>Date of contract monitoring visit</th>
<th>Date of final review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice lead</td>
<td>Contract monitoring team</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No.</th>
<th>Contract Requirement</th>
<th>Expected evidence</th>
<th>Findings</th>
<th>FINAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Public Liability</td>
<td>Up to date adequate public liability insurance. Policy number</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

21.1.4. The Contractor shall at all times hold adequate public liability insurance in relation to liabilities to third parties arising under or in connection with the Contract.

---

Compliance with GMS Contract – Initial finding: Y/N

---

Appendix 1
<table>
<thead>
<tr>
<th>No.</th>
<th>Contract Requirement</th>
<th>Expected evidence</th>
<th>Findings</th>
<th>FINAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>CQC Registration</td>
<td>CQC Registration number and provider ID</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Health and Social Care Act 2008 requires all providers that carry out regulated activities to be registered with the CQC. From April 2013 this will include all primary medical services providers.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Data Protection Act</td>
<td>Data Protection Registration Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The practice must be registered under Data Protection Act. [Data Protection Act in conjunction with GMS Schedule 6 Part 9 para 125 23.1.1. The Contractor shall comply with all relevant legislation and have regard to all relevant guidance issued by the Board or the Secretary of State or Local Authorities in respect of the exercise of their functions under the 2006 Act.]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Contract Requirement</td>
<td>Expected evidence</td>
<td>Findings</td>
<td>Compliance with GMS Contract – Initial findings</td>
</tr>
<tr>
<td>-----</td>
<td>--------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>----------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>4</td>
<td><strong>Confidentiality of personal data</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>16.6. <strong>Confidentiality of personal data</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>16.6.1. <em>The Contractor shall nominate a person with responsibility for practices and procedures relating to the confidentiality of personal data held by it.</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Named individual for lead with responsibility for confidentiality policies</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>In contract of employment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Contract Requirement</td>
<td>Expected evidence</td>
<td>Findings</td>
<td>Compliance with GMS Contract – Initial findings</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------</td>
<td>-------------------</td>
<td>----------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>5</td>
<td>Insurance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>21.1.1. The Contractor shall at all times have in force in relation to it an indemnity arrangement which provides appropriate cover.</td>
<td>Policy number of indemnity insurance certificate in date</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>21.1.2. The Contractor shall not sub-contract its obligations to provide clinical services under the Contract unless it is satisfied that the sub-contractor has in force in relation to it an indemnity arrangement which provides appropriate cover.</td>
<td>Diarised for renewal</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>21 Insurance.docx</td>
<td>Evidence if services subcontracted that the practice checked that the sub-contractor has adequate insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Contract Requirement</td>
<td>What evidence do you have to demonstrate you meet this requirement. If none please give reason and what plans are in place to remedy this: (include action plan and timescales)</td>
<td>Expected evidence</td>
<td>Findings</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------</td>
<td>---------</td>
</tr>
</tbody>
</table>
| 6   | Infection Control    | **7.12.1. The Contractor shall ensure that it has appropriate arrangements for infection control and decontamination** | Written protocol to ensure that premises, equipment and arrangements for infection control and decontamination meet the minimum national standards  
Has the practice had Public Health infection control visit – if so have all actions been completed? |         |       |                                             |               |
| 7   | Health and Safety    | **Health and Safety at work Act in conjunction with GMS Schedule 6 Part 9 para 125** | Health and Safety policy, regularly reviewed (at least annually)  
Evidence read by all staff.  
Process for auditing compliance  
Risk assessments |         |       |                                             |               |
Practice Leaflet

16.7.1. The Contractor shall-

(a) compile a practice leaflet which shall include the information specified in Schedule 3;

(b) review its practice leaflet at least once in every period of 12 months and make any amendments necessary to maintain its accuracy; and

(c) make available a copy of the leaflet, and any subsequent updates, to its patients and prospective patients.

16.7.2. Where the Contractor has a website, the Contractor shall publish on that website details of the practice area specified in clause 13.2.1 including the area known as the outer boundary area specified in clause 13.3.1 by reference to a sketch diagram, plan or postcode.

Demonstrate leaflet available for patients/prospective patients

Evidence of annual review

The leaflet should contain all reference as contained in schedule 3

Schedule 3 - Practice leaflet.docx

Practice area on website
<table>
<thead>
<tr>
<th>No.</th>
<th>Contract Requirement</th>
<th>What evidence do you have to demonstrate you meet this requirement. If none please give reason and what plans are in place to remedy this: (include action plan and timescales)</th>
<th>Expected evidence</th>
<th>Findings</th>
<th>FINAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Complaints Process</td>
<td>24.1.1. The Contractor shall establish and operate a complaints procedure to deal with any complaints in relation to any matter reasonably connected with the provision of services under the Contract.</td>
<td>Complaints policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Does it include complaint can be made to NHS England and details</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>How is it advertised?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Newly Registered Patients</td>
<td><strong>Newly Registered Patients</strong>&lt;br&gt;<strong>alcohol dependency screening</strong>&lt;br&gt;<strong>7.7 Newly registered patients</strong>&lt;br&gt;<strong>7.7A.1. Newly registered patients – Alcohol screening</strong></td>
<td>Registration policy that covers non-discrimination.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Evidence of new patient health check within 6 months of registration</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Is ethnicity data recorded?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Is alcohol screening recorded?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Contract Requirement</td>
<td>Expected evidence</td>
<td>Findings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>----------------------</td>
<td>-------------------</td>
<td>---------</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 11  | Patient refusals, removals | - Remonvals policy to include non-discriminatory reasons for refusal  
- Lack of ID is not reason for refusal and should be included in policy if routinely asked for  
- Template letters for refusals i.e. out of area  
- Template warning letters  
- Evidence of warning letter  
- Process for removals under act of violence | |
<table>
<thead>
<tr>
<th>No.</th>
<th>Contract Requirement</th>
<th>What evidence do you have to demonstrate you meet this requirement. If none please give reason and what plans are in place to remedy this: (include action plan and timescales)</th>
<th>Expected evidence</th>
<th>Findings</th>
<th>Final Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Accountable GP 7.7B. Accountable GP 7.9. Patients aged 75 years and over 7.7 and 7.9 Accountable GP and over 75</td>
<td>Advertised Website Practice leaflet How allocated Over 75 health checks offered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Contract Requirement</td>
<td>Expected evidence</td>
<td>Findings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>--------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Medicine Act Compliance</strong></td>
<td></td>
<td>Policy and procedures in line with requirements of the medicines act for the storage prescribing, dispensing, recording and disposal of drugs, including controlled drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td><strong>14.1 Prescribing and Dispensing</strong></td>
<td></td>
<td>Cold chain audits</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>14.1.1. The Contractor shall comply with any directions given by the Secretary of State for the purposes of section 88 of the 2006 Act as to the drugs, medicines or other substances which may or may not be ordered for patients in the provision of medical services under the Contract</td>
<td>Part 14 - prescribing and dispensing.docx</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Contract Requirement</td>
<td>Expected evidence</td>
<td>Findings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>--------------------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>----------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td><strong>Transfer of Patient's Data</strong>&lt;br&gt;16.1.6. The Contractor shall send the complete records relating to a patient to the Board –&lt;br&gt;(a) where a person on its list dies, before the end of the period of 14 days beginning with the date on which it was informed by the Board of the death, or (in any other case) before the end of the period of one month beginning with the date on which it learned of the death; or&lt;br&gt;(b) in any other case where the person is no longer registered with the Contractor, as soon as possible at the request of the Board,</td>
<td>Mechanisms to ensure that the medical records are transferred to the new practice when patients leave the practice&lt;br&gt;To include process for deceased patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Contract Requirement</td>
<td>Expected evidence</td>
<td>Findings</td>
<td>FINAL FINDINGS</td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>--------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>----------</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Electronic Transmission of Patient Data</td>
<td>Policy for transmission of records using Gp2GP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>16.3.  Electronic transfer of patient records</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>16.3.1.    The Contractor must use the GP2GP facility for the safe and effective transfer of any patient records:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Clinical Governance Arrangements</td>
<td>Clinical governance lead MDT meetings, practice meetings, policies in place, procedure for dealing with MHRA alerts etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>GMS Schedule 6 Part 9 Paragraph 121]</td>
<td>Management of test results</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical governance systems should enable quality assurance of services and promote quality improvement as well as enhancing patient safety.</td>
<td>Management of Doc Man</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Significant Event Analysis – discussed at team meetings – written records</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Contract Requirement</td>
<td>What evidence do you have to demonstrate you meet this requirement. If none please give reason and what plans are in place to remedy this: (include action plan and timescales)</td>
<td>Expected evidence</td>
<td>Findings</td>
<td>FINAL FINDINGS</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------</td>
<td>----------</td>
<td>----------------</td>
</tr>
</tbody>
</table>
| 17  | Patient Online Access | **16.5. Patient online Services**  
16.5.1. The Contractor must promote and offer to its registered patients the facility for a patient:  
(a) to book, view, amend, cancel and print appointments online;  
(b) to order repeat prescriptions for drugs, medicines or appliances online; and  
(c) to view and print a list of any drugs, medicines or appliances in respect of which the patient has a repeat prescription | Process  
Application form  
Where advertised/How promoted  
Evidence of number of appointments are allocated to online  
Practices that have not achieved a minimum of 10 per cent of patients registered for online services – online ordering of repeat prescriptions, online appointment booking or online access to patient records – will work with NHS England to help them achieve greater use of those online services.  
Evidence of use of e-RS for all their practice to first, consultant-led, outpatient appointments from October 2018, where available | | |
<table>
<thead>
<tr>
<th>No.</th>
<th>Contract Requirement</th>
<th>What evidence do you have to demonstrate you meet this requirement. If none please give reason and what plans are in place to remedy this: (include action plan and timescales)</th>
<th>Expected evidence</th>
<th>Findings</th>
<th>FINAL FINDINGS</th>
</tr>
</thead>
</table>
| 18  | Patient Participation | 5.2.1. The Contractor must establish and maintain a group known as a “Patient Participation Group” comprising of some of its registered patients for the purposes of— | Process for engagement with the PPG  
Examples of where the practice reacted to and where applicable, implemented new systems and processes following patient feedback  
Is the membership of the group reviewed annually to ensure appropriate representation of registered  
Is it formally constituted with roles and responsibilities clearly defined  
How regularly does it meet  
Distribution of minutes | | | Compliance with GMS Contract - Initial findings |
<table>
<thead>
<tr>
<th>No.</th>
<th>Contract Requirement</th>
<th>Expected evidence</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td><strong>Friends and Family Test</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>16.7A.1 <em>The Contractor must give all patients who use the Contractor's practice the opportunity to provide feedback about the service received from the practice through the friends and family test.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>16.7A.2 <em>The Contractor must-</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>16.7A.2.1 <em>report the results of completed friends and family tests to the Board; and</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>16.7A.2.2 <em>publish the results of such completed Tests, in the manner approved by the Board.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mechanism for feeding back and acting upon</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Use of Mjog text messaging service</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Timely upload onto national reporting system</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Publication of reports</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>FFT accessible for all patients including those with different needs e.g. dementia, hearing loss, children and young people.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Contract Requirement</td>
<td>Expected evidence</td>
<td>Findings</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------</td>
<td>-------------------</td>
<td>----------</td>
</tr>
<tr>
<td>20</td>
<td><strong>Publication of Earnings Information</strong>&lt;br&gt;16.8A The Contractor must publish each year on its practice website (if it has one) the information specified in clause 16.8A.2&lt;br&gt;16.8A Publication of earnings.docx</td>
<td>Evidence of earnings published by 31 March for all GP’s providing services under the contract for at least 6 months&lt;br&gt;Website&lt;br&gt;Available for patients who ask for a hardcopy&lt;br&gt;Suggested wording&lt;br&gt;“All GP practices are required to declare the mean earnings (e.g. average pay) for GPs working to deliver NHS services to patients at each practice. The average pay for GPs working in [insert practice name] in the last financial year was £xx,xxx before tax and National Insurance. This is for [2] full time GPs, [3] part time GPs and [1] locum GP who worked in the practice for more than six months.”</td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Contract Requirement</td>
<td>Expected evidence</td>
<td>Findings</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------</td>
<td>-------------------</td>
<td>----------</td>
</tr>
<tr>
<td>21</td>
<td>Whistleblowing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**GMS Schedule 6 Part 9 para 125**

“Freedom to speak in primary Care”

Policies to be reviewed by 2017

NHS England becomes “prescribed person” – meaning primary Care staff can raise concerns of inappropriate activity to NHSE where direct approach is not favoured, suitable or appropriate

Draft document

Policy available and evidence read by all staff.

“Freedom to Speak in Primary Care”
<table>
<thead>
<tr>
<th>No.</th>
<th>Contract Requirement</th>
<th>What evidence do you have to demonstrate you meet this requirement. If none please give reason and what plans are in place to remedy this: (include action plan and timescales)</th>
<th>Expected evidence</th>
<th>Findings</th>
<th>Compliance with GMS Contract – initial findings: Y/N</th>
<th>FINAL FINDINGS</th>
</tr>
</thead>
</table>
| 22  | Storage of Vaccines | 7.11. Storage of vaccines  
7.11.1. The Contractor shall ensure that-  
(a) all vaccines are stored in accordance with the manufacturer’s instructions; and  
(b) all refrigerators in which vaccines are stored have a maximum/minimum thermometer and that readings are taken on all working days. | Policy to include incident reporting in line with Public Health England guidance.  
Readings taken on all working days  
Cover in absence | | | |
<table>
<thead>
<tr>
<th>No.</th>
<th>Contract Requirement</th>
<th>What evidence do you have to demonstrate you meet this requirement. If none please give reason and what plans are in place to remedy this: (include action plan and timescales)</th>
<th>Expected evidence</th>
<th>Findings</th>
<th>Compliance with GMS Contract – Initial findings: N or Y</th>
<th>FINAL FINDINGS</th>
</tr>
</thead>
</table>
| 23  | Vaccine and Immunisations  
9.4. Vaccines and immunisations  
9.4.2. The specified information referred to in clause 9.4.1(e) is—  
(a) the patient’s consent to immunisation or the name of the person who gave consent to the immunisation and that person’s relationship to the patient; | Procedures to ensure that all batch numbers and expiry dates are recorded for all vaccines administered  
Immunisation consent – scanned in to patient records |                  |         |                                                      |              |
<table>
<thead>
<tr>
<th>No.</th>
<th>Contract Requirement</th>
<th>Expected evidence</th>
</tr>
</thead>
</table>
| 24  | Anaphylaxis and First Line Treatment  
9.4.3. The Contractor must ensure that all staff involved in the administration of immunisations are trained in the recognition and initial treatment of anaphylaxis. | Training records for all staff involved in administering vaccines for recognition of anaphylaxis and ability to administer appropriate first-line treatment |
| 25  | Minor Surgery  
9.8. Minor surgery  
9.8.1. The Contractor shall make available to patients where appropriate curettage and cautery and, in relation to warts, verrucae and other skin lesions, cryocautery.  
9.8.2. The Contractor shall ensure that its record of any treatment provided pursuant to clause 9.8.1 includes the consent of the patient to that treatment. | Evidence of patient consent  
Management of process and recording  
Is any minor surgery sub-contracted? Is Sub-contracting of clinical matters complied with to include insurance (as No 24) |
15.1 Persons Who Perform Services

Policy ensuring that, upon employment, clinical staffs are:

a) registered with the relevant professional body - not suspended/interim suspension
b) 2 satisfactory clinical references relating to recent posts which lasted for 3 months without a significant break – or where not possible a full explanation and alternative referees
c) GPs, inclusion on the National Medical Performers lists – if conditions evidence of monitoring
d) Member of recognised MDU
e) Professional registration is checked annually for each employed clinician/partner
f) DBS checks undertaken where appropriate or evidence of risk assessment why not
g) Suitably qualified and trained with previous employment experience
15.8. Appraisal and assessment

15.8.1. The Contractor shall ensure that any medical practitioner performing services under the Contract -
(a) participates in the appraisal system provided by the Board, unless he participates in an appropriate appraisal system provided by another health service body or is an armed forces GP; and
(b) co-operates with the Board in relation to the Board’s patient safety functions.

15.8.2. The Board must provide an appraisal system for the purposes of clause 15.8.1(a) after consultation with the Local Medical Committee (if any) which is formed for the area in which the Contractor provides services under the Contract and with such other persons as appear to it to be appropriate.

All GP’s and nurses and practice staff have annual appraisal. Dates recorded.
The practice supports all staff in undertaking training to maintain their competence

Process for the identification and remedy of poor performance

Staff Employment Documents

Relevant employment law in conjunction with GMS Schedule

Staff have written terms and conditions of employment conforming to or exceeding the statutory minimum – up to date and relevant to job role
<table>
<thead>
<tr>
<th>No.</th>
<th>Contract Requirement</th>
<th>What evidence do you have to demonstrate you meet this requirement. If none please give reason and what plans are in place to remedy this: (include action plan and timescales)</th>
<th>Expected evidence</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6 Part 9 para 125(compliance with legislation and guidance)</td>
<td>Comprehensive induction - covered such topics as safeguarding, infection control, fire safety, health and safety and confidentiality. Induction programmes tailored to individual roles to ensure that both clinical and non-clinical staff covered key processes suited to their job role, as well as mandatory and essential training modules. Locum induction pack. Staff appraisals in place and evidence of training being supported Equal Opportunities Policy to ensure that the practice complies with current legislation on employment and discrimination?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Safeguarding and Vulnerable Adults**

*GMS Schedule 6 Part 9 para 125 (compliance with legislation and guidance)*

Local Authorities have local procedures in place which reflect the Department of Health’s ‘No Secrets’ guidance. Care Act 2014 in April 2015. Good medical practice code’ (2013) stresses the need for doctors to protect patients and take prompt action.

Designated lead for Safeguarding vulnerable adults

Aware of reporting mechanism

EMIS alert flags?

Dudley CCG Safeguarding Children, Young People & Adults Information Resource Pack available (published on members news (News Item Ref: WMN93 090616)

Staff training records for vulnerable adult protection procedures – Included at induction

Can staff demonstrate knowledge of the CCG/Social Services adult protection advisors?

Practices may find it useful to refer to British Medical Association’s “Safeguarding vulnerable adults – a tool kit for general practitioners” (2011)
<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Protection</td>
<td>GMS Schedule 6 Part 9 para 125 (compliance with legislation and guidance) 'Working Together to Safeguard Children' - statutory guidance</td>
</tr>
<tr>
<td></td>
<td>All relevant staff undertaken the appropriate level of child protection training? How many and who?</td>
</tr>
<tr>
<td></td>
<td>Who is the designated lead for safeguarding children and young people – is training up to date?</td>
</tr>
<tr>
<td></td>
<td>Evidence of how the safeguarding lead ensures all staff are aware of their responsibilities and the process to follow</td>
</tr>
<tr>
<td></td>
<td>Active and appropriate engagement in local safeguarding procedures and effective work with other relevant organisations.</td>
</tr>
<tr>
<td></td>
<td>EMIS alert flags?</td>
</tr>
<tr>
<td></td>
<td>Up to date training</td>
</tr>
<tr>
<td></td>
<td>Level 1: All staff including non-clinical managers and staff working in healthcare settings. This includes GP practice reception staff.</td>
</tr>
<tr>
<td></td>
<td>Level 2: Minimum level required for non-clinical and clinical staff who have some degree of contact with children and young people and/or parents/carers. This includes Practice Nurses and Healthcare Assistants.</td>
</tr>
<tr>
<td></td>
<td>Level 3: Clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns. This includes GPs.</td>
</tr>
<tr>
<td></td>
<td>Level 4: Named professionals</td>
</tr>
<tr>
<td></td>
<td>Level 5: Designated professionals</td>
</tr>
<tr>
<td>No.</td>
<td>Contract Requirement</td>
</tr>
<tr>
<td>-----</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 31  | consenting children to medical treatment  
GMS Schedule 6 Part 9 para 125(compliance with legislation and guidance) | Practice policy covering consent in line with GMC guidance - Gillick competence’ - ‘Fraser guidelines’ |                                                                         |
<table>
<thead>
<tr>
<th>No.</th>
<th>Contract Requirement</th>
<th>Expected evidence</th>
<th>Findings</th>
<th>FINAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>32</td>
<td>Frailty registers</td>
<td>Practices will be required to routinely identify moderate and severe frailty in patients aged 65 years and over, using the EmisWeb reporting tool 1. Practice should have a process in place to identify mild/moderate/severe from original information shared by Tom Robinson 2. Patients should have been clinically reviewed and appropriately read coded 3. Practice should have a robust ongoing process for registers to be kept up-to-date Queries should be directed to <a href="mailto:Rebecca.willetts1@nhs.net">Rebecca.willetts1@nhs.net</a></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Additional Comments

<table>
<thead>
<tr>
<th>Completed By</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TITLE OF REPORT:</strong></td>
<td>Board Assurance Framework (BAF) &amp; Risk Register (RR) for Primary Care Commissioning Committee</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>PURPOSE OF REPORT:</strong></td>
<td>To provide the Committee with an updated BAF &amp; RR</td>
</tr>
<tr>
<td><strong>AUTHOR OF REPORT:</strong></td>
<td>Mr D King - Head of Membership Development &amp; Primary Care</td>
</tr>
<tr>
<td><strong>MANAGEMENT LEAD:</strong></td>
<td>Mrs C Brunt, Chief Nurse</td>
</tr>
<tr>
<td><strong>CLINICAL LEAD:</strong></td>
<td>Dr T Horsburgh, Clinical Executive for Primary Care</td>
</tr>
<tr>
<td><strong>KEY POINTS:</strong></td>
<td>The BAF &amp; RR as at 15 December 2018 is attached</td>
</tr>
<tr>
<td><strong>RECOMMENDATION:</strong></td>
<td>Committee is asked to review the current status of risks and accept the recommendations made by the Primary Care Operational Group, highlighted in red.</td>
</tr>
<tr>
<td><strong>FINANCIAL IMPLICATIONS:</strong></td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>WHAT ENGAGEMENT HAS TAKEN PLACE:</strong></td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:</strong></td>
<td>No conflicts of interest were declared in advance.</td>
</tr>
<tr>
<td><strong>ACTION REQUIRED:</strong></td>
<td>✔ Decision Assurance</td>
</tr>
</tbody>
</table>

**Date of Meeting:** 22 February 2019  
**Report:** Board Assurance Framework & Risk Register  
**Agenda item No:** 7.0
<table>
<thead>
<tr>
<th>Date</th>
<th>Action taken</th>
<th>Details</th>
<th>Initial Risk Score</th>
<th>Current Risk Score</th>
<th>Controlled / Assured Security</th>
<th>Completeness of Score Card</th>
</tr>
</thead>
<tbody>
<tr>
<td>28/09/2018</td>
<td>Continue to review</td>
<td>Reporting monthly information from DMU to the CCGs to ensure the clinical service is safe. Recruitment activity is in line with the CCG's agreed strategy.</td>
<td>2</td>
<td>4</td>
<td>X</td>
<td>2</td>
</tr>
<tr>
<td>28/09/2018</td>
<td></td>
<td>2) Implementing the CCG's GP Forward Plan. 1) Developing the MCP model of care in advance of MCP 'go live'.</td>
<td>2</td>
<td>4</td>
<td>X</td>
<td>2</td>
</tr>
<tr>
<td>21/07/2017</td>
<td></td>
<td>(R) PCC approval of the GPRP. 2) Developing the MCP model of care in advance of MCP 'go live'. 1) Developing the STP primary care strategy.</td>
<td>3</td>
<td>4</td>
<td>X</td>
<td>2</td>
</tr>
<tr>
<td>08-Nov-18</td>
<td></td>
<td>Business continuity plan for PCCs and individual practices in place. Business continuity plans for PCCs and individual practices in place.</td>
<td>2</td>
<td>4</td>
<td>X</td>
<td>2</td>
</tr>
<tr>
<td>Title of Report:</td>
<td>Quality and Safety Report</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
<td>--------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purpose of Report:</td>
<td>To provide on-going assurance to the Primary Care Commissioning Committee (PCCC) regarding quality and safety in accordance with the CCG’s statutory duties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Author of Report:</td>
<td>Mr J Young, Head of Quality Assurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management Lead:</td>
<td>Mrs C Brunt, Chief Nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Lead:</td>
<td>Dr Ruth Edwards, Clinical Lead, Quality &amp; Safety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Key Points: | • Two CQC reports have been published since the last meeting  
• Special Allocation Scheme review process has been agreed |
| Recommendation: | The Primary Care Commissioning Committee is asked to:  
• Note this report for assurance |
| Financial Implications: | None to report |
| What Engagement Has Taken Place: | n/a |
| Any Conflicts of Interest Identified in Advance: | No conflicts of interest were declared in advance. |
| Action Required: | ✓ Assurance |
Primary Care Analysis Tool

Primary Care Analysis Report
PCCC, 22/02/2019

Produced: 11/02/2019

Katie Hayes - Senior Insight Officer
Jim Young – Head of Quality Assurance
### Primary Care Analysis Report – PCCC Summary

#### Care Quality Commission (CQC)
- **Keelinge House Surgery** have been rated as good overall and for all domains following a previous overall RI rating for the safe domain.
- **Bath Street Medical Centre** have been rated as good overall and for all domains following a previous overall RI rating for the responsive domain.

#### Infection Prevention & Control (IPC)

**Immunisations**
- Practices continue to discuss & action transfer of stocks where appropriate; DPMA playing a role in helping co-ordinate this.
- Uptake levels remain lower than the same time last year, in part due to the delivery schedule; as a result clinics and follow-up on individual patients is continuing later than usual.
- CCG continues to engage with NHSE to help address any issues; work has already begun on better planning for next season, including early guidance on the recommended vaccines for various patient groups.
- The local imms group met on 09/01/19 and identified some potential improvements for next year – these will be raised with NHSE at a regional meeting on 11/03/2019.

**Audits**
- 10 audits have now been completed since April.

#### Serious Incidents (SIs)
- There is only one primary care SI currently open, managed by NHSE as it relates to a cold chain incident.

#### Service Developments
- **Datix** - seven practices are currently using Datix for incident reporting; a presentation & discussion at the GP Members event on 21/06/18 gained agreement to provide Datix to all practices and arrange a training session via the DPMA. This was delivered at the October DPMA meeting and details have subsequently been sent out to all practices to enable them to register for access. To date a further 10 practices have requested access.

#### Other

**Special Allocation Scheme (Excluded patient scheme)**
- There are currently 24 patients on the EPS.
- A process & documentation for reviewing and identifying patients suitable for return to mainstream general practice has now been agreed.
- Two review meetings have now been held to identify patients able to come off the scheme.
# Care Quality Commission (CQC) Ratings

This section shows the results for the latest CQC inspections, the scores are calculated as follows; 1. Inadequate, 2. Requires Improvement, 3. Good, 4. Outstanding.

<table>
<thead>
<tr>
<th>GP Practice</th>
<th>Visit Date</th>
<th>Sum of CQC</th>
<th>Overall Rating</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well Led</th>
</tr>
</thead>
<tbody>
<tr>
<td>AW SURGERIES</td>
<td>Jan 2019</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>KEELING HOUSE</td>
<td>Jan 2019</td>
<td>15</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>BATH STREET MEDICAL CENTRE</td>
<td>Dec 2018</td>
<td>15</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>THE WATERFRONT SURGERY</td>
<td>Nov 2018</td>
<td>15</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>BEAN MEDICAL PRACTICE</td>
<td>Oct 2018</td>
<td>15</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>STOURSIDE MEDICAL PRACTICE</td>
<td>Oct 2018</td>
<td>15</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>COSELEY MEDICAL CENTRE</td>
<td>Aug 2018</td>
<td>14</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>LION HEALTH</td>
<td>Jul 2018</td>
<td>17</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>THORN'S ROAD</td>
<td>Jun 2018</td>
<td>15</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>AW SURGERIES</td>
<td>Mar 2018</td>
<td>14</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>CASTLE MEADOWS SURGERY</td>
<td>Feb 2018</td>
<td>13</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>PEDMORE MEDICAL PRACTICE</td>
<td>Jan 2018</td>
<td>15</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>
DUDLEY CLINICAL COMMISSIONING GROUP  
PRIMARY CARE COMMISSIONING COMMITTEE

**Date of Committee:** 22 February 2019  
**Report:** Finance Report  
**Agenda item No:** 9.0

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Primary Care Commissioning Finance Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>The report provides an overview of financial performance against budgets delegated to Committee for Month 10 2018/19.</td>
</tr>
<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mr P Cowley, Senior Finance Manager</td>
</tr>
<tr>
<td>MANAGEMENT LEAD:</td>
<td>Mr M Hartland, Chief Operating and Finance Officer</td>
</tr>
<tr>
<td>CLINICAL LEAD:</td>
<td>Dr T Horsburgh, Clinical Executive for Primary Care</td>
</tr>
</tbody>
</table>

**KEY POINTS:**

- There have been no changes to the budget reported to this Committee since the previous report.
- A small underspend is forecast in respect of budgets reported to Committee, with a break-even position reported against co-commissioned primary care services, and an underspend in respect of Core commissioning budgets offsetting an overspend in respect of GP Forward View allocations.
- The £1.50 per head non-recurrent transformation funding has been made recurrent from 2019/20 onwards to support PCN development, in line with NHS England guidance.

**RECOMMENDATION:** Committee is requested to note the reported financial position for assurance.

**FINANCIAL IMPLICATIONS:** Budget reported to Committee: £45,561,000

**WHAT ENGAGEMENT HAS TAKEN PLACE:** Not applicable

**ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:** No conflicts of interest were identified in advance.

**ACTION REQUIRED:** ✔ Assurance
Finance Report (February 2019)

This report submitted to Dudley CCG Primary Care Commissioning Committee provides a breakdown of financial performance for Co-commissioned Primary Care for January 2019.

Contents

Financial Overview .................................................. p2
Financial Detail ....................................................... p3
Budgets reported to the committee have an annual value at January 2019 of £45,561,000, including both the delegated co-commissioning allocation and core CCG budgets.

There have been no changes to the allocation reported to Committee in January.

Allocation Breakdown

- GP Forward View: £2,565k
- Primary Care Co-Commissioning: £42,007k
- CCG Core Commissioning: £989k
Financial Detail

Delegated Co-Commissioning

Expenditure against the delegated Co-Commissioning allocation is forecast to achieve a break-even position against budget.

The level of forecast expenditure in respect of Maternity locum claims in this financial year continues to be above the budgeted level, with two additional claims received since the previous report. The current forecast assumes that no further claims will be received in the remainder of this financial year, so there is a risk that a further increase will be seen. However, as noted in the previous report the forecast is currently based upon the maximum claimable amount so the forecast for these claims may also reduce should actual claims come in at less than the maximum.

The reported financial position assumes that, following the confirmation of Q4 list sizes, there will be no further calls upon the contingency reserve.
Financial Detail (continued)

Core Commissioning

A break even position is reported against the GP with Special Interest. This report also includes the budget received for diabetes transformation, which now totals £55,000. This funding will be committed in full.

The Primary Care Investments report shows a small underspend of £2,000, due to the closure of Crestfield Surgery and the cease of Practice Engagement Scheme payments.

Primary Care Investments are made up of:
• £474,000 for the Practice Engagement Scheme.
• £278,000 recharge for the cost of the Enhanced Practice Based Pharmacy Scheme.
• £126,000 contribution to the cost of the Prescribing Ordering Direct service.

GP Forward View

A small overspend is currently reported against the GP Forward View allocations, with an overspend of £1,000 reported against the Non-Recurrent Transformational Support fund.

Funding for GPFV Extended Access, and the Non-Recurrent Transformation Support, have been committed in full from the start of the financial year, and programmes are in place to fully utilise the allocations for Reception and Clerical Training and Online Consultation Software by the end of the financial year.

Committee should note that the £1.50 per head non-recurrent transformation fund has been funded recurrently for 2019/20 to support Primary Care Network Development, in line with NHS England Planning Guidance.
**TITLE OF REPORT:** Terms of Reference for the Primary Care Development Group, GPFV Workforce Sub-group and changes to the Primary Care Reporting Structure

**PURPOSE OF REPORT:** To present to the Committee final versions of the Primary Care Development Group, GPFV Workforce Sub-group Terms of reference and changes to the Primary Care reporting structure for assurance and ratification

**AUTHOR OF REPORT:** Mrs J Taylor, Primary Care Commissioning Manager

**MANAGEMENT LEAD:** Mrs C Brunt, Chief Nurse

**CLINICAL LEAD:** Dr T Horsburgh, Clinical Executive for Primary Care

**KEY POINTS:**
- Amendments made with regards to removal of the Primary Care Strategy Group, redefining the focus, functions and reporting arrangements of each of the groups
- Revised Terms of Reference are presented
- Associated changes to the Primary Care reporting arrangements have been updated

**RECOMMENDATION:** The Committee is asked to:
- Note the Primary Care development Group Terms of Reference for final ratification
- Note the GPFV Workforce Sub-group Terms of Reference for final ratification
- Note changes in the Primary Care Structure for the delivery of the GPFV work programme

**FINANCIAL IMPLICATIONS:** Not applicable

**WHAT ENGAGEMENT HAS TAKEN PLACE:** Not applicable

**ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:** No conflicts of interest identified in advance

**ACTION REQUIRED:**
- Decision
- Approval
- Assurance
Dudley Primary Care Development Group
Terms of Reference – Version 3.1

AMENDMENT HISTORY

<table>
<thead>
<tr>
<th>VERSION</th>
<th>DATE</th>
<th>AMENDMENT HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>V1.0</td>
<td>April 2017</td>
<td>Initial draft created</td>
</tr>
<tr>
<td>V1.0</td>
<td>April 2017</td>
<td>Standardised format adopted</td>
</tr>
<tr>
<td>V1.1</td>
<td>20/4/2017</td>
<td>Amendments made following review by Caroline Brunt</td>
</tr>
<tr>
<td>V1.2</td>
<td>16/06/2017</td>
<td>Amendments made following review by members of the Group</td>
</tr>
<tr>
<td>V2.1</td>
<td>23/05/2018</td>
<td>Amendments made following change to GPFV Delivery structure</td>
</tr>
<tr>
<td>V3.0</td>
<td>31/01/2019</td>
<td>Amendments made following change to GPFV Delivery structure and removal of Primary Care Strategy Group</td>
</tr>
</tbody>
</table>

REVIEWERS
This document has been reviewed by:

<table>
<thead>
<tr>
<th>NAME</th>
<th>DATE</th>
<th>TITLE/RESPONSIBILITY</th>
<th>VERSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emma Smith</td>
<td>April 2017</td>
<td>Governance Support Manager</td>
<td>V1.0</td>
</tr>
<tr>
<td>Caroline Brunt</td>
<td>19/4/2017</td>
<td>Chief Nurse</td>
<td>V1.0</td>
</tr>
<tr>
<td>Clair Huckerby</td>
<td>16/06/2017</td>
<td>Pharmaceutical Advisor</td>
<td>V1.0</td>
</tr>
<tr>
<td>Caroline Brunt</td>
<td>11/7/2018</td>
<td>Chief Nurse</td>
<td>V2.1</td>
</tr>
<tr>
<td>Emma Smith</td>
<td>11/7/2018</td>
<td>Governance Support Manager</td>
<td>V2.1</td>
</tr>
<tr>
<td>Joanne Taylor &amp; Rachel Gretton</td>
<td>31/01/2019</td>
<td>Primary Care Commissioning Manager &amp; Primary Care Commissioning Support Officer</td>
<td>V3.0</td>
</tr>
</tbody>
</table>

APPROVALS
This document has been approved by:

<table>
<thead>
<tr>
<th>VERSION</th>
<th>BOARD/COMMITTEE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2.0</td>
<td>Primary Care Commissioning Committee</td>
<td>21/7/2017</td>
</tr>
<tr>
<td>D2.1</td>
<td>Primary Care Commissioning Committee</td>
<td>20/7/2018</td>
</tr>
<tr>
<td>D3.0</td>
<td>Primary Care Commissioning Committee</td>
<td></td>
</tr>
</tbody>
</table>

NB: The version of this policy posted on the intranet must be a PDF copy of the approved version.

Please note that any changes to these Terms of Reference must be done in line with the Terms of Reference Development Guidance. Changes must be agreed at the Group and ratified through the Committee. The Governance Team must be included in any revision to ensure that the statutory duties are unaffected and in line with the CCGs Constitution.
Dudley Primary Care Development Group – Terms of Reference

1. Introduction & Purpose

1.1 The Primary Care Development Group (“Group”) is established to enable General Practice to respond to future development requirements of Primary Care and commissioning of schemes outlined within the General Practice Forward View (GPFV)

1.2 Dudley CCG has significant additional resources for the development of primary care that are made available from NHS England in order to implement the General Practice Forward View (GPFV)

1.3 The additional resources will be commissioned by the Primary Care Commissioning Committee (“The Committee”) and targeted in those areas identified within the GPFV as follows:

   a. Primary Care at Scale
   b. Access
   c. Workload
   d. Care Redesign – 10 high impact changes
   e. Investment

1.4 The Group will be:

   a. Supported by a team from within the CCG to provide the capability and capacity to manage areas requiring development.
   b. Oversee and direct the resources and investment for primary care development that have been provided to the CCG
   c. Define the communication and reporting arrangements to practices.

2. Membership

2.1 The Group will initially comprise the following members (see schedule 1):

   - Primary Care Commissioning Manager – (Chair)
   - GP Member – Education/ Locality Integrated Lead - Stourbridge, Wollescote & Lye (SWL)
   - GP Member – Primary Care/ Locality Integrated Lead - Halesowen, Quarry Bank (HQB) – (Vice Chair)
   - GP Member – GP Clinical lead - Commissioning and Pathways Development
   - Practice Manager - CCG Representative
   - Practice Manager – DPMA and Kingswinford, Amblecote & Brierley Hill (KAB) locality
   - Practice Manager – DPMA and Dudley & Netherton (D&N) Locality
   - Primary Care IT Manager
   - Primary Care Contracts Manager
   - Senior Finance Manager – Primary Care
   - Director of Membership Development and Primary Care
   - Primary Care Commissioning Support Officer
   - Pharmaceutical Advisor

2.2 The Group may be supported by other members of the CCG who may be in attendance at meetings pertinent to the agenda and areas of development being discussed. The support will be available from all teams within the CCG.

2.3 The Group shall reach decisions regarding recommendations made to the Primary Care Commissioning Committee by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary.
2.4 The Group will register and declare any interest as part of their recommendations and will consider any recommendations made for final agreement prior to presentation at the Committee for final ratification. The Committee has the statutory responsibility for ensuring that the recommendations of the Group are considered, and that the CCG is exercising and complying with its statutory duties as set out in the Committee Terms of Reference.

3. Quorum

3.1 A meeting of the Group will be quorate provided that at least four members are present of which:

- One must be either the Chair or Vice-Chair of the Group
- One must be a GP member, Practice Manager of the Group (in addition to the Chair or Vice-Chair)
- One must be a CCG manager – primary care contracts manager or senior finance lead for primary care

3.2 The CCG will invite members to the Group on their competencies.

4. Frequency and notice of meetings

4.1 The Secretary to the Group will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than five working days before the date of the meeting. When the Chair of the Group deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify. The reasons for calling a meeting at short notice will be recorded in the notes of the meeting.

4.2 The Group will formally meet on a bi-monthly basis.

5. Authority

5.1 The Group will determine its terms of reference, work plan and financial plan for final ratification by the Committee.

5.2 The Group will ensure that appropriate arrangements for the assessment and procurement of any training, education or support for the purpose of primary care development are in place and comply with the relevant polices of the CCG in relation to the procurement and Standing Financial Instructions (SFIs). The Committee will ultimately be responsible for the commitment of resources, and approval of any development support or schemes for primary care development, based on the recommendations of the Group. As potential bidders to the CCG through procurement, the Collective will be keen to ensure that it has at all stages respected the governance processes of the CCG.

6. Remit, duties and responsibilities

6.1 The Group will be responsible for developing all relevant areas of primary care practice including implementation of those associated with the agreed GPFV strategy for Dudley. They will be responsible for presenting on the implementation plan for approval of the Committee and assurance NHS England following discussion and consensus agreement amongst member practices.

6.2 The development plan will define the way in which additional resources allocated by NHS England for the implementation of the GPFV will be utilised, and the outcomes that will be expected and aligned to the delivery of a new care model in Dudley subsequently to be procured as part of the MCP.
6.3 The Group will determine the leadership role(s) and accountability for implementation any primary care development support package.

6.4 The Group will determine the training plan which supports the delivery of statutory and mandatory training in Primary Care and delivery of the Dudley Quality Outcomes for Health framework.

6.5 The CCG will continue to make those existing programmes for which the Group is responsible, available to all practices, with the Group having oversight on the evaluation including value for money of those programmes.

6.6 The Group will be responsible for working with other statutory and voluntary agencies to maximise the benefits from investment in primary care services for the people served by the CCG.

6.7 Members of the Group have a collective responsibility for the operation of the Group.

6.8 The Group may delegate tasks to such people, or individual members as it shall see fit, provided that any such delegations are consistent with the CCG's relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.

6.9 The Group may call experts, as required, to attend meetings and inform discussions.

6.10 Members of the Group shall respect confidentiality requirements as set out in the CCG’s Constitution, and comply with Section 8 of the Constitution; Standards of Business Conduct and Managing Conflicts of Interest.

6.11 The Group will prepare an updated action plan report to the Committee setting out the recommendations of the Group, and clearly articulating any potential risks and mitigations in delivery of the project plan.

6.12 The Group will determine its objectives, work plan and financial plan for approval by the Committee.

7. Finance

7.1 The Group will be responsible for planning and making recommendations to the Committee in relation to those resources identified by the Committee for primary care development. This includes:

   a. Resources within the delegated primary care commissioning budgets in relation to primary care development, training and education.

   b. Resources allocated to the CCG for the commissioning and implementation of the GPFV

7.2 The Committee will provide the Group with a schedule of resources that is able to be directed by the Group in discharging its responsibilities as set out in these Terms of Reference.

7.3 The Group recognises that any funding received from a third party to the Group, for example any further funding from the CCG or NHS England, may need to be monitored by them and the Group undertakes to execute any such responsibilities.
7.4 As part of the preparation of the bid submission, the Group will, together with agreed partner bidders, prepare investment plans for the delivery of services provided under the MCP model.

8. **Reporting**

8.1 The Group will report to Committee following the bi-monthly meeting to provide assurance on the delivery programme. The Group will make recommendations for approval to the Committee (through the Strategy Group) on all aspects of its work and will present plans for the use of the resources that have been allocated to the CCG for primary care development.

8.2 The Group will determine its objectives, work plan and financial plan for approval of the Committee.

8.3 The Committee will be responsible for approving and establishing the Group and its Terms of Reference.

8.4 The Group will ensure that appropriate arrangements for the assessment and procurement of any training, education or support for the purpose of primary care development are in place and comply with the relevant polices of the CCG in relation to the procurement and Standing Financial Instructions (SFIs).

8.5 The Committee will ultimately be responsible for the commitment of resources, and approval of any development support or schemes for primary care development, based on the recommendations of the Group.

8.6 The Committee will ultimately be responsible for ensuring that the Group is fully complying with all relevant polices and procures of the CCG.

9. **Managing Conflicts of Interest**

9.1 Conflicts of interest are a common and sometimes unavoidable part of the delivery of healthcare. The CCG is required to manage any conflicts of interest through a transparent and robust system. Members of the Group are encouraged to be open and honest in identifying any potential conflicts during the meeting. The Chair of the Group and all members are provided in advance of each meeting, via the agenda, the latest declarations of interest for all members of the Group. The Chair will be required to recognize any potential conflicts that may arise from themselves or a member of the meeting.

9.2 It is imperative that the CCG ensures complete transparency in any decision-making processes through robust record-keeping. If any conflicts of interest are declared or otherwise arise in a meeting, the chair must ensure the following information is recorded in the minutes; who has the interest, the nature of the interest and why it give rise to a conflict; the items on the agenda to which the interest relates; how the conflict was agreed to be managed and evidence that the conflict was managed as intended.

10. **Relationship with the governing body**

10.1 As this is a sub--group of the Commmittee all formal communications with the Governing Body will be made through the normal Committee processes.

11. **Review of Group effectiveness**

11.1 The Group will self-assess within six months of the date of these new Terms of Reference and report to the Strategy Group on its performance in the delivery of its objectives, and subject to the restrictions and requirements of the formal procurement process and separation of Commissioner and bidder responsibilities.
11.2 Any changes to the terms of reference will be approved by the Committee.

Schedule 1 – Dudley Primary Care Development Group

<table>
<thead>
<tr>
<th>Role at Group</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Commissioning Manager - Chair</td>
<td>Joanne Taylor</td>
</tr>
<tr>
<td>GP Member – Clinical Lead for Education/ locality Integrated Lead SWL</td>
<td>Dr Rebecca Willetts</td>
</tr>
<tr>
<td>GP Member – Clinical Lead for Primary Care/ Locality Integrated Lead HQB</td>
<td>Dr Rebecca Lewis</td>
</tr>
<tr>
<td>GP Member - Commissioning and pathways development</td>
<td>Dr Abrar Malik</td>
</tr>
<tr>
<td>Practice Manager - DPMA and KAB locality</td>
<td>Sonia Clark</td>
</tr>
<tr>
<td>Practice Manager – CCG Representative</td>
<td>Carol Tyler</td>
</tr>
<tr>
<td>Practice Manager – Dudley &amp; Netherton (D&amp;N)</td>
<td>Kelly Houseman</td>
</tr>
<tr>
<td>Primary Care IT Manager</td>
<td>Paresh Patel</td>
</tr>
<tr>
<td>Primary Care Contracts Manager</td>
<td>Julie Robinson</td>
</tr>
<tr>
<td>Senior Finance Manager – Primary Care</td>
<td>Phil Cowley</td>
</tr>
<tr>
<td>Head of Primary Care Development</td>
<td>Daniel King</td>
</tr>
<tr>
<td>Primary Care Commissioning Support Officer</td>
<td>Rachel Gretton</td>
</tr>
<tr>
<td>Pharmaceutical Advisor</td>
<td>Clair Huckerby / Jas Johal</td>
</tr>
</tbody>
</table>
Dudley GP Forward View Workforce Sub-group

Terms of Reference – Version 2.0

AMENDMENT HISTORY

<table>
<thead>
<tr>
<th>VERSION</th>
<th>DATE</th>
<th>AMENDMENT HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>V1.0</td>
<td>May 2018</td>
<td>Initial draft created</td>
</tr>
<tr>
<td>V2.0</td>
<td>31/01/2019</td>
<td>Amendments following changes to GPFV delivery structure</td>
</tr>
</tbody>
</table>

REVIEWERS

This document has been reviewed by:

<table>
<thead>
<tr>
<th>NAME</th>
<th>DATE</th>
<th>TITLE/RESPONSIBILITY</th>
<th>VERSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPFV workforce sub-group members</td>
<td>7/6/2018</td>
<td></td>
<td>V1.0</td>
</tr>
<tr>
<td>Caroline Brunt</td>
<td>11/7/2018</td>
<td>Chief Nurse</td>
<td>V1.0</td>
</tr>
<tr>
<td>Emma Smith</td>
<td>11/7/2018</td>
<td>Governance Support Manager</td>
<td>V1.0</td>
</tr>
<tr>
<td>Joanne Taylor &amp; Rachel Gretton</td>
<td>31/01/2019</td>
<td>Primary Care Commissioning Manager &amp; Primary Care Commissioning Support Officer</td>
<td>V2.0</td>
</tr>
</tbody>
</table>

APPROVALS

This document has been approved by:

<table>
<thead>
<tr>
<th>VERSION</th>
<th>BOARD/COMMITTEE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>V1.0</td>
<td>Primary Care Commissioning Committee</td>
<td>20/07/2018</td>
</tr>
<tr>
<td>V2.0</td>
<td>Primary Care Commissioning Committee</td>
<td></td>
</tr>
</tbody>
</table>

NB: The version of this policy posted on the intranet must be a PDF copy of the approved version.

Please note that any changes to these Terms of Reference must be done in line with the Terms of Reference Development Guidance. Changes must be agreed at the Group and ratified through the Committee. The Governance Team must be included in any revision to ensure that the statutory duties are unaffected and in line with the CCGs Constitution.
Dudley GPFV Workforce Sub-group – Terms of Reference

1. Introduction & Purpose

1.1 The GPFV Workforce Sub-group (“The Group”) is established to enable General Practice to respond to future workforce requirements of Primary Care outlined within the General Practice Forward View (GPFV)

1.2 Dudley CCG has additional resources available from NHS England for implementation of the Black Country STP GPFV Workforce Strategy. This was submitted to NHS England for assurance to workforce requirements outlined within the national General Practice Forward View (GPFV) plan.

1.3 The additional resources will be overseen by the Primary Care Commissioning Committee (“The Committee”) and targeted to implement the BC STP GPFV Workforce Strategy.

1.4 The Group will be:
   a. Supported by a team from within the CCG to provide the capability and capacity to manage areas requiring training, education and development.
   b. Oversee and direct the resources and investment for implementation of the BC STP GPFV Workforce Strategy
   c. Define the communication and reporting arrangements to Committee and practices.

2. Membership

2.1 The Group will initially comprise the following members (see schedule 1):

- OD and HR Lead – (Chair)
- Head of Primary Care Development – (Vice Chair)
- Primary Care Commissioning Manager
- GP Member – Education/ Locality Integrated Lead - Stourbridge, Wollescote & Lye (SWL)
- GP Member – GP Clinical Lead – Workforce/ locality Integreated Lead - Halesowen, Quarry Bank (HQB)
- GP Member – GP Clinical lead - Commissioning and Pathways Development
- Practice Managers – Dudley Practice Manager Allilance Representatives (DPMA)
- Practice Manager – CCG Representative
- Practice Nurse Mentor
- Pharmaceutical Advisor
- Primary Care Commissioning Support Officer
- Black Country Training Hub Representatives
- Health Education England Representative

2.2 The Group may be supported by other members of the CCG who may be in attendance at meetings pertinent to the agenda and areas of workforce development being discussed.

2.3 The Group shall reach decisions regarding recommendations made to the Committee by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary.

2.4 The Group will register and declare any interest as part of their recommendations and will consider any recommendations made for final agreement prior to presentation at the Committee for final ratification. The Committee has the statutory responsibility for ensuring that the recommendations of the Group are considered, and that the CCG is exercising and complying with its statutory duties as set out in the Committee Terms of Reference.
3. **Quorum**

3.1 A meeting of the Group will be quorate provided that at least four members are present of which:

- One must be either the Chair or Vice-Chair of the Group
- One must be a GP member, Practice Manager, Practice Nurse or Pharmaceutical Advisor of the Group (in addition to the Chair or Vice-Chair)
- One must be a CCG Manager

3.2 The CCG will invite members to the Group on their competencies.

4. **Frequency and notice of meetings**

4.1 The Secretary to the Group will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than five working days before the date of the meeting. When the Chair of the Group deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify. The reasons for calling a meeting at short notice will be recorded in the notes of the meeting.

4.2 The Group will formally meet on a bi-monthly basis.

5. **Authority**

5.1 The Group will determine its terms of reference, work plan and financial plan for approval by the Committee.

5.2 The Group will ensure that appropriate arrangements for the assessment and procurement of any training, education or support for the purpose of primary care workforce development are in place and comply with the relevant polices of the CCG in relation to the procurement and Standing Financial Instructions (SFIs). The Committee will ultimately be responsible for the commitment of resources, and approval of any development support or schemes for primary care development, based on the recommendations of the Group. As potential bidders to the CCG through procurement, the Collective will be keen to ensure that it has at all stages respected the governance processes of the CCG.

6. **Remit, duties and responsibilities**

6.1 The Group will be responsible for developing all relevant areas associated with the agreed BC STP GPFV Workforce strategy for Dudley. They will be responsible for presenting on the implementation plan for approval by the Committee and assurance NHS England following discussion and consensus agreement amongst member practices.

6.2 The implementation plan will define the way in which additional resources allocated by NHS England for the implementation of the BC STP GPFV Workforce Strategy will be utilised, and the outcomes that will be expected and aligned to the delivery of a new care model in Dudley subsequently to be procured as part of the MCP.

6.3 The Group will have specific responsibilities for directing and recommending the annual training plan prepared by the Dudley Practice Management Alliance (DPMA). The training plan supports the delivery of statutory and mandatory training in Primary Care and delivery of the Dudley Quality Outcomes for Health framework.
The Group will have specific responsibilities for directing and making recommendations regarding the content, delivery and format of the GP/Nurse Education Programme in Dudley. This will be aligned to the training needs and requirements of the operating model designed by Primary Care in response to the MCP procurement.

The Group will have specific responsibilities for directing and making recommendations to the Committee on activities of the CCG in supporting practice nurse education and revalidation.

The CCG will continue to make those existing programmes for which the Group is responsible, available to all practices, with the Group having oversight on the evaluation including value for money of those programmes.

The Group will be responsible for working with other statutory and voluntary agencies to maximise the benefits from investment in primary care workforce for the people served by the CCG.

The Group will have specific responsibilities for participating in the Birmingham and Black Country Training Hub – ensuring that the Group is able to act on behalf of practices to access additional funding and support that is organised through the Training Hub to support primary care.

Members of the Group have a collective responsibility for the operation of the Group.

The Group may delegate tasks to such people, or individual members as it shall see fit, provided that any such delegations are consistent with the CCG’s relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.

The Group may call experts, as required, to attend meetings and inform discussions.

Members of the Group shall respect confidentiality requirements as set out in the CCG’s Constitution, and comply with Section 8 of the Constitution; Standards of Business Conduct and Managing Conflicts of Interest.

The Group will prepare an updated action plan report to the Committee setting out the recommendations of the Group, and clearly articulating any potential risks and mitigations in delivery of the project plan.

The Group will determine its objectives, work plan and financial plan for approval by the Committee

7. **Finance**

The Group will be responsible for planning and making recommendations to the Committee in relation to those resources identified by the Committee for primary care workforce development. This includes:

a. Resources within the delegated primary care commissioning budgets in relation to primary care workforce development, training and education.

b. Resources allocated to the CCG for the commissioning and implementation of the BC STP GPFV Workforce Strategy

The Committee will provide the Group with a schedule of resources that is able to be directed by the Group in discharging its responsibilities as set out in these Terms of Reference.

The Group recognises that any funding received from a third party to the Group, for example any
further funding from the CCG or NHS England, may need to be monitored by them and the Group undertakes to execute any such responsibilities.

7.4 As part of the preparation of the bid submission, the Group will, together with agreed partner bidders, prepare investment plans for the delivery of services provided under the MCP model.

8. Reporting

8.1 The Group will report to Committee following the bi-monthly meeting to provide assurance on the delivery programme. The Group will make recommendations for approval to the Committee (through the Strategy Group) on all aspects of its work and will present plans for the use of the resources that have been allocated to the CCG for primary care workforce development.

8.2 The Group will determine its objectives, work plan and financial plan for approval of the Committee.

8.3 The Committee will be responsible for approving and establishing the Group and its Terms of Reference.

8.4 The Group will ensure that appropriate arrangements for the assessment and procurement of any training, education or support for the purpose of primary care workforce development are in place and comply with the relevant polices of the CCG in relation to the procurement and Standing Financial Instructions (SFIs).

8.5 The Committee will ultimately be responsible for the commitment of resources, and approval of any development support or schemes for primary care workforce development, based on the recommendations of the Group.

8.6 The Committee will ultimately be responsible for ensuring that the Group is fully complying with all relevant polices and procures of the CCG.

9. Managing Conflicts of Interest

9.1 Conflicts of interest are a common and sometimes unavoidable part of the delivery of healthcare. The CCG is required to manage any conflicts of interest through a transparent and robust system. Members of the Group are encouraged to be open and honest in identifying any potential conflicts during the meeting. The Chair of the Group and all members are provided in advance of each meeting, via the agenda, the latest declarations of interest for all members of the Group. The Chair will be required to recognize any potential conflicts that may arise from themselves or a member of the meeting.

9.2 It is imperative that the CCG ensures complete transparency in any decision-making processes through robust record-keeping. If any conflicts of interest are declared or otherwise arise in a meeting, the chair must ensure the following information is recorded in the minutes; who has the interest, the nature of the interest and why it give rise to a conflict; the items on the agenda to which the interest relates; how the conflict was agreed to be managed and evidence that the conflict was managed as intended.

10. Relationship with the governing body

10.1 As this is a sub-group of the Committee all formal communications with the Governing Body will be made through the normal Committee processes.

11. Review of Group effectiveness

11.1 The Group will self-assess within six months of the date of these new Terms of Reference and
report to the Strategy Group on its performance in the delivery of its objectives, and subject to the restrictions and requirements of the formal procurement process and separation of Commissioner and bidder responsibilities.

11.2 Any changes to the terms of reference will be approved by the Committee.
### Schedule 1 – Dudley GPFV Workforce Sub-group

<table>
<thead>
<tr>
<th>Role at Group</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head of OD and HR</td>
<td>Steve Stanier</td>
</tr>
<tr>
<td>Primary Care Commissioning Manager</td>
<td>Joanne Taylor</td>
</tr>
<tr>
<td>GP Member – Clinical Lead for Education/ Locality Integrated Lead SWL</td>
<td>Dr Rebecca Willetts</td>
</tr>
<tr>
<td>GP Member – Clinical Lead for Primary Care/ Locality Integrated Lead HQB</td>
<td>Dr Rebecca Lewis</td>
</tr>
<tr>
<td>GP Member - Commissioning and pathways development</td>
<td>Dr Abrar Malik</td>
</tr>
<tr>
<td>Practice Manager - DPMA Representative</td>
<td>Jacqui Jones</td>
</tr>
<tr>
<td>Practice Manager – CCG Representative</td>
<td>Carol Tyler</td>
</tr>
<tr>
<td>Practice Manager</td>
<td>Bina Tah</td>
</tr>
<tr>
<td>Practice Manager</td>
<td>Kelly Houseman</td>
</tr>
<tr>
<td>Practice Nurse Mentor</td>
<td>Pauline Billingham</td>
</tr>
<tr>
<td>Dudley &amp; Black Country Training Hub</td>
<td>Bev Wakelam / Marie Hawkins / Rachel Russon</td>
</tr>
<tr>
<td>Pharmaceutical Advisor</td>
<td>Clair Huckerby/Jas Johal</td>
</tr>
<tr>
<td>Health Education England</td>
<td>Conrad Newbold / Julian Mellor / Heidi Mitchell</td>
</tr>
<tr>
<td>Primary Care Commissioning Support Officer</td>
<td>Rachel Gretton</td>
</tr>
<tr>
<td>Head of Membership Development and Primary Care</td>
<td>Daniel King</td>
</tr>
</tbody>
</table>
Primary Care Commissioning & Development. Executive Lead: Caroline Brunt. Source of Funding: Delegated commissioning budget and GPFV.

Primary Care Development of MCP. Executive Lead: Daniel King. Source of Funding: Value Proposition for Program Costs.

Statutory Function – approval and assurance.

New care model implementation

STP alignment

Function: Share best practice across the STP footprint, explore opportunities for collaboration and delivery of schemes on an STP footprint where appropriate and standardise approaches across the STP in relation to delivery of GPFV.

Funding source: N/A

Members: Primary care leads across all 4 CCG’s

GP Collaborative Steering Group (Category C)

Function: Negotiate a partnership proposition for the MCP. Negotiate integration agreement; prepare bid submission in response to MCP procurement.

Funding source: Value proposition in relation to program costs.

Membership: TOR agreed by Finance & Performance Committee and Board. Dudley CCG Chair, Clinical Executive for Primary Care, Director of Membership Development and Primary Care

Note: only relationship and accountability to CCG in respect of program costs.

Primary Care Operational Group (Category B)

Function: Review and Monitor Contractual Performance

Funding source: N/A: no budgetary responsibilities

Members: Contracts, Quality & Finance Managers, Clinical Exec for Quality, LMC, Pharmacists, Practice Manager and Non Exec.

GP Collaborative (Category C)

Function: To inform and guide GP Collaborative Steering Group

Membership: Determined by all practices that signs an MOU with the Steering Group.

Primary Care Operational Group (Category B)

Function: Assurance & co-ordination of the work of the workforce group and implementation and tracking of the GPV. Development of schemes to be commissioned from primary care to implement requirements of GPFV within the new care model. Includes all aspects of the GPFV relating to primary care development.

Funding source: delegated commissioning budget and GPFV.

GPV Workforce Sub-Group (Category A&B)

Function: Assurance & co-ordination of the work of the workforce group and implementation and tracking of the GPV to implement workforce requirements of GPFV within the new care model.

Members: TOR to be devised GP led, should include GP, practice management and practice nurse representation, includes external representation from HEE and training Hub

Locality Meetings

Footnotes:

- Time limited structure transitioning into an MCP i.e. primary care development group responsibilities will sit in the MCP once established.
- The GP Collaborative Steering Group only reports to F&P on the Financial Accountability of program costs delegated to it.
- The views of the Primary Care Collaborative will be expressed at the Primary Care Development Group in an advisory capacity i.e. non-voting member on sustainability and implementation of schemes moving into MCP.
- Primary Care Commissioning and Development funded through delegated Commissioning budget, including GPFV monies.
- Primary Care Development of MCP funded through value proposition for program costs.
<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Update Report from the Primary Care Development Group and GPFV Workforce sub-group – GPFV work programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>To update the Committee following the Primary Care Development Group (PCDG) and GPFV Workforce sub-group meetings held on 17th January 2019</td>
</tr>
<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mrs J Taylor, Primary Care Commissioning Manager</td>
</tr>
<tr>
<td>MANAGEMENT LEAD:</td>
<td>Mrs C Brunt, Chief Nurse</td>
</tr>
<tr>
<td>CLINICAL LEAD:</td>
<td>Dr T Horsburgh, Clinical Executive for Primary Care</td>
</tr>
</tbody>
</table>

**KEY POINTS:**

- The PCDG and GPFV Workforce sub-groups have been established to oversee the implementation of the Dudley CCG GP Forward View (GPFV) Plan
- A high level project plan has been developed for both groups to monitor the delivery of all key work streams outlined within the GPFV plan and a progress update report is received at each meeting
- The group received an update from the primary care development group (PCDG) to include the following work streams:
  - Black Country STP leads
  - Practice Manager Development Training Programme
  - IT update
  - Extended access
  - Productive General Practice Quick Start
  - Coaching Offer from NHS England for GP’s and Practice Managers
  - DPMA Training and Buddy Schemes
  - Ten High Impact Actions
  - On-line and group consultation
  - Primary Care Networks (PCNs) in Dudley
  - GP Resilience Fund 2017/18 & 2018/19
  - Practice Manager Development Fund: Additional Funding for LMC’s
- The group received an update from the GPFV Workforce sub-group to include the following work streams:
  - Primary Care Workforce Analysis
  - GP Retention including Intensive Support Site Update
  - Early Career Peer Network Programme
  - GPN Fast Track Programme
  - STP GPN Retention Plan
  - Update from Training Hub
  - Portfolio Career Applications
  - General Training Update
| RECOMMENDATION: | The Committee is asked to:  
- Note the update from the Primary Care Development Group and GPFV Workforce sub-group for assurance  
- Note that the sub-groups will ensure that all transformation and improving access funds which have been directly allocated by NHSE to the CCG are used in accordance with the Statutory Financial Instructions (SFIs), and comply with all relevant guidance and legislation in relation to managing conflicts of interest and procurement |
| FINANCIAL IMPLICATIONS: | All finances will be contained within the allocation for GPFV |
| WHAT ENGAGEMENT HAS TAKEN PLACE: | Localities in development of Extended Access Scheme 2018/19  
- Dudley Practice Managers Alliance (DPMA)  
- Dudley LMC  
- GP Collaborative practices  
- Clinical Executive  
- Dudley Practice Managers Alliance |
| ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE: | No conflicts of interest identified in advance |
| ACTION REQUIRED: | Decision  
Approval  
Assurance ✓ |
1.0 INTRODUCTION

This report provides an update from the Primary Care Development Group (PCSG) and GPFV Workforce sub-group following meetings held on 17th January 2019.

2.0 BACKGROUND

2.1 Originally the Primary Care Strategy Group (PCSG) which had been formally established and approved as a sub-group reporting to the Committee in May 2017, to oversee and assure Committee that plans outlined within the GPFV plan are on track for successful delivery;

2.2 In November 2018 the Primary Care team were asked to review their work programmes resulting in a re-structure of the GPFV delivery programme to assume direct reporting arrangements and assurance responsibilities to Committee from the PCDG and GPFV Workforce sub-groups respectively;

2.3 Changes to the reporting arrangements are presented to Committee separately.

3.0 PROJECT PLAN FOR DELIVERY OF GPFV

3.1 A high level project plan has been developed for the PCDG and GPFV Workforce sub-group to monitor the delivery of all key work streams outlined within the GPFV plan;

3.2 Project updates and presented and reviewed by both groups (Appendix 1) on a regular basis and no significant risks relating to delivery of the GPFV plan have been identified which require escalation to Committee.

4.0 UPDATE FROM PRIMARY CARE DEVELOPMENT GROUP

4.1 Black Country STP Leads

4.1.1 The primary care leads across the four CCG’s within the STP footprint continue to meet on a regular basis to share good practice and identify areas;

4.1.2 The STP has appointed a Programme Director and Programme Manager to oversee the successful delivery of the GPFV work programme across the STP footprint;

4.1.3 The STP continues to deliver the programmes in the high intensity support site for GP retention (GPRISS) and gain National recognition for their successful delivery.
4.2 Practice Manager Development Training Programme

4.2.1 The STP has identified a small amount of funding which is surplus to the PM development training fund received in 2018/19. The CCG has canvassed the views of the DPMA who has expressed an interest to undertake Health & Safety training.

4.3 IT Update

4.3.1 Patient Wi-Fi is being rolled out and is now active at 39 out of the 48 sites (81%). The remaining 7 sites still have on-going issues with wayleave agreements which are being addressed with the respective landlords;

4.3.2 Docman10 is being implemented in two practices but it has been highlighted that 14 sites have insufficient network capacity and will therefore cannot be upgraded until after their HSCN upgrade but the CCG will proceed with implementation at the remaining 28 sites;

4.3.3 Further work is being undertaken to refresh the Network to enhance the current firewalls which should be complete over the next few weeks;

4.3.4 Prescription Ordering Direct (POD) phase 2 will be installing a new telephony solution over the next few weeks and we now have 11 practices using the POD covering a population of approximately 100K.

4.4.1 Extended Access

4.4.1 The CCG received their 2nd assurance visit from NHSE last week. There will be a few new requirements which will need to be included within the updated service specifications for 2019/20 contracts, which will include:

- The ability to be able for NHS 111 to directly book into extended access appointments
- A target on utilisation of 85%
- NHS Digital mandating the GPFV data to be submitted by the 15th of the following month
- Appointment data to be directly extracted by NHS digital

4.4.2 The CCG is in the process of undertaking a contract review with the 5 lead practices and will be undertaking a capacity review before issuing changes to the contract for 2019/10.

4.5 Productive General Practice Quick Start

4.5.1 The CCG have engaged with 8 practices to undertake the programme which commenced November 2018;

4.5.2 This is a rapid improvement cycle programme over a 12 week period which has external facilitators working directly with the practices to obtain tangible improvements and efficiencies within the practice;

4.5.3 In addition the practices engage in a number of group based learning sessions to share good practice;

4.5.4 Preliminary feedback from the practices is excellent and the CCG plan to have a learning event at the end of the programme through localities in April.
4.6 Coaching Offer from NHS England for GP’s and Practice Managers

4.6.1 As part of the offer as an Intensive support site NHSE have a dedicated coaching offer for GP’s and Practice Managers which has been distributed to all member practices;

4.6.2 To date there has been poor uptake for this programme despite extensive advertising and feedback from member practices this may be due to the fact that Dudley CCG has invested for a number of years in a similar offer locally for GP’s;

4.6.3 The CCG will continue to actively promote all schemes contained under the GPRISS work programme;

4.7 DPMA Training and Buddy Schemes

4.7.1 The DPMA had previously been commissioned to deliver schemes around providing a buddy system to Practice Managers requiring support and mandatory training and education packages for practice staff;

4.7.2 The current buddy system is not functioning as well as it should and members of the group felt that a formal criteria and process needed to be developed which may include formal accreditation of the people undertaking the buddy function;

4.7.3 The group have recommended a review of the mandatory training co-ordinated through the DPMA and an options appraisal will be developed and presented to Committee in the future.

4.8 Ten High Impact Actions

4.8.1 Delivery of two of the High Impact actions form part of the practice engagement scheme for 2018/19 and following completion a report will be presented to the group and then subsequently to Committee;

4.8.2 The group continues to monitor progress of potential efficiencies and reduction in GP administration time dealing with correspondence within the practice as a result of the clinical correspondence training and continue to promote the on-line training webinar;

4.8.3 The CCG has further invested in medical terminology training to support clinical correspondence implementation but the group requested a more in depth course which will be organised in the near future.

4.9 Online and Group Consultation

4.9.1 The CCG has awarded the contract to the preferred provider – Sense.ly and development has commenced on requirements for the solution to support on-line consultations;

4.9.2 A workshop took place with early adopter practices outlining the solution and mapping of patient journeys to gain a better understanding of the algorithms and triggers in the current system;
4.9.3 Further development work is required regarding alignment to the Dudley quality Outcomes for Health template for the provision of on-line long-term conditions management, which is due to be completed for April 2019;

4.9.4 The second cohort of group consultation training has taken place with 8 practices and practices are actively organising sessions within their practice;

4.9.5 The group received positive feedback on the process but will continue to monitor progress and report to Committee on a regular basis.

4.10 Primary Care Networks (PCNs) in Dudley

4.10.1 The development of PCN’s is a key deliverable published within the Long Term Plan for which NHSE will have an assurance process which includes development of a maturity matrix;

4.10.2 NHSE will be planning to place significant investment through PCN’s in the future and the CCG will need to allocate funding in 2019/20 to support their development;

4.10.3 The CCG has developed a paper (Appendix 2) outlining our local position on PCN’s which will be presented to Committee but may be need to be updated once the new GP contract has been published.

4.11 GP Resilience Fund 2017/18 & 2018/19

4.11.1 The group received an update on the funding received for 17/18 and 18/19 by NHSE with all monies being virtually allocated.

4.12 Practice Manager Development Fund: Additional Funding for LMC’s

4.12.1 The LMC have received notification from NHSE for additional funding which has been made available for PM development which will need to be allocated by the end of March 2019;

4.12.2 The LMC will be working closely with the Training hub to develop an action plan and delivery timetable to cover all requirements by NHSE which include:
- Engagement workshop to cover on-line consultation
- Appraisal training
- Peer mentor case studies

5.0 UPDATE FROM GPFV WORKFORCE SUB-GROUP

5.1 Primary Care Workforce Analysis

5.1.1 Following on from the workforce audit carried out locally with the analysis being presented at DPMA and locality (PCN) forums for a detailed discussion. The CCG has undertaken a further piece of work developing a skills matrix across the current roles within Primary Care;
5.1.2 The intention is for the CCG to support development of a workforce plan at PCN level which will align to the wider workforce plan which will be required in development and mobilisation of the MCP;

5.1.3 The group recognise that this will be extremely challenging and will be sourcing external support and resource to undertake this piece of work.

5.2 GP Retention including Intensive Support Site Update

5.2.1 All 4 work streams within the programme have commenced and are progressing with particular interest in the portfolio careers and first 5’s programmes as direct funding to individual GP’s is specifically attached to these programmes;

5.2.2 The STP GP Clinical lead regularly communicates to practices to promote these schemes and the CCG will need to identify funding in 2019/20 for the continuation of schemes which are deemed successful following evaluation.

5.3 Early Career Peer Network Programme

5.3.1 The CCG had previously developed a programme to support GP’s early on in their career and despite having initial interest the numbers in attendance had diminished due to the timing of the meetings;

5.3.2 The programme has now been revamped to run consecutively with the current GP Education programme every six weeks (April to November 2019) and will be fully funded non-recurrently as a pilot;

5.3.3 The programme has been promoted through Members News and GP education and will be fully evaluated.

5.4 GPN Fast Track Programme

5.4.1 The CCG are working closely with the BC STP and the BC Training Hub to develop a fast track GPN skills programme to run April – June 2019;

5.4.2 The programme will enable new qualified nurses or nurses wishing to transition into a GPN role to obtain the core skills required in a fast track 3 month programme (usually 12 months), as a mechanism of increasing the GPN workforce across the STP;

5.4.3 The BC STP has secured funding from HEE for 12 fully funded places which will cover:

- The role of the GPN in GP practice
- Immunisation
- Indemnity cover for nurses
- Cytology
- Ear irrigation
- New patient and NHS Health checks
- Long term conditions management – hypertension, asthma, COPD, diabetes, CHD
- Safeguarding / Chaperone training
5.4.4 The programme will be fully evaluated with a view to secure recurrent funding as part of our STP GPN strategy if the programme is successful.

5.5 **STP GPN Retention Plan**

5.5.1 A BC STP group has been formed to explore and develop plans for GPN retention. The group will be planning a series of co-design workshops during February / March in each of the Black Country areas with the existing GPN workforce. Each of the workshops will explore what is currently working well, what are the barriers to choosing a career as a GPN and potential solutions to inform the GPN retention plan.

5.6 **Update from Training Hub**

5.6.1 The training hub has secured funding from the LWAB to undertake a Health Care Assistant (HCA) training programme across the STP footprint to be delivered during February / March 2019. The programme will cover all the core skills and competencies required for a HCA in GP practice;

5.6.2 The Hub is working closely with the BC STP to deliver the GPN fast track programme and has secured modules for the key elements of immunisation, cytology and ear irrigation;

5.6.3 The Hub has agreed to work with the LMC on delivery of the PM development programme and is in the process of organising the requirements which have been set out by NHSE;

5.6.4 The Hub is currently scoping out additional GP training requirements with a view to providing a training programme in the future.

5.7 **Portfolio Career Applications**

5.7.1 The BC STP have received a number of applications as part of the GRISS programme funding to support future portfolio careers;

5.7.2 Each CCG has been sent there respective applications (8 in Dudley) which had undergone a selection and decision making process from which 6 had been supported;

5.7.3 The group received the outcome of this process for information.

5.8 **General Training Update**

5.8.1 The CCG have commissioned a number of training to support GP practice staff which have included:

- Community Info Champion Training (provided by Healthwatch) – 16 sessions with attendance by 74 members of staff
- Care Navigation – “From Receptionists to Active Sign poster” – 9 sessions with attendance from 77 members of staff
- Medical Terminology – 2 sessions with attendance from 20 members of staff
- Practice Manager Modules – 9 modules completed since May 2018 with a 30% attendance rate
6.0 **RECOMMENDATION**

The Committee is asked to:

- Note the updates from the Primary Care Development Group and GPFV Workforce sub-group for assurance
- Note that both sub-groups will ensure that all transformation and improving access funds which have been directly allocated by NHSE to the CCG are used in accordance with the Statutory Financial Instructions (SFIs), and comply with all relevant guidance and legislation in relation to managing conflicts of interest and procurement
## Work stream Update – Workforce Sub-group

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Management Lead/ Report Author</th>
<th>Clinical Lead</th>
<th>Reporting Period</th>
<th>Last report status</th>
<th>Current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPFV</td>
<td>Joe Taylor/ Rachel Gretton</td>
<td>Dr Becci Lewis</td>
<td>October – December 2018</td>
<td>Amber</td>
<td>Amber</td>
</tr>
</tbody>
</table>

### Current RAG Assessment:
- 19 - Work streams
- 49 - Projects
- 12 - Green
- 0 – Red
- 16 – Amber
- 23 - Blue

### Progress This Month:
- Medical Assistant Role being explored
- Communications sent to GP’s and PM’s across Black Country Promoting intensive support site schemes
- Early Career Peer Network Programme - GP’s in first 5 years – a programme syllabus had been developed and was planned to commence in January 2019, but has been postponed until April due to low numbers
- 6 GP’s across the Black Country had been recruited to be mentors across the STP GP Peer Support Programme
- Primary Care Pharmacists – students placed in years 1, 3, 4 and 5 will be carrying out audit work allowing for PBP’s to focus on other areas
- A final draft strategy for Nurse career is being finalised, this includes HCA to ANP Competencies
- DCCG looking at a fast track programme for Nursing staff to gain core skills. Scoping exercise with practices to gain interest

### Planned Activities for Coming Month:
- Plans to formalise practices within Primary Care Networks continues including development of an MOU
- Plans to pilot Nurse Fast Track programme from April through to June 2019
- HCA training programme organised through Training Hub, to be completed by the end of March 2019
- Ongoing work with PCNs at February localities regarding skills matrix and workforce planning
- Continue to work with STP colleagues on delivery of the GPRISS programme
- Set up of a Nurse locum bank
- Expressions of interest will be requested for the GPA role

### Key Risks
- Delay in engagement and delivery of the Early Career Peer Network Programme
  - Flyers to be distributed to promote programme at GP education events
  - Continue to raise profile through Locality meetings and GP Members Newsletter

### Actions in place to address
- Workforce Development plans at PCN level
  - Focused session at February Locality meetings
  - Sourcing external support to provide required capacity/capability for delivery
  - Will be requirement of PCN MOU and practice engagement scheme 2019/20

### Risk change
- Recurrent funding for GPRISS and GPN retention
  - Each CCG within STP footprint to allocate recurrent funding towards ongoing GPRISS schemes
  - GPN Fast track programme pilot to be fully evaluated and ongoing business case to be developed

### Additional on-going plans to ‘get to green’:
- Working group liaising regularly to anticipate and tackle issues.
### Work stream Update – Primary Care Development Group

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Management Lead/ Report Author</th>
<th>Clinical Lead</th>
<th>Reporting Period</th>
<th>Last report status</th>
<th>Current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPFV</td>
<td>Joe Taylor / Rachel Gretton</td>
<td>Rebecca Lewis / Abrar Malik</td>
<td>October - December 2018</td>
<td>Amber</td>
<td>Amber</td>
</tr>
</tbody>
</table>

#### Current RAG Assessment:
- **GPFV Overview**
- **6 - Work streams**
- **43 - Projects**
- **19 - Green**
- **0 - Red**
- **16 - Amber**
- **6 - Blue**
- **Primary Care At Scale**
- **Access**
- **3 - Work streams**
- **18 - Projects**
- **14 - Green**
- **0 - Red**
- **1 - Amber**
- **3 - Blue**
- **Workload**
- **5 - Work streams**
- **27 - Projects**
- **22 - Green**
- **0 - Red**
- **3 - Amber**
- **2 - Blue**
- **Ten High Impact Actions**
- **10 - Work streams**
- **17 - Projects**
- **8 - Green**
- **0 - Red**
- **4 - Amber**
- **6 - Blue**
- **Investment**
- **1 - Work stream**
- **1 - Project**
- **0 - Green**
- **0 - Red**
- **1 - Amber**
- **0 - Blue**

#### Progress This Month
- Clinical Correspondence Management – Weekly WebEx sessions available to practices
- Medical Terminology training had been organised to complement the above processes – 1 session completed, 1 booked for January 2019
- Patient Wi-Fi – currently in the process of completing. Challenges around landlords and wayleave documents were being discussed
- Engagement is underway with Egton to install Docman Share and Docman 10
- CAS Alert is in phase 2, with no indication of patient safety risk so far
- POD Phase 2 – IT infrastructure underway. Two further practices would be joining Oct/Nov - now 10 in total
- Best Practice Guidance had been finalised and would be shared with practices. Some revisions were required within the ‘Starters Pack’
- Care Navigation – 24 practice staff had undergone EPI Care Navigation training and 14 had undergone the Healthwatch Community Information Champion module from October to December. 148 practice staff in total are now trained between Care Navigation/Community Information Champion Training
- Online Consultation - A Waiver had been completed for an agreed solution. 9 practices wish to become early implementers, contract with provider has now been signed for commencement January 2019
- Group Consultation – 2 practices had undertaken group consultations with varying success, 6 other practices have undertaken the training with dates for commencement in January 2019
- Practice Manager Training Programme – Three modules would take place during September – now completed
- PGP Quick Start – 8 practices commenced currently completed GBL1 & 2 and first module
- Coaching Offer from NHSE – DCCG had agreed to lead on peer mentorship and EOI’s been circulated to create a pool of GP’s across the STP
- Primary Care Networks – development of a document outlining the CCG position on Primary Care Networks (PCN’s), first assisance visit with NHSE

#### Key Risks
- Delays in implementation of on-line consultation
- Implementation plan from January 2019 in place
- Engagement workshop with GP practice January 2019
- PGP Quick start – cancellation of sessions due to staff sickness at 1 practice
- Plan to provide catch up sessions to practice during 2nd half of delivery programme and dates organised

#### Planned Activities
- Targeted approach to practices not undertaken clinical correspondence management training
- Feedback requested from practices using clinical correspondence management workflow
- 9 practices had not undertaken any Care Navigation or Community Information Champion training – these practices would be targeted
- PGP Quick Start programme – practices to share individual learning at GBL 3 and 4 – to be shared with wider practices at future locality event
- Update on GP Resilience programme
- Further progress with PCN development including development of MOU
- Review of Extended Access Capacity and specification required

#### Additional on-going plans to ‘get to green’:
- Working group liaising regularly to anticipate and tackle issues.
Appendix 2

SUMMARY: PRIMARY CARE NETWORKS (PCNs) IN DUDLEY

CONTEXT - DUDLEY MULTISPECIALTY COMMUNITY PROVIDER (MCP)

Since 2014, Dudley CCG has led work with local providers and other stakeholders to develop a new model for integrated primary, community and mental health services – this has resulted in the successful procurement of the Dudley MCP.

The MCP will be a single provider that will hold the budget for and manage a broad range of primary and community services, including core primary care, out-of-hours and urgent-care centre services, community physical health services, community mental health and learning disability services, some outpatient services, intermediate care and end-of-life care. It will also hold the budget for some hospital-based emergency services so that it has an incentive to reduce usage.

The MCP model is enabled by the integration of primary care services whereby general practice have more influence and co-ordination for the care provided to their patients by other community services, including multidisciplinary teams. These teams will become part of the wider primary health care team.

In order for general practice to assume this responsibility, GP practices have already organised themselves into PCNs – referred to locally as our localities. This paper summarises the development of our PCNs to date, and how they will develop as the MCP model is mobilised.

THE NUMBER OF PCNs IN DUDLEY

We have 5 PCNs that we refer to as our ‘localities’. The attached map sets out the configuration of each. They are organised geographically, and serve populations of between 50,000 – 70,000 patients. (Appendix A).

HOW WERE OUR PCNs FORMED?

Our PCNs were formed over 10 years ago, originally as a mechanism to engage practices in the commissioning of services within PCTs.

With the advent of CCGs our PCNs were further developed to elect members on to the CCG governing body and set the commissioning agenda for the CCG – culminating in the procurement of the MCP.

Over the last 3 years our PCNs have further developed to take on the responsibility for co-ordinating the delivery of community based services, through the creation of Multi-Disciplinary Teams (MDTs) in every practice, and the provision of extended access GP appointments.
WHAT SERVICES LINK IN TO THE PCNs

Every practice in Dudley has a Multi-Disciplinary Team (MDT). The teams are designed to work to the principles of shared responsibility for shared outcomes for a shared population using a population health management approach. These teams bring together:

- GPs
- Community nurses
- Mental health workers
- Social workers
- Practice based pharmacists
- Voluntary sector services
- Other specialist health services eg heart failure, Macmillan etc
- Consultant outreach

They have been aligned, from different organisations and management structures, in a team based setting to create a collaborative environment and work more effectively together to deliver the right outcome for the patient.

In the future, All PCNs will have two Integrated Community Teams serving a group of practices with a joint population of approximately 35,000 patients. They will be led from an appointed GP integration lead from one of the practices within the group, that co-ordinates the delivery of the MDT services for their population.

All PCNs provide extended access to GP appointments at evenings and weekends – this is co-ordinated and led by a lead practice within each PCN.

WHAT SERVICES ARE PLANNED TO BE BROUGHT ON BOARD, HAS THERE BEEN ANY CONSIDERATION GIVEN TO INCLUDING PHARMACY, OPTOMOTRISTS, DENTAL?

The ICT’s bring together a group of staff to deal with population health management issues around a geography following services will be organised and delivered by the 10 integrated care teams. Services are then operationalised to the same geography operating under the direction of each PCN (with a dedicated GP lead) via the MCP from 1st April 2019. There will be 10 teams (x2 in each PCN) providing:

- community based physical health services for adults and children;
- all mental health and learning disability services;
- intermediate care services and NHS Continuing Healthcare
- end of life services;
- voluntary and community sector services;
- practice based pharmacists and continuing healthcare who currently operate in every practice and PCN
In addition each PCN will have a range of additional services available to their population which will be operationalised following a transitional process within the MCP. These will include:

- out-patient services for adults and children;
- urgent care centre and primary care out of hours service;
- primary medical services provided under existing GMS/PMS/APMS contracts;
- services commissioned by Dudley MBC’s Office of Public Health including health visiting, family nurse partnership, substance misuse and sexual health services;
- adult social care services (to be phased in)

DO ANY OF THE PCNs HAVE A SPECIALIST PILOT SUCH AS DIABETES, FRAILTY ETC

Yes. Respiratory consultants, diabetologists and psychiatrists have been aligned to the PCN, and we have specific MDT’s for end of life / palliative care. There are also plans for specific MDTs operating for children, involving children’s social care and education and mental health, involving psychiatrists.

WHAT SUPPORT WOULD BE HELPFUL i.e. RESOURCE CAPACITY, BACKFILL FUNDING, DEVELOPMENT TOOLS ETC

If resource capacity were to be made available, it would be used to further develop the MCP model of care which would include:

A Clinical Communications Centre (single point of access)

Business intelligence to advance population health management

Workforce development support to develop system workforce planning across primary and community services

IS THERE ANY COLLABORATION AT AN STP LEVEL TO SHARE AND DEVELOP THE PCN MODEL

Yes. The STP primary care leads meet monthly, share best practice, and agree common approaches to the development and implementation of the GP Forward View (GPFW). The maturity of PCNs and the function of PCNs vary dependent on the place based models of care with each CCG however, there is collaboration in relation to design, implementation and organisational development support required to enable PCNs. Dudley is currently supporting both Walsall and Wolverhampton with the development of their multi-disciplinary/integrated care team models.
THERE ARE COMMON FEATURES OF OUR PCNs

All practices with our PCNs currently

- Operate from the same clinical system (EMIS) and have interoperability between practices to review medical records, book appointments and set tasks. This interoperable IT function is currently used to support the delivery of extended access and PCN based MDT meetings
- Have access to risk stratification, and all GPs are using risk stratification to identify and discuss patients within their practice and PCN MDT meetings
- Have sight of resource use and impact on system performance – using a bespoke Business Intelligence (BI) analysis tool for tracking and addressing performance at practice and PCN level
- Meet on a monthly basis, with their PCN to discuss operational issues with their PCNs
- Memorandum of Understanding agreed and signed two years ago to support the development of the MCP model of care and to agree to work as a partnership to respond to the procurement with NHS provider partners.

ADDITIONAL - HIGHLIGHTS FOR PCN DEVELOPMENT IN 2019/20

- Memorandum of Understanding (MOU) to be developed that will sit as a schedule within the MCP Integration Agreement (IA) – the IA is the agreement that sets out how the practice and the MCP work together, including adherence to the objectives for service integration and the key principles for joint working that underpin the delivery of the MCP clinical model and MCP outcomes framework.
- Development of PCN work force development plans, that contribute and form part of the MCP workforce development plan.
- Introduction of transitional governance arrangements that will enable PCNs to take on the operational management of ICTs.
**DUDLEY CLINICAL COMMISSIONING GROUP**
**PRIMARY CARE COMMISSIONING COMMITTEE**

**Date of Committee:** 22 February 2019  
**Report:** STP - General Practice Forward View Planning Proposals  
**Agenda Item:** 12.0

<table>
<thead>
<tr>
<th><strong>TITLE OF REPORT:</strong></th>
<th>STP - General Practice Forward View Planning Proposals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PURPOSE OF REPORT:</strong></td>
<td>To seek approval for the proposed governance arrangements and suggested areas of planning priorities to be undertaken at an STP level, designed to continue the implementation of the GPFV and meet the requirements for the STP as outlined in the NHS Long Term Plan.</td>
</tr>
<tr>
<td><strong>AUTHOR OF REPORT:</strong></td>
<td>Sarah Southhall - Head of Primary Care (Wolverhampton CCG) &amp; GPFV Programme Director (Black Country STP)</td>
</tr>
<tr>
<td><strong>MANAGEMENT LEAD:</strong></td>
<td>Mrs C Brunt, Chief Nurse</td>
</tr>
<tr>
<td><strong>CLINICAL LEAD:</strong></td>
<td>Dr T Horsburgh, Clinical Executive for Primary Care</td>
</tr>
</tbody>
</table>

**KEY POINTS:**
- The GPFV has been identified by the Black Country and West Birmingham STP as one of the key priority areas where opportunities exist from enhanced collaborative working.
- The NHS Long Term Plan has clear requirements for key deliverables to be produced on an STP footprint rather than through individual CCGs.
- The CCGs have come together to propose a draft Programme Plan and Governance arrangements to deliver both of the above requirements.

**RECOMMENDATION:**
Committee note and approve the plan and the suggested governance arrangements.

**FINANCIAL IMPLICATIONS:**
No financial implications.

**WHAT ENGAGEMENT HAS TAKEN PLACE:**
No engagement issues at this stage.

**ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:**
No conflicts of interest identified in advance.

**ACTION REQUIRED:**
 ✓ Decision
1.0 INTRODUCTION

To seek approval for the proposed governance arrangements and suggested areas of planning priorities to be undertaken at an STP level, designed to continue the implementation of the GPFV and meet the requirements for the STP as outlined in the NHS Long Term Plan.

1. BACKGROUND AND CURRENT SITUATION

1.1. One of the key priorities identified by the Black Country and West Birmingham STP was the continued implementation of the GPFV and the agreement to maximise the opportunities that existed for a co-ordinated Programme Management approach to delivering key components of this at an STP level. Key opportunities include:
   - Retention and Recruitment of the General Practice workforce
   - Sharing best practice and lessons learnt across the GPFV
   - Attracting critical funding (otherwise unavailable at a CCG level) to the region that enables sustainability and improvement of Primary Care services for patients across the STP. An example being the £417k received for Retention Schemes for GPs.

1.2. In addition to this, reporting on elements of the GPFV, assurance returns and more importantly funding opportunities that are increasingly requested/offered by NHSE on an STP footprint all of which require planning and co-ordination in delivery.

1.3. More recently, the NHS Long Term Plan requires key strategic planning documents to be produced at an STP level for Primary Care, the main deliverable being a Primary Care STP Strategy due by September 2019.

1.4. To this end, Primary Care Leads from all the CCGs that make up the STP have come together to suggest key priorities and a proposed governance structure to meet the challenges and opportunities outlined above.

2. KEY PLANNING PRIORITIES

2.1. The priorities have been established using the following principles:
   - Meeting the requirements of the NHS 2019/20 Operational Planning and Contracting preparation document, published in December 2018 and the subsequent NHS Long Term Plan
   - Meeting the assurance requirements placed upon the STP from NHSE
   - Mapping the GPFV plans for all CCGs within the STP against the recommendations made in the GPFV, with a focus on those where opportunities exist for greater collaboration
   - Planning for key risks that have been identified for the region e.g. General Practice workforce recruitment and retention
   - Continually looking to improve services for our population
   - A desire to base projects on evidence to ensure resources are channelled to tackle the right problems and opportunities that exist in the system
   - Discussion and agreement with Primary Care Leads from each CCG within the STP
2.2. The proposed work programme was structured in line with the GPFV chapters. These are visualised in summary format below and each has a working draft detailed plan available on request (detail still being shaped by the Primary Care Leads in line with emerging priorities from NHSE and the Long Term Plan) with a summary critical path attached at Appendix A. The immediate priority areas are highlighted on each table.

2.2.1 Workforce

2.2.2 Workload
2.2.3 Investment and Funding

2.2.4 For Access and Infrastructure chapters the STP Programme will focus on projects that:

- Ensure that new Access NHSE Assurance targets are met e.g. website access, on-line consultations and inter-operability between 111 and Practices all in accordance with National Access Standards
- Establish a GPFV Digital Workstream of the Programme to deliver the digital agenda for the GPFV as defined in the Long Term Plan and to underpin the rest of the Programme. Primary Care Leads will set the direction for this group and receive assurance and reporting on progress.

3. TIMELINES

3.1 The key timelines for the immediate planning horizon are:

<table>
<thead>
<tr>
<th>Key Deliverables/Milestones</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Network Development Plan</td>
<td>28/2/2019</td>
</tr>
<tr>
<td>GP Retention Scheme Intensive Support Site Project Closure and Evaluation</td>
<td>31/3/2019</td>
</tr>
<tr>
<td>General Practice Workforce Strategy Refreshed (includes plans to meet NHSE trajectories, GPs with Extended Roles, General Practice workforce retention and recruitment sustainability plans post March)</td>
<td>30/4/2019</td>
</tr>
<tr>
<td>Primary Care Networks in Place</td>
<td>30/6/2019</td>
</tr>
<tr>
<td>Training Hub Funding Extension Ends</td>
<td>31/7/2019</td>
</tr>
<tr>
<td>Primary Care Strategy Developed and Submitted to NHSE</td>
<td>1/9/2019</td>
</tr>
</tbody>
</table>
1.2 Subject to approval the high level plans and governance processes across all CCGs within the STPs more detailed plans will be produced by the appropriate delivery groups for each piece of work.

4. GOVERNANCE

4.1 The Programme will form part of the Black Country and West Birmingham STP governance structure (see Appendix B), however for decision making purposes the current individual CCG Primary Care governance processes will need to be followed both from a statutory and good practice perspective.

4.2 The existing Primary Care Leads monthly meeting will reshape to provide the following functions in the setting, delivery and assurance of the Programme:-

- Set and monitor progress towards Programme Vision, Success Measures and Outcomes
- Agreeing Programme Plan, Structure and Priorities
- Agreeing Resource Allocation
- Programme Plan Progress Review
- Programme Level Risk and Issue Management
- Finance and Funding of the Programme
- Sign off of STP and NHSE Assurance Reports
- Agreeing escalations to and receiving requests from STP and CCG Governance Processes
- Evaluating Outcomes and Performance against Measures
- Managing Inter-Dependencies with other Programmes and Business As Usual

4.3 This will be the STP Delivery function for the GPFV element of the wider STP Programme (as per Appendix B)

4.4 Project delivery groups will be established as appropriate to deliver the products and milestones of the plan. These will be established with clear terms of reference and will report directly to the Primary Care Leads meeting using well established methods of project management processes. Progress on all aspects of the Programme will also be reported via the newly established STP Project Management Office and will flow the governance processes as outlined in Appendix B.

4.5 Primary Care Leads from each of the CCGs will ensure that regular updates on the Programme are delivered to their own internal existing Primary Care and CCG governance processes.

4.6 It must also be noted that there are also additional governance processes that are required to meet NHSE Assurance – these are also included on Appendix B

5. CLINICAL VIEW

5.1. Clinical views will be sought as part of the development of the STP Primary Care Strategy.

6. PATIENT AND PUBLIC VIEW

6.1. Public consultation will be undertaken as part of the development of the STP Primary Care Strategy.
7. **KEY RISKS AND MITIGATIONS**

7.1. The key risks and mitigating actions that are currently associated with delivery of the Programme are included at Appendix C.

7.2. In terms of the report itself and the specific requirement for an STP Primary Care Strategy to be produced and submitted by 1/9/2019, emphasis needs to be placed on the risk that the timescales bring in that the usual CCG governance routes may need to be followed by virtual means to meet the deadlines and that any Strategy submitted marked as draft, so that the usual processes such as Public Engagement can take place.

8. **IMPACT ASSESSMENT**

*Financial and Resource Implications*

8.1. Outline Impact Assessment for finances and resource implications will be produced as part of the Primary Care Strategy development, due by 1/9/2019.

*Quality and Safety Implications*

8.2 Outline Impact Assessment for quality and safety implications will be produced as part of the Primary Care Strategy development, due by 1/9/2019.

*Equality Implications*

8.3. Outline Impact Assessment for equality implications will be produced as part of the Primary Care Strategy development, due by 1/9/2019.

*Legal and Policy Implications*

8.4. Any foreseen impact on legal & policy implications will be identified during the development of the Primary Care Strategy and whilst implementing the programme of work.

9.0 **RECOMMENDATION**

Committee is asked to:

- Note and approve the plan and the suggested governance arrangements

**Appendices**

- Appendix A - High Level Programme Plan
- Appendix B - Governance Diagram
- Appendix C - Programme Risk Log and Mitigating Actions
APPENDIX A - Black Country and West Birmingham Sustainability and Transformation Partnership (STP) - GPFV Programme High Level Critical Path

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Governance PC Leads</td>
<td>Draft Programme Plan Complete</td>
<td>Plan Prioritisation</td>
<td>CCG x4 Authorisation of High Level Plan</td>
<td>Primary Care STP Workforce Strategy</td>
</tr>
<tr>
<td>2</td>
<td>Workforce</td>
<td>Primary Care STP Workforce Strategy</td>
<td>Training Hub Funding Extension Ends</td>
<td>GPR ISS Completion</td>
<td>Workforce Retention Schemes Sustainability Business Case</td>
</tr>
<tr>
<td>3</td>
<td>Workload and High Impact Actions</td>
<td>Primary/Secondary Care Interface Toolkit Planning</td>
<td>Workshop</td>
<td>Action Plan</td>
<td>Primary Care Network Development Plan</td>
</tr>
</tbody>
</table>

Last Updated: 01/02/2019
GPFV STP Delivery Group (Primary Care Leads)

Task & Finish Groups Aligned to Programme Priorities

GPFV Transformation Group Meeting

GPFV Sub Group meeting

Existing CCG Governance

NHSE Governance

Suggested GPFV Governance Forum

Appendix B – Proposed Governance Diagram
### Description Of Risk

**GP Retention - Sustainability**
Continued risk in the region around the retention of Practice Nurses/Staff as well as a significant number reaching a potential retirement age. This could potentially put Practices at risk of losing workforce capability across the Programme.***

**GP Retention**
The retention schemes do not produce the desired benefits and/or produce poor tangible outcomes, leading to GP retention rates continuing to decrease.

**IGPR**
Due to the delays in the mobilisation phases of the project from NHSE the STP is unlikely to recruit the IGPRs that are currently built in to the NHSE Trajectory - representing 12 for this financial year. This is compounded by lessons learnt from the experience in BSOL.

**Training Hub Procurement**
Delay to reprocurement of Training Hub(s) will result in continuation of a model that is inconsistent in its approach giving rise to variation in delivery across existing CEPNs. If no definite funding for CEPN Networks is allocated to the current contracts then there will be a period of time when Wolverhampton CCG have no CEPN/Training Hub provision and a new provider has successfully completed the procurement process. Additionally there is likely to be a change in CEPN/Training Hub KPIs that may include elements that have previously been covered by the CEPN KPIs. If this happens that there is a risk that the provider may not have sufficient capacity.

**Protected Learning Time**
There is inconsistency across the STP around protected learning time. The risk is around Practice teams having the ability to release staff for training and development opportunities to deliver the increased workforce capability across the Programme.

**Practice Nurse Retention**
There is a risk in the region around the retention of Practice Nursing/Staff as well as a significant number reaching a potential retirement age. This could potentially put Practices at risk.

**STP Consultants**
STP meeting on line consultation targets due to a combination of product issues and slow take up/demand number reaching a potential retirement age. This could potentially put Practices at risk.

**Primary Care Networks**
All CCGs within the STP area do not meet the NHSE criteria for having Primary Care Networks in place by June 2019. This could lead to increased assurance reporting and reputational risk.

**STP Roles - Time Limited**
STP Programme roles are time limited and there is a risk that the Programme will need supporting beyond the current support arrangements.

### Consequence Score and Likelihood Score

<table>
<thead>
<tr>
<th>Likelihood Score</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Rare</td>
<td>Unlikely</td>
<td>Possible</td>
<td>Likely</td>
<td>Almost certain</td>
</tr>
<tr>
<td>Consequence</td>
<td>Catastrophic</td>
<td>Unlikely</td>
<td>Possible</td>
<td>Likely</td>
<td>Almost certain</td>
</tr>
</tbody>
</table>

#### Table 3: Risk scoring = Consequence x Likelihood (L x C)

- **Likelihood Score**
  - Catastrophic: 5
  - Major: 4
  - Moderate: 3
  - Minor: 2
  - Negligible: 1

- **Consequence Score**
  - Financial: 5
  - Reputation: 5
  - Efficiency: 5

- **Actions Required**
  - Low: Acceptable risk, no further action
  - Medium: Monitor situation, may require minor action to reduce risk within service/department affected, may affect other services, risk assessment
  - High: Risk Assessment as a priority, shares with Trust Risk Manager and Responsible Head of Service
  - Extreme: Immediate attention required to identify and solve/minimize actions that can be taken to mitigate risk
TITLE OF REPORT: Primary Care Operational Plan and GP Contract 2019/20

PURPOSE OF REPORT:
- To update on the Primary Care Operational Plan for 2019/20.
- To update on the GP Contract 2019/20 and plans for implementation.

AUTHOR OF REPORT: Mr D King, Head of Membership Development and Primary Care

MANAGEMENT LEAD: Mrs C Brunt, Chief Nurse

CLINICAL LEAD: Dr T Horsburgh, Clinical Executive for Primary Care

KEY POINTS:

Primary Care Operational Plan 2019/20
- The CCG submitted its draft operational plan for 2019/20 to NHS England on the 12th February 2019. This is a requirement of the ‘NHS Operational and Planning and Contracting Guidance for 2019/20’
- The plan incorporates the draft operational plan for primary care for 2019/20 appended to this paper.
- The plan will be reviewed by NHS England with a view to finalising by 1st April 2019.
- The primary care plan will be reviewed, updated and refreshed in accordance as required and reported back to the Committee for approval in April 2019.

GP Contract
- NHS England and the British Medical Association’s (BMA) GP committee have reached an agreement for general practice contract reform for the next five years with the aim of supporting the delivery of the NHS long term plan.
- They have jointly published a new framework for general practice over the next five years to 2023/24: Investment and evolution: A five year framework for GP contract reform to implement The NHS Long Term Plan
- This is the most significant and comprehensive change to the GMS contract since 2004.
- The CCG is well placed and is already meeting, or has plans in place, to meet the requirements of the new GP contract.
- The implications of the GP contract are being reviewed across the CCG and a summary of changes and recommendations will be brought to the Committee in March for consideration.
| RECOMMENDATION: | Note the draft operational plan for primary care, and that a final plan will be presented to Committee for approval in April 2019.  
Note the GP contract is being reviewed and that a paper will be brought back to Committee in March 2019. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>FINANCIAL IMPLICATIONS:</td>
<td>Not applicable at this stage.</td>
</tr>
</tbody>
</table>
| WHAT ENGAGEMENT HAS TAKEN PLACE: | GP member practices  
Primary Care Network (locality) meetings |
| ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE: | No conflicts of interest were declared in advance. |
| ACTION REQUIRED: | ✓ Decision  
Assurance |
1.0 INTRODUCTION

1.1 This report is intended to provide assurance to the Committee that the CCG has produced a primary care operational plan for 2019/20, and that plans are in place to review the GP contract changes.

2.0 PRIMARY CARE OPERATIONAL PLAN

2.1 The CCG submitted its draft operational plan for 2019/20 to NHS England on the 12th February 2019. This is a requirement of the ‘NHS Operational and Planning and Contracting Guidance for 2019/20’

2.2 The plan incorporates the draft operational plan for primary care for 2019/20 – set out in Appendix 1.

2.3 The primary care operational plan is draft, and will be subject to review and amendment between now and the 1st April 2019. The review and amendment will be based on further details that are to be published on the GP contract and feedback from NHS England.

2.4 A final version of the plan will be brought back to the Committee for approval in April 2019.

3.0 GP CONTRACT

3.1 NHS England and the British Medical Association’s (BMA) GP committee have reached an agreement for general practice contract reform for the next five years with the aim of supporting the delivery of the NHS long term plan.

3.2 They have jointly published a new framework for general practice over the next five years to 2023/24: Investment and evolution: A five year framework for GP contract reform to implement The NHS Long Term Plan – set out in Appendix 2.

3.3 This is the most significant and comprehensive change to the GMS contract since 2004. The CCG is well placed and is already meeting, or has plans in place, to meet the requirements of the new GP contract.

3.4 The implications of the GP contract are being reviewed across the CCG and a summary of changes and recommendations will be brought to the Committee in March. Specifically, each area of the GP contract is being reviewed by the following leads

- Primary Care Networks, Daniel King, Head of Membership Development and Primary Care
- Prescribing, Clair Huckerby, Consultant Pharmacist Primary Care Medicines Optimisation
- Quality and Outcomes Framework, Jo Taylor, Primary Care Commissioning Manager
- GMS Contract, Julie Robinson, Primary Care Contracts Manager
- Finance, Phil Cowley, Senior Primary Care Finance Manager
- Information Technology, Paresh Patel, Primary Care IT Manager

4.0 RECOMMENDATION

4.1 The Committee is asked to:

- Note the draft operational plan for primary care, and that a final plan will be presented to Committee for approval in April 2019.
- Note the GP contract is being reviewed and that a paper will be brought back to Committee in March 2019.
Primary care at our heart

The commissioning of our model of care rests upon the unique position of primary care - starting with the person, registered with the practice. The role of the GP is therefore fundamental. They take overall responsibility for the care provided by other services.

In our model, these services include multi-disciplinary teams (MDTs), a wider network of community based and voluntary sector services organised around Dudley’s five Primary Care Networks (PCNs).

Our commissioning of primary care is therefore aligned to our commissioning of the Multispecialty Community Provider (MCP) – to deliver improved health outcomes for our registered practice population through a range of integrated, responsive and innovative primary and community health and care services.

Investment and Evolution: A five year framework for GP contract reform to implement the NHS Long Term Plan

The document published on 31st January by NHSE and the BMA translates the commitments in The NHS Long Term Plan into a five-year framework for the GP services contract.

The Primary Care Commissioning Committee will be reviewing the detail however, our initial assessment of the requirements set out in the document are to a large extent are already being achieved in Dudley as part of our commissioning of the MCP model of care, our Dudley Quality Outcomes for Health Framework (DQOFH), and development of our MDTs and PCNs that are already well established.

Investing in Primary Care

The CCG has for a number of years prioritised and invested in the development of primary care and implementation of our new care model within the MCP. In addition to the £3 per head invested during 2017/18 and 2018/19, the CCG has committed over £650,000 each year into the support, mentoring and training of practices, as well as engagement and development of our PCNs.

In addition to these funds, the CCG has invested further in schemes to reduce the burden of prescribing administration by funding additional pharmacist support into general practices, launching a centralised repeat prescribing function, and commissioning link workers to assist practices in social prescribing.

We will continue to invest in our new model of care and meet the commitments within the long-term plan, retaining the schemes outlined above, committing to continue investing a recurrent £1.50 per head into PCN development and investing a further £300,000 in the expansion of our centralised repeat prescribing team to cover additional practices.
We will be producing a financial plan that sets out our investment in primary care development for approval of the Primary Care Commissioning Committee (PCCC) by March 2019.

**Primary Care Networks**

The MCP model is enabled by the integration of primary care services whereby general practice have more influence and co-ordination for the care provided to their patients by other community services, including multidisciplinary teams. These teams will become part of the wider primary health care team.

In order for general practice to assume this responsibility, GP practices in Dudley have already organised themselves into PCNs.

We have 5 PCNs that we refer to as our ‘localities’. The attached map sets out the configuration of each. They are organised geographically, and serve populations of between 50,000 – 70,000 patients.

**Primary Care Networks and Multidisciplinary Teams**

All practices in Dudley has an MDT. The teams are designed to work to the principles of shared responsibility for shared outcomes for a shared population using a population health management approach. These teams bring together:

- GPs
- Community nurses
- Mental health workers
- Social workers
- Practice based pharmacists
- Voluntary sector services
- Other specialist health services e.g. heart failure, Macmillan etc.
- Consultant outreach

**Primary Care Networks and Integrated Care Teams**

PCNs will have two Integrated Community Teams (ICTs) serving a group of practices with a joint population of approximately 35,000 patients. They will be led from an appointed GP integration lead from one of the practices within the PCN, that co-ordinates the delivery of the MDT services for their population.

All PCNs provide extended access to GP appointments at evenings and weekends – this is co-ordinated and led by a lead practice within each PCN.

The ICTs bring together a group of staff to deal with population health management issues with a PCN. The ICT services operate under the direction of each PCN (with a dedicated GP lead) via the MCP from 1st April 2019. There will be 10 teams (x2 in each PCN) providing:

- Community based physical health services for adults and children;
- All mental health and learning disability services;
- Intermediate care services and NHS Continuing Healthcare
- End of life services;
- Voluntary and community sector services;
- Practice based pharmacists and continuing healthcare who currently operate in every practice and PCN

In addition each PCN will have a range of additional services available to their population which will be introduced in phased way once the MCP is in place. These will include:

- Out-patient services for adults and children;
- Urgent care centre and primary care out of hours service;
- Primary medical services provided under existing General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Personal Medical Service (AMPS) contracts;
- Services commissioned by Dudley MBC’s Office of Public Health including health visiting, family nurse partnership, substance misuse and sexual health services;
- Adult social care services (to be phased in)

**Primary Care Development – General Practice Forward View (GPFV)**

Our GPFV implementation plan describes how we will support and enable the continued development of our model of care.

Our GPFV implementation plan will be updated and refreshed for 2019-20 to ensure that we

- Continue our clinically-led programme of investment in primary care transformation, to ensure that primary care services are safe and sustainable, and able to play a leading role in the successful delivery of the MCP.
- Offer expanded choice and enhanced access to primary care services for our population by expanding roles such as practice based pharmacists.
- Provide training and development to improve the working of MDTs and ICTs, and widen the range of clinical and non-clinical input to those teams.
- Ensure that we take full advantage of the opportunities offered by new technology to drive innovation, underpin integration of services, improve efficiency and empower patients.
- Support and encourage practices in their ongoing efforts to work collaboratively, build effective support and development networks and manage growing demand safely and sustainably.
- Invest in the infrastructure and estate needed to support and promote our ambitions.
- Maximise the benefits and opportunities offered by the adoption of borough wide frameworks (such as Dudley Quality Outcomes for Health).
- Evaluate what we do through constant monitoring, challenge and peer review.

**Primary Care Commissioning – Dudley Quality Outcomes for Health Framework (DQOFH)**
In commissioning primary care, we have replaced the Quality Outcomes Framework (QOF), Local Incentive Schemes (LIS) and Directed Enhanced Services (DES) with the DQOFH.

The DQOFH provides a rationalised set of performance indicators (with the aim of increasing efficiency) alongside an increased focus on care planning and shared decision making for people with long-term conditions (LTCs) (with the aim of increasing effectiveness).

**Aims of the Dudley Quality Outcomes for Health Framework**

- Simplify and rationalise QOF.
- Drive up standards and address unwarranted variation.
- Facilitate holistic management of individuals with LTCs, including increased focus on care planning.
- Focus measures and incentive payments on actions seen as having a strong evidence base.
- Develop outcomes that could be shared between primary and secondary care.

The PCCC will continue to review and refresh the outcomes measures commissioned from primary care through the DQOGH – this will include refreshing and producing

- DQOFH commissioning framework and outcomes
- Participation agreement to enable practices to voluntary participate
- Business rules
- Performance monitoring framework and process

**Primary Care Contracting**

We will maintain our compliance in discharging our delegated commissioning and contracting activities for primary care, assured by our Primary Care Commissioning Committee and external audit.

The PCCC will receive and approve a work plan that will include our approach to

- Primary care commissioning and contracting; (DQOFH and GMS contact reviews)
- Primary care contract and performance management;
- Primary care financial management; and
- Governance of all primary medical care delivery.

The PCCC will participate in external assurance and audit of delegated functions, and produce an annual review related to our delegated commissioning and contracting functions.

**Primary Care Workforce**

The MCP sets out how primary care professionals will increasingly work at different organisational levels and at scale (their own practice, a neighbourhood of practices and across the local health economy). The MCP will open up opportunities in
pathway design, service leadership, education, training and research, or developing areas of specialist clinical interest supported by colleagues from secondary care. These changes will develop a more unified team approach, creating portfolio opportunities to offer more satisfying and rewarding career choices in primary care.

In preparation for the MCP, working with our PCNs, we will

- Undertaken workforce mapping across primary care (and the wider MCP)
- Facilitate the development of a workforce development plan for PCNs, the MCP and the Black Country and West Birmingham Sustainability and Transformation Partnership (STP).
- Ensure that our GPFV implementation plan supports the development of new roles and competency frameworks for use in the MCP

The CCG will contribute to the STP activities by undertaking

- Regular promotion of the Black Country STP as a great place to work including marketing material such as the promotion of portfolio careers across the STP.
- Encouraging practices to participate in a range of other projects associated with GPFV recruitment and the introduction of new roles, in addition to flexible career options for early, mid to late career GPs.
- Undertaking a recruitment programme (including advertising practice vacancies across the STP, working with universities, recruitment events, providing relocation support etc.).
- Continue to undertake and expand engagement activities across the system within primary and secondary care e.g.; learning events, progress updates, sharing learning and best practice, via the primary care-secondary care interface toolkit.
- Sharing our learning on the development of the MCP as the STP continues its transition to an ICS

**Primary Care Engagement**

We will continue our annual programme of GP engagement visits, engaging practices in their commissioning performance and delivery of the Quality, Innovation, Productivity and Prevention (QIPP) programme. We will continue to meet with every practice and seek their views on the development of the integration agreement – the agreement that determines the relationship between the practice and MCP.

We will continue to meet with the GP membership on a monthly basis through our PCN meetings, and bi-monthly with the wider membership events;

We will continue to engage with practice managers on a regular basis at the Dudley Practice Management Alliance to discuss practice management development and the development of General Practice as part of our GPFV implementation plan.

**Engagement with patients**
We will continue to engage directly with the public on matters which are most important to them. This will include holding public meetings in those areas relating to service changes.

Healthwatch continues to work in collaboration with the Primary Care Commissioning Committee to ensure we constantly continue to consider the patient voice in any decisions we make; and we will continue to have engagement with our Patient Participation Groups through our Patient Opportunity Panel as part of our commissioning activities.

**Primary Care and the STP**

We are already working collaboratively with other CCGs within the STP taking consistent approaches to the way in which we commission and develop primary care for example;

- Collaborative workforce planning
- Participating in the STP Intensive Support Site (ISS) on projects to increase the number of GPs retained in the Black Country
- Bidding and securing additional resource to support the training and development of primary care staff
- Joint working with the Black Country training hub to implement our GPFW plans

In 2019-20 we will

- Contribute the development of the STP primary care strategy
- Contribute and lead on specific projects and schemes on behalf of the STP
- Identify areas for a common approach to the commissioning or contracting of services across the STP
- Identify and develop common approaches the governance of delegated commissioning functions across the STP

**Primary Care – Summary of Commitments**

<table>
<thead>
<tr>
<th>Plan</th>
<th>Investments and Evolution: A five year framework for GP contract reform to implement the NHS Long Term Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- The PCCC will review the document published on 31st January 2019 with a view to ensuring that the requirements are achieved specifically;</td>
</tr>
<tr>
<td></td>
<td>- Reviewing and aligning the Dudley Quality Outcomes for Health Framework with the proposed changes to the Quality and Outcomes Framework (QOF)</td>
</tr>
<tr>
<td></td>
<td>- Ensuring that our PCNs are prepared and able to deliver the requirement of the DES by 1st July 2019</td>
</tr>
<tr>
<td></td>
<td>- Ensuring that our GPFW development agenda aligns to the requirements described in the document</td>
</tr>
<tr>
<td></td>
<td>- Working with the MCP transition team and MCP transition board to ensure that the MCP operating model enables the PCNs to achieve investment in primary care workforce</td>
</tr>
<tr>
<td></td>
<td>-</td>
</tr>
</tbody>
</table>
| **Investing in Primary Care** | - We will continue to invest in our new model of care and meet the commitment of the long term plan.  
- We will be producing a financial plan that sets out our investment in primary care development for approval of the Primary Care Commissioning Committee by March 2019. |
| **Primary Care Networks and Integrated Care Teams** | - We are already achieving the requirement of the Long Term Plan in respect of having all practices operating within a PCN.  
- We will supporting the development and implementation of 10 integrated care teams (ICTs) that will become operation across our PCNs from 1st April 2019  
- We will be producing a PCN development plan and local workforce plan which supports the development of the MCP model of care |
| **Primary Care Development – GFW** | - We will review and refresh our GFW implementation plan |
| **Primary Care Commissioning – Dudley Quality Outcomes for Health** | We will review and refresh  
- DQOFH commissioning framework and outcomes  
- Participation agreement to enable practices to voluntary participate  
- Business rules  
- Performance monitoring framework  
- Performance monitoring process |
| **Primary Care Contracting** | - We will review and refresh our programme of General Medical Services (GMS) contractual visits. |
| **Primary Care Workforce** | - We will undertake workforce mapping across primary care (and the wider MCP)  
- Facilitate the development of a workforce development plan for PCNs, the MCP and the STP  
- Ensure that our GFW implementation plan supports the development of new roles and competency frameworks for use in the MCP  
- Contribute to the implementation of the STP workforce development initiatives |
| **Primary Care Engagement** | - We will continue with our rolling programme of practice engagement visits  
- All practices will receive structured visits to  
  o Discuss commissioning performance  
  o Discuss practice involvement and contribution to delivery of QIPP  
  o Consult on the development of the Integration Agreement with the MCP  
- We will ensure that we fulfil our duty to engage and continue to work with Healthwatch, our Patient Participation Groups and Patient Opportunity Panel |
| **Primary Care and the STP** | - We will contribute the development of the STP primary care strategy  
- Contribute and lead on specific projects and schemes on behalf of the STP  
- Identify areas for a common approach to the commissioning or contracting of services across the STP  
- Identify and develop common approaches the governance of delegated commissioning functions across the STP |
|---|---|
Investment and evolution:

A five-year framework for GP contract reform to implement *The NHS Long Term Plan*

31 January 2019
Contents

Foreword and summary ........................................................................................................... 3
1. Addressing the workforce shortfall .................................................................................. 8
2. Solving Indemnity Costs ................................................................................................. 17
3. Improving the Quality and Outcomes Framework (QOF) ........................................... 19
4. Introducing the Network Contract DES .......................................................................... 25
5. Going 'digital-first' and improving access ....................................................................... 33
6. Delivering new network services .................................................................................... 40
7. Guaranteeing investment ................................................................................................ 51
8. Supporting research and testing future contract changes .............................................. 55
9. Schedule of future contract changes and development work ........................................ 57
Annex A: QOF indicator changes ....................................................................................... 60
Annex B: QOF Quality Improvement ................................................................................... 67
Annex C: Network Contract DES Registration Form .......................................................... 87
Annex D: Additional detail on main 2019/20 contract changes ........................................ 90
Annex E: Network Contract DES Workforce Role Descriptions and Outputs ................. 96
Glossary of Terms .................................................................................................................. 103
Foreword and summary

General practice is the bedrock of the NHS, and the NHS relies on it to survive and thrive.

This agreement between NHS England and the BMA General Practitioners Committee (GPC) in England, and supported by Government, translates commitments in The NHS Long Term Plan¹ into a five-year framework for the GP services contract. We confirm the direction for primary care for the next ten years and seek to meet the reasonable aspirations of the profession.

In our discussions we shared five main goals:

- secure and guarantee the necessary extra investment;
- make practical changes to help solve the big challenges facing general practice, not least workforce and workload;
- deliver the expansion in services and improvements in care quality and outcomes set out in The NHS Long Term Plan, phased over a realistic timeframe;
- ensure and show value for money for taxpayers and the rest of the NHS, bearing in mind the scale of investment;
- get better at developing, testing and costing future potential changes before rolling them out nationwide.

Specifically, this agreement:

1. **Seeks to address workload issues resulting from workforce shortfall.**

   Through a new Additional Roles Reimbursement Scheme, Primary Care Networks (PCNs) will be guaranteed funding for an up to estimated 20,000+ additional staff by 2023/24. This funds new roles for which there is both credible supply and demand. The scheme will meet a recurrent 70% of the costs of additional clinical pharmacists, physician associates, first contact physiotherapists, and first contact community paramedics; and 100% of the costs of additional social prescribing link workers. By 2023/24, the reimbursement available to networks amounts to £891 million of new annual investment. Practices will continue to fund all other staff groups including GPs and nurses in the normal way through the core practice contract, which grows by £978 million of new annual investment by 2023/24 and will support further expansion of available nurse, GP and other staff numbers. NHS England will also create and part-fund a new primary care Fellowship Scheme² aimed at newly qualifying nurses and GPs, as well as Training Hubs. Current NHS England recruitment and retention schemes under the General Practice Forward View³ will be extended. Rises in
employer superannuation contributions will be fully funded. We have asked the Government to introduce a partial pension scheme.

2. **Brings a permanent solution to indemnity costs and coverage.** The new and centrally-funded *Clinical Negligence Scheme for General Practice* will start from April 2019. All of general practice will be covered, including out-of-hours and all staff groups. Membership will be free. The scheme is funded through a one-off permanent adjustment to the global sum. Practice contract funding nonetheless rises in 2019/20 by 1.4%, as a result of the overall investments agreed. Future costs of NHS practice under the scheme will be funded centrally, not met individually by practices.

3. **Improves the Quality and Outcomes Framework (QOF).** We are implementing the findings of the QOF Review. 28 indicators, worth 175 points in total, are being retired from April 2019. 74 points will be used to create a new Quality Improvement domain. The first two *Quality Improvement Modules* for 2019/20 are prescribing safety and end-of-life care. 101 points will be used for 15 more clinically appropriate indicators, mainly on diabetes, blood pressure control and cervical screening. The current system of exception reporting will be replaced by the more precise approach of the *Personalised Care Adjustment*. This will better reflect individual clinical situations and patients’ wishes. In 2019, we will review the heart failure, asthma and chronic obstructive pulmonary disease domains. In 2020, we will review the mental health domain for change in 2021/22. Long term Quality Improvement module and indicator development will benefit from the new primary care testbed programme.

4. **Introduces automatic entitlement to a new Primary Care Network Contract.** In *The NHS Long Term Plan*, Primary Care Networks are an essential building block of every Integrated Care System, and under the *Network Contract Directed Enhanced Service (DES)*, general practice takes the leading role in every PCN. The Network Contract is a DES established in accordance with Directions given to NHS England. Eligibility depends on meeting registration requirements. The Network Contract DES supports practices of all sizes, working together within neighbourhoods. Like existing GMS, the Network Contract DES will be backed by financial entitlements. If every network takes up 100% of the national *Network Entitlements* we intend, including a recurrent £1.50/patient support, plus a new contribution to clinical leadership. £1.799 billion would flow nationally through the Network Contract DES by 2023/24. CCGs could also add local investment through *Supplementary Network Services*. We expect 100% geographical coverage of the Network Contract DES by July 2019, so that no patients or practices are disadvantaged. Each network must have a named accountable *Clinical Director* and a *Network Agreement* setting out the collaboration between its members. Together, the Clinical Directors will play a critical role in shaping and supporting their Integrated Care System and dissolving the historic divide between primary and community medical services. A new *Primary Care Network development programme* will be centrally funded and delivered through Integrated Care Systems.
5. **Helps join-up urgent care services.** *The NHS Long Term Plan* envisages Primary Care Networks joining up the delivery of urgent care in the community. Funding and responsibility for providing the current CCG-commissioned enhanced access services transfers to the Network Contract DES by April 2021 latest. From July 2019, the Extended Hours DES requirements are introduced across every network, until March 2021. Following an *Access Review* in 2019, a more coherent set of access arrangements will start being implemented in 2020 and reflected in the Network Contract DES with coverage everywhere in 2021/22. 111 direct booking into practices will be introduced nationally in 2019. As part of these access arrangements, £30 million of additional annual recurrent funding will be added to the global sum from 2019/20. Working with NHS Digital, GP activity and waiting times data will be published monthly from 2021, alongside hospital data. Publication of the data will expose variation in access between networks and practices and we will include a new measure of patient-reported experience of access.

6. **Enables practices and patients to benefit from digital technologies.** NHS England will continue to ensure and fund IT infrastructure support including through the new *GP IT Futures* programme, which replaces the current *GP Systems of Choice*. Additional national funding will also give Primary Care Networks access to digital-first support from April 2021, from an agreed list of suppliers on a new separate national framework. All patients will have the right to digital-first primary care, including web and video consultations by April 2021. All patients will be able to have digital access to their full records from 2020 and be able to order repeat prescriptions electronically as a default from April 2019. A *Review of Out-of-area Registration and Patient Choice* will start in 2019. The rurality index payment and London adjustment will be changed from April 2019 to avoid unwarranted redistribution between different types of provider. To safeguard the model of comprehensive NHS primary medical care, from 2019 it will no longer be possible for any GP provider either directly or via proxy to advertise or host private paid-for GP services that fall within the scope of NHS-funded primary medical services. NHS England will consult in 2019 on expanding this ban on private GP services to other providers of mainly NHS services. In recognition of income loss and workload from subject access requests, £20 million of additional funding will be added to the global sum for the next three years.

7. **Delivers new services to achieve NHS Long Term Plan commitments.** The scale of the investment in primary medical care under this agreement was secured for phased and full delivery of all relevant *NHS Long Term Plan* commitments. The annual increase in funding for the Additional Roles Reimbursement Scheme is subject to agreeing seven national *Network Service Specifications* and their subsequent delivery. Each will include standard national processes, metrics and expected quantified benefits for patients. The specifications will be developed with GPC England as part of annual contract negotiations and agreed as part of confirming each year’s funding. Five of the seven start by April 2020: structured medication reviews, enhanced health in care homes, anticipatory care (with community services), personalised care and
supporting early cancer diagnosis. The other two start by 2021: cardio-vascular disease case-finding and locally agreed action to tackle inequalities. A Review of Vaccination and Immunisation arrangements and outcomes under the GP contract will take place in 2019 and also cover screening. Available by 2020, a new Network Dashboard will set out progress on network metrics, covering population health, urgent and anticipatory care, prescribing and hospital use. Metrics for the seven new services will be included. A national Network Investment and Impact Fund will start in 2020, rising to an expected £300 million in 2023/24. This is intended to help networks make faster progress against the dashboard and NHS Long Term Plan goals. Part of the Investment and Impact Fund will be dedicated to NHS utilisation, which could cover: (i) A&E attendances; (ii) emergency admissions; (iii) hospital discharge; (iv) outpatients; and (v) prescribing. The Fund will be linked to performance and its design will be agreed with GPC England and Government. We envisage that access to the Fund becomes a national network entitlement, with national rules as well as locally agreed elements. Networks will agree with their Integrated Care System how they spend any monies earned from the Fund.

8. **Gives five-year funding clarity and certainty for practices.** Resources for primary medical and community services increase by over £4.5 billion by 2023/24, and rise as a share of the overall NHS budget. This agreement now confirms how much of this will flow through intended national legal entitlements for general practice under the practice and network contracts. GPC England and NHS England have agreed that we do not expect additional national money for practice or network contract entitlements, taken together, until 2024/25. Funding for the practice contract is now agreed for each of the next five years, and increases by £978 million in 2023/24. As a result, DDRB will not make recommendations on GP partner net income. Under this agreement, we assume that practice staff, including salaried GPs, will receive at least a 2.0% increase in 2019/20, but the actual effect will depend on indemnity arrangements within practices. NHSE and GPC have asked the government to ask the DDRB not to make recommendations for salaried GPs for the 2019 pay round. We have further asked the Government to continue to include recommendations on the pay of salaried GPs in the DDRB remit from the 2020 pay round onwards. Recommendations will need to be informed by affordability and in particular the fixed contract resources available to practices under this deal and will inform decisions by GP practices on the pay of salaried GPs. We have asked the Government to ensure that DDRB continues, as usual, to recommend on GP trainees, educators and appraisers. As now, the Government will decide how to respond to DDRB recommendations. A new Balancing Mechanism will, if required, adjust between the global sum and the workforce reimbursement sum in the Network Contract DES, depending on real terms partner pay levels. This will be designed by NHS England and GPC England in 2019. As a corollary of major investment, and to safeguard public trust in the GP partnership model, pay transparency will increase. GPs with total NHS earnings above £150,000 per annum will be listed by name and earnings in a national publication, starting with 2019/20 income. The Government will look to introduce the same pay transparency across other independent contractors in the NHS at the same time.
9. **Tests future contract changes prior to introduction.** A new *testbed* programme will be established to provide real-world assessment. Under this, different clusters of GP practices in Primary Care Networks will each develop or test a specific draft contract change such as a service specification, QOF indicator or QI module. Some clusters will work with innovators to discover promising approaches and develop prototypes. Testing is likely to include rapid cycle evaluation, with assessment of costs and benefits. Each cluster will be commissioned nationally, topic by topic, normally through open calls for practice or network participation. Network participation in research will also be encouraged from 2020/21, given the proven link to better quality care.

This document marks the expansion of a major programme of collaboration between NHS England and the BMA over the next five years. We include a schedule of planned work. We now need to get the further design work and implementation detail right. The profession and patients expect the benefits we intend to bear fruit.

[Signature]

**DR RICHARD VAUTREY**  
GPC ENGLAND CHAIR

**IAN DODGE**  
NHS ENGLAND NEGOTIATING TEAM CHAIR
1. **Addressing the workforce shortfall**

1.1 **By far the biggest challenge facing general practice is that it doesn't have enough people to do the work required.** This is creating unsustainable workload pressures. Helping to fix this problem is our top priority. This five-year plan and funding settlement works towards resolving these issues.

1.2 The causes of the workforce shortfall are many and well-known, including:

- the rising frailty and complexity of patients;

- the growth in population;

- nearly a decade of declining share of NHS investment, prior to NHS England’s establishment in 2013/14;

- the declining average time commitment from GPs struggling to cope with their workload, as well as a new generation of GPs choosing a different work-life balance;

- concern about the level of risk associated with the partnership model, with early and mid-career GPs finding it undesirable\(^6\);

- the lifetime and annual pension caps prompting earlier retirement and reduced time commitments;

- the fall in the proportion of nurses working in primary and community services, as hospital nurse numbers have expanded. This is in the context of an NHS-wide nursing shortfall\(^7\).

**Increasing the numbers of nurses and GPs**

1.3 *The NHS Long Term Plan* recommits to increasing the number of doctors in general practice by a net extra 5,000 ‘as soon as possible’. Much as we would like a bigger number, this would not be credible. The number of new recruits has been increasing\(^8\). But this has been more than offset by the number of GPs leaving the profession or opting for part-time working. 2017/18 saw a marginal net increase, after two years of slight decline\(^9\).

1.4 To help deliver against the extra 5,000 doctors in general practice, **NHS England will now extend the following general practice programmes for the duration of the five year period 2019/20-2023/24:**

- international recruitment, supplementing the UK-trained GP workforce with qualified doctors from EEA and non-EEA countries;
• **retained doctors**, supporting experienced GPs to continue to practice rather than retire\(^\text{10}\);

• **GP retention programmes**, ensuring support is available to retain GPs rather than reduce their commitment or leave the profession;

• **the practice resilience programme**, ensuring continuing support for practices in acute need of help, often as part of a network\(^\text{11}\);

• the **specialist mental health service for GPs** who need help\(^\text{12}\); and

• **the Time for Care National Development Programme**\(^\text{13}\), supporting thousands of practices across the country, often in networks, to make sustainable improvements to the way they work, and help ease workload pressures.

1.5 **Increasing the number of nurses and doctors working in General Practice will be boosted by increased funding for the core GP practice contract,** which rises by £978 million a year by 2023/24 as a result of investments under this agreement.

1.6 The **GP Forward View** committed to increase the number of full time equivalent nurses working in general practice by 1,000. Good progress is being made, with an increase in over 600 between September 2015-18. This will now be further supported by guaranteed placements in primary care for undergraduate nurses, supported by Health Education England; an increase in apprenticeships; and credentialing of the Royal College of Nursing’s Advanced Level Nurse Practitioner\(^\text{14}\). Experienced nurses in primary care who may be considering roles in other settings or retirement will be able to broaden their roles to include nurse education, mentoring, supervision and leadership roles.

1.7 **As recommended by the GP Partnership Review**\(^\text{15}\), **NHS England will also introduce a new voluntary two-year primary care fellowship programme for newly qualified nurses and doctors entering general practice.** This will offer a secure contract of employment alongside a portfolio role tailored, where possible, to the aims of the individual and the needs of the primary care system. This will enable newly qualified nurses to consider primary care as a first destination role, in the knowledge that they will receive support in their early years to become confident in practice and work in supportive multi-disciplinary teams across Primary Care Networks. There is emerging evidence that such approaches will also for example increase the number of GP trainees taking up substantive roles in primary care. On completing their fellowship, these clinicians may be more encouraged to become full partners. The arrangements will be designed in 2019.

1.8 **Working with Health Education England, NHS England will establish primary care training hubs from 2020/21.** These will enable more consistent
provision of training and continuing professional development for primary care staff in the community.

1.9 *The NHS Long Term Plan* commits to a major expansion in the community mental health workforce and integration between physical and mental health. Building on the co-location of IAPT workers in primary care, a significant proportion of community mental health staff will become aligned with Primary Care Networks. This will particularly help older people with mental health problems, dementia and co-morbid frailty, as well as the primary care workforce.

**Pensions**

1.10 The annual allowance cap creates an incentive for GPs to either cut their time commitment to the NHS, or quit the NHS pension scheme altogether, thus leaving themselves and their families without coverage for ill-health retirement or death-in-service. This could be resolved by creating a new ‘partial pension’ option. Under this, GPs could choose to halve the rate at which their pension builds up, and in return pay half rate contributions. *The Local Government Pension Scheme*¹⁶ already has a 50% pension option and we have asked Government to consider this for GPs.

1.11 In December 2018, the Department for Health and Social Care launched a consultation¹⁷ to increase the employer contribution rate from 14.3% to 20.6% from April 2019. For this reason, alongside the five-year settlement for NHS England in June 2018, the Government committed to provide additional funding for the full costs arising from this actuarial revaluation for the NHS in England. General Practice will not have to bear any additional costs.

**Additional roles reimbursement**

1.12 In the absence of sufficient levels of GP and nurse supply, practices have been creating other roles faster than anticipated: over 5,000 extra in the past three years, achieving NHS England’s target two years early.

1.13 Expansion of the multi-disciplinary team will now be given a major boost, through a new reimbursement mechanism within the Network Contract DES. As a means of building capacity, direct reimbursement has distinguished antecedence in the form of the 1965 *General Practice Charter*¹⁸. Proposed by the BMA and implemented in 1966, the *Charter* successfully established nurses and receptionists within general practice through a 70% reimbursement model.

1.14 The *Additional Role Reimbursement Scheme* will now be established as part of the new Network Contract DES. This will provide certainty for newly joining staff and practices alike. The scheme will start from 1 July 2019.

1.15 This scheme is the biggest new investment offered under this agreement. In 2023/24, NHS England will make £891 million available. That equates to
£726,000 new annual funding for a network with an averagely-weighted 50,000 population. This calculation is derived from ONS population growth forecasts applied to registered populations.

1.16 The reimbursement will be recurrent and not subject to any taper. For each of the next five years, the total funding under the scheme will rise substantially to pay for workforce expansion. The scale of that increase will be confirmed through annual contract changes, and is subject to agreeing the seven new national service specifications to support different facets of *The NHS Long Term Plan*, outlined in Chapter 6.

### TABLE 1: INTENDED FUNDING FOR ADDITIONAL ROLE REIMBURSEMENT

<table>
<thead>
<tr>
<th>Year</th>
<th>National total (from July)</th>
<th>Average maximum per 50k typical network</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019/20</td>
<td>£110 m</td>
<td>£92,000</td>
</tr>
<tr>
<td>2020/21</td>
<td>£257 m</td>
<td>£213,000</td>
</tr>
<tr>
<td>2021/22</td>
<td>£415 m</td>
<td>£342,000</td>
</tr>
<tr>
<td>2022/23</td>
<td>£634 m</td>
<td>£519,000</td>
</tr>
<tr>
<td>2023/24</td>
<td>£891 m</td>
<td>£726,000</td>
</tr>
</tbody>
</table>

**Scale and scope**

1.17 The funding for the scheme is intended to create up to an estimated 20,000+ additional posts in five specific different primary care roles. *These five reimbursable roles are clinical pharmacists, social prescribing link workers, physician associates, first contact physiotherapists and first contact community paramedics.* Model role specifications will be published by March 2019 as a guide for networks. Networks will decide the job descriptions of their own staff, and in so doing they will want to bear in mind the new service requirements in the Network Contract DES. These staff are in addition to the additional nurses and GPs that will be funded through the real terms increases in the core GP contract.

1.18 The roles have been chosen by NHS England and GPC England for four pragmatic reasons:

(i) we estimate that we can get enough supply;

(ii) we see strong practice demand;

(iii) the tasks they perform help reduce GP workload, improve practice efficiency and deliver *NHS Long Term Plan* objectives; and

(iv) they are relatively new roles, where it is possible to demonstrate additional capacity, unlike GPs and practice nurses.
1.19 The five roles are becoming more widespread in primary care in different parts of the country, enriching the skill mix of the general practice team and enabling GPs to ‘work at the top of their license’. They will now be established nationwide, and at much greater scale. By 2024, clinical pharmacists, social prescribing link workers, physician associates, first contact physiotherapists and first contact community paramedics will have become an integral part of the core general practice model throughout England – not just ‘wrap around’ support that could instead be redeployed at the discretion of other organisations.

1.20 The scope of the scheme extends gradually. This reflects available supply and funding:

- in 2019 it starts with clinical pharmacists and social prescribing link workers only;
- in 2020 physician associates and first contact physiotherapists are added; and
- in 2021 it also includes first contact community paramedics. Only at this point do enough additional paramedics come out of training; and we want to avoid net transfer from the ambulance service.

1.21 GPC England’s longstanding ambition for every practice is to benefit from having a pharmacist\(^1\). By 2023/24, a typical network of 50,000 patients could choose to have its own team of approximately six whole time equivalent clinical pharmacists: enough to give equivalent effect to that ambition. Alternatively, the network could decide on a higher, or lower number, depending on local context. A dedicated team makes it possible to create varied and tailored roles: undertaking structured medication reviews, improving medicine optimisation and safety, supporting care homes, as well as running practice clinics. Clinical pharmacists should be supervised by a senior clinical pharmacist, and through this model it will be easier to support pharmacist professional and career development at network rather than practice level. We will also bring onto the scheme the pharmacists funded under the existing Clinical Pharmacists in General Practice Scheme\(^2\) and the separate Pharmacists in Care Homes Scheme\(^3\). The latter will involve reimbursing some pharmacy technicians currently funded by CCGs. During 2019, we will explore the practicality of allowing the reimbursement of pharmacy technicians as a part of the pharmacist team, as a complement to clinical pharmacists.

1.22 NHS England and GPC England are committed to making funding available for up to an estimated 20,000+ additional staff across these five groups by 2024, but the actual distribution of the workforce increase across the five roles will depend on the choices that individual networks make, working with their system partners, given the flexibility they will have under their ‘additional roles sum’ and taking into account their existing workforce.
Reimbursement levels

1.23 70% of the actual ongoing salary costs of additional clinical pharmacists, physician associates, first contact physiotherapists and community paramedics - and 100% of the actual on-going salary costs for social prescribing link workers - will be met, up to the relevant maximum amounts.

1.24 By reimbursing 100% of the social prescribing link workers, the NHS is making its full financial contribution to social prescribing and personalised care delivery. Emerging practice suggests that many networks may choose to fund a local voluntary sector organisation to employ the link workers and run the service of behalf of the network.

1.25 The reimbursement proportion will be fixed at these percentages within the new Network Financial Entitlements. The percentages will neither taper nor increase during the next five years. This gives networks maximum confidence to recruit to the full.

1.26 The eligible maximum pay against which the 70% (or 100%) reimbursement will apply is the sum of (a) the weighted average salary for the specified Agenda for Change band\(^22\); plus (b) the associated employer on-costs. It will not include any recruitment and retention premiums that networks may choose to offer. Networks will need, if required, to be able to justify the salary offered to new staff. On-costs will be revised to take account of any pending change in employer pension contributions, if and when these are confirmed. Table 2 sets out the AfC bands for the five groups and the maximum reimbursable amounts for clinical pharmacists and social prescribing link workers in 2019/20. The maximum reimbursement amounts for subsequent years will be confirmed in line with applicable Agenda for Change rates.

### TABLE 2: MAXIMUM REIMBURSABLE AMOUNTS AT 2019/20 LEVELS

<table>
<thead>
<tr>
<th>Role</th>
<th>AfC band</th>
<th>Maximum reimbursable amount in 2019/20 (with on costs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical pharmacist</td>
<td>7-8A</td>
<td>37,810</td>
</tr>
<tr>
<td>Social prescribing link worker</td>
<td>Up to 5</td>
<td>34,113</td>
</tr>
<tr>
<td>First contact physiotherapist</td>
<td>7-8A</td>
<td>N/A – reimbursement available from 20/21</td>
</tr>
<tr>
<td>Physician associate</td>
<td>7</td>
<td>N/A - reimbursement available from 20/21</td>
</tr>
<tr>
<td>First contact community paramedic</td>
<td>6</td>
<td>N/A – reimbursement available from 21/22</td>
</tr>
</tbody>
</table>

Funding extra capacity, not existing workers
1.27 The intention of the scheme is to grow additional capacity through new roles, and by doing so, help to solve the workforce shortage. It is not to fill existing vacancies or subsidise the costs of employing people who are already working in primary care, whether funded by a practice, a CCG or a local NHS provider. **Reimbursement through this route will only be for demonstrably additional people** (or, in future years, replacement of those additional people as a result of staff turnover). This additionality rule is also essential for demonstrating value for money for the taxpayer.

1.28 NHS England will work with CCGs and NHS Digital to establish the baseline for all five groups in March 2019 and how on-going assessment of delivery can be supported. **As part of this agreement, NHS England will expect CCGs to continue any local schemes which fund posts in the five reimbursable roles, and to confirm their plans with their Local Medical Committees.** For example, if a CCG is currently funding the local community provider for a physiotherapist or community paramedic working in a local practice, that local funding continues and cannot be claimed under the new additional role reimbursement scheme.

1.29 The only exception to the ‘additionality’ rule is existing clinical pharmacists reimbursed under either (i) the national Clinical Pharmacists in General Practice scheme, or (ii) the national Pharmacists in Care Homes scheme. Both schemes have tapered funding. Both will be subsumed into the new more generous arrangement.

1.30 **These rules will be reinforced by explicit monitoring and assurance arrangements with payment clearly linked to additional staff recruited. Funding will be released from 1 July 2019 onwards on an actual salary claims basis up to the maximum amount, at the point networks can demonstrate that the additional staff have been recruited.**

1.31 **Each network will be able to decide which provider organisation employs the staff.** This could be a single lead practice, a GP federation, or a community, mental health or an NHS trust (or voluntary sector organisation) if the network and that party agree.
**The Additional Roles Sum**

1.32 **From 2020/21, each network will be allotted a single combined maximum reimbursement sum, covering all five staff roles.** This additional roles sum will be a fair share of the annual national expenditure amounts shown in table 1.

1.33 **Each network’s share will be based on weighted capitation.** The basis for weighting will be confirmed in 2019.

1.34 Networks will be able to claim up to the maximum sum each year, in line with the reimbursement rules set out in paragraphs 1.9-1.30. Every network has a different local starting point and faces different circumstances. And so we are giving networks the flexibility to decide how many of each of the reimbursable staff they wish to engage, within their Additional Roles Sum. This could mean, for example, that in 2020/21, one network chooses to employ more physician associates, but fewer clinical pharmacists. However, the national supply will be limited; and each network will need sufficient of each of the different groups in order to perform the associated national service specifications.

1.35 **GPC England and NHS England will develop and agree detailed guidance for the scheme as part of discussions for the 2020/21 contract.** We will work to ensure that everyone can have confidence in the transaction processing arrangements; in the data and monitoring; in the assurance and audit; and the evaluation.

1.36 **By no later than 2023, we will have undertaken and published a full review of the scheme, to inform future options that could apply from 2024/25 onwards.** Our intention has been to pump-prime these additional roles during the first five years of The NHS Long Term Plan. One possibility is to consider whether there are other additional roles that should be pump-primed in future, and for the 2023/24 funding for these five roles to become a single ‘Network Global Sum’ from 2024/25 onwards. GPC England and NHS England share a bigger ambition for core general practice to expand further, and through Primary Care Networks, become the default footprint of community-based care.

**Introductory arrangements for 2019/20**

1.37 **2019/20 will be an introductory year, with simpler rules, prior to the full scheme taking effect.** Rather than introduce a capitated sum, between 1 July 2019 until 31 March 2020, every network of at least 30,000 population will be able to claim 70% funding as above for one additional whole-time equivalent (WTE) clinical pharmacist and 100% funding for one additional WTE social prescribing link worker. This will deliver by 2020 on the government’s commitment in the loneliness strategy that by 2023 all local systems will have implemented social prescribing connector schemes.
1.38 Beyond 100,000 network size, the 2019/20 reimbursement scheme doubles to two WTE clinical pharmacists and two social prescribers; with a further WTE of each, for every additional 50,000 network population size. Were a single ‘super-practice’, covering 200,000 patients, agreed as a network by its CCG in line with national rules, it would be eligible for four additional of each in 2019/20.

1.39 With agreement from the CCG, the 2019/2020 entitlement could be used to vary between numbers of clinical pharmacists and social prescribers, e.g. a typical network could hire two clinical pharmacists or two social prescribing link workers instead of one of each.

1.40 **Fuller guidance on the introductory scheme for 2019/20 will be developed and issued by March 2019.**
2. Solving Indemnity Costs

2.1 In recent years, the spiralling cost of purchasing professional indemnity cover has not only cast a shadow over the profession, but also contributed to specific NHS problems such as filling out-of-hours rotas.

2.2 Costs were unexpectedly high in 2016/17 and 2017/18. Additional one-off funding of £30m and £60m was made available by NHS England and paid to practices\textsuperscript{23}. NHS England confirms that, based on the evidence, it will provide one-off funding in 2018/19 to meet its assessment of inflation in actual indemnity costs in 2018/19.

2.3 These payments have been important temporary fixes. But the lack of a permanent solution has hindered recruitment and retention. That is one of the reasons why the Government announced in October 2017 its intention to introduce a new state-backed scheme from April 2019\textsuperscript{24}. Solving the indemnity issue has been a top priority for everyone. GPC England and NHS England established a dedicated indemnity sub-group in August 2018 to drive timely progress, to inform the Government’s plans.

2.4 We have now agreed the following:

• the new Clinical Negligence Scheme for General Practice will start from 1 April 2019, operated by NHS Resolution. It will be established through government regulations;

• all NHS GP service providers including out-of-hours provision will be eligible to become members of the Scheme. They will not have to pay a subscription for membership, either now or in future. Instead, the future costs of this scheme will be met by NHS England, through a centrally-held primary care allocation;

• coverage of the scheme will extend to all GPs and all other staff working in delivery of primary medical services, as defined in forthcoming regulations. It will automatically cover contractor and salaried GPs, GP locums, prison GPs, nurses, Allied Health Professionals and all other professional groups delivering those services; and

• it will also cover their wider NHS primary care work, including out-of-hours cover. This will remove the perverse limitation to participation, and serve to ease the out-of-hours participation challenge.

2.5 The purpose of the new state-backed scheme is to solve the indemnity problem, not to deliver at the same time either a reduction in GP pay or a windfall increase. Following extensive discussion, NHS England and GPC England have agreed a one-off permanent adjustment to the global sum figure that takes account of the existing contributions from general practice for
2.6 NHS England and GPC England confirm that the global sum increase in 2019/20 represents the full and fair settling by general practice of their contribution to indemnity costs for future NHS practice.

2.7 The Government and NHS Resolution will provide further details in February 2019 on next steps that practices and professionals need to take to ensure that they are covered after 1 April 2019. Practices and staff will still need to take out separate medical defence organisation cover for professional practice, additional advisory services, and private work.

2.8 Current arrangements for indemnity costs of practice staff vary. Some pay their own indemnity, whilst others have it paid by their practice. What constitutes a fair solution for practice staff will therefore vary and will be a matter for practices to decide. Locums will no longer need to pay indemnity when working for GP practices or networks. The cost of locums for practices should therefore be adjusted accordingly.

2.9 In order to maximise resources going directly into primary care provision, it will be important to analyse and tackle the modifiable underlying causes of financial settlements under the new scheme. To that end, the Government, NHS England, GPC England, and NHS Resolution all commit to further joint work. All parties will also seek to keep under review how well the new NHS Resolution service is working for its new primary care members.
3. Improving the Quality and Outcomes Framework (QOF)

3.1 In 2017, NHS England started the most significant review of the Quality and Outcomes Framework (QOF) since it began in 2004. This involved extensive analysis of the evidence, as well as engagement with practices, voluntary sector organisations and members of the public. Following the 2018/19 contract agreement and with the support of GPC England, the review was published in July 2018\(^\text{25}\).

3.2 The Review concluded that a significant refresh would be desirable, to support a broader definition of high quality care, recognise changes in clinical evidence, and align better with professional values. In England, unlike Scotland\(^\text{26}\) and Wales\(^\text{27}\), the broad consensus has been for evolution of the QOF, rather than its wholesale or partial abolition. This is in line with a Local Medical Committee Conference resolution in 2017.

3.3 The Quality and Outcomes Framework has many aspects that are both valued and valuable. The strong focus on specific biomedical markers is evidence-based, and has demonstrably improved care: most notably, it achieved a 16.6% drop in emergency admissions in the incentivised conditions of asthma, chronic obstructive pulmonary disease, coronary heart disease, congestive heart failure, hypertension, stroke, diabetes and epilepsy\(^\text{28}\). QOF also provides vital core income to cover practice staff pay and expenses.

3.4 Quality achievement can go backwards when indicators are dropped. A recent retrospective analysis of indicators no longer in use showed, for example, that reported hypertension control for under 79s with no co-morbidity dropped by 13.7% in 2014/15\(^\text{29}\). Care is required when making decisions about which indicators to retire and when.

3.5 The QOF also has three notable weaknesses:

- first, it can feel excessively like ‘tick-box medicine’. A better outcome, particularly for people with complex needs, may come from taking a more holistic, personalised and targeted approach;

- second, arrangements for exception reporting are too crude, as well as lacking transparency; and

- third, the scheme has been much slower than it should have been in adapting to the changing evidence base (e.g. to take on board recommendations on cervical screening).

3.6 To implement the Review, and address QOF’s weaknesses, a dedicated NHS England and GPC England sub-group has developed proposals. We have now agreed to introduce a number of significant improvements from April 2019. These improvements are also designed to help secure early progress on clinical priorities identified in The NHS Long Term Plan.
3.7 **QOF implementation guidance will be issued by end March 2019, with full details about the 2019/20 changes.** Associated changes to the Statement of Financial Entitlements will also be completed by end March 2019. Annex A lists all the indicator changes.

**Retiring the least useful indicators**

3.8 QOF currently comprises 559 points. We have agreed that 28 indicators worth 175 points in total – i.e. 31% of the complete scheme - will be retired from April 2019. This follows advice from the QOF Technical Working Group, on the development of an objective indicator assessment methodology. The 28 are ‘low value’ indicators which either: (a) do not now align with national evidence-based guidance; or (b) have poor measurement properties; or (c) are now viewed as a core professional responsibility.

**Recycling points into more clinically appropriate indicators**

3.9 Of these 175 points, 101 points will be recycled into 15 more clinically appropriate indicators.

3.10 The new indicators cover five areas. They are:

- **reducing iatrogenic harm and improving outcomes in diabetes care (43 points).** The changes seek to address the problems with the current ‘one size fits all’ approach: the potential over-treatment of frail patients and under-treatment of patients without frailty. Intensive glucose lowering treatment of Type 2 diabetes in older people is of limited benefit and there is increasing evidence of harm, including severe hypoglycaemia and congestive heart failure, which outweighs potential benefits. In the current indicator set we seek to mitigate against this by incentivising a range of glucose targets. As these are not stratified to patient groups, they risk rewarding under-treatment of younger adults who are at greater risk of the macro and microvascular complications of diabetes. The proposed changes should address this by focusing achievement of lower glycaemic targets upon this patient population. It is anticipated that the resulting improvements in glycaemic control will lead to improved patient outcomes, reduced complications and associated health care utilisation;

- **aligning blood pressure control targets with NICE guidance (41 points).** We have agreed to: (a) reintroduce HYP003 (blood pressure controlled to 140/90 mmHg or less in patients aged 79 years or younger with hypertension), and (b) extend age-stratified targets to patients with coronary heart disease and stroke or transient ischaemic attack (TIA). The benefits of blood pressure lowering treatment for the prevention of cardiovascular disease are well established. A recent meta-analysis identified a significantly reduced risk of major cardiovascular events, including coronary heart disease, stroke and heart failure for every 10mmHg reduction in systolic
blood pressure. These are all significant causes of morbidity, mortality and healthcare utilisation;

- **supporting an age-appropriate cervical screening offer (11 points).** The changes will bring QOF into alignment with National Screening Committee recommendations. They should ensure that women receive age-appropriate advice and care that is determined by the Committee as being the optimal approach to the identification and prevention of cervical cancers. More importantly, the changes ensure that we do not continue to incentivise poor quality care; and will help with earlier cancer diagnosis;

- offering pulmonary rehabilitation for patients with Chronic Obstructive Pulmonary Disease (2 points);

- improving focus on weight management as part of physical health care for patients with schizophrenia, bipolar affective disorder and other psychoses (4 points).

**Introducing the Personalised-Care Adjustment**

3.11 Exception reporting is a necessary feature. But the existing system fails to distinguish between those patients who have not received or been offered care, and those who have done so on the basis of informed choices. As a result, high levels of exception reporting are often unhelpfully perceived to equate to poor quality care.

3.12 To solve this issue, **NHS England and GPC England have agreed to replace the current blunt system of exception reporting with a more precise ‘personalised care adjustment’.** It will also allow practices to differentiate between five different reasons for adjusting care and removing a patient from the indicator denominator:

- **unsuitability** for the patient, e.g. because of medicine intolerance or allergy, or contra-indicated polypharmacy;

- **patient choice,** following a shared-decision making conversation. Other parts of this agreement document outline the additional support to help practices focus on personalising care, and tackling over-medicalisation and over-medication;

- the patient **did not respond** to offers of care – recording of this will change to capture actual invitations sent to patients;

- the specific service is **not available** (in relation to a limited number of indicators only: HF002, AST002, COPD002, DM014 and the new pulmonary rehabilitation indicator); or
newly diagnosed or newly registered patients, as per existing rules.

3.13 A further problem with exception reporting is that some IT systems remove decision-support prompts when the patient is recorded as an exception. As a result, some practices decide to leave exception coding to the end of the year, resulting in increased workload, and associated stress and scrutiny. **We are aiming to reduce the end of year coding burden, by changing the data extraction process** to ensure that the prompts remain available to support opportunistic care, especially when these codes relate to patients not responding to invitations. QOF guidance will also be amended with the aim of improving the quality of invitations for care.

**Focusing on quality improvement**

3.14 QOF is based on quantified target delivery against evidence-based indicators. It is not designed to nurture a broader sense of professionalism and quality improvement, which we know underpins the technical attainment of good care. Previous attempts to tackle this within the QOF have been notably weak and unsuccessful (for example, aspects of the Quality and Productivity Indicators between 2011-14)

3.15 Nonetheless, we wish to empower and support professionals working in primary care to focus on quality improvement and, learning from the current approaches in Scotland and Wales, we have agreed to introduce provision in the QOF to support professionally-led quality improvement cycles, within and between practices. Our purpose is to support activities that are highly valued by patients and professionals, do not easily lend themselves to traditional QOF metrics, and which are expected to improve significantly the quality of care.

3.16 In 2019/20, the remaining 74 points arising from indicator retirement will be used to create two Quality Improvement modules within a new quality improvement domain. NHS England and GPC England have worked with the Royal College of General Practitioners, NICE and the Health Foundation to develop these, and they are attached at Annex B. Each module will be supported by QOF for one year, before being replaced by different topics. **For 2019/20, the modules will cover:**

- prescribing safety. Extensive literature exists on the opportunity to cut errors and adverse drug reactions. Evidence from Scotland suggests that improvements will be sustained beyond the duration of the incentive. And this module will dovetail with at least four complementary changes: (a) the expansion of clinical pharmacists in general practice; (b) the nationally-backed roll-out of the pharmacist-led information technology intervention for medical errors (PINCER or equivalent) by the AHSNs; (c) the drive to tackle polypharmacy for complex patients, including in care homes; and (d) the quality payment scheme for community pharmacy;
• **end-of-life care.** The Royal College of GPs has already been developing a QI module in this area; and we can also benefit from the work undertaken by Macmillan. The current QOF indicator on end of life care, which is being retired, has had limited impact upon patient and carer experience. A less formulaic approach could reap bigger benefits. This is also a neglected aspect of care, which the *NHS Long Term Plan* highlights as ripe for more personalised approaches.

3.17 We anticipate that many CCGs will already be funding schemes to drive improvement in these two areas. If there is duplicative funding, we expect CCGs to reinvest this money in alternative ways, and do so in collaboration with their constituent LMCs.

3.18 **Through a rapid evaluation process, we will seek to learn early lessons from the introduction of the QI domain, to inform its subsequent development.** We will seek to understand four core questions: (a) is it improving patient care? (b) is it valued by practitioners? (c) is it a smart investment, given other possibilities? And (d) should QI investment continue to be channelled through QOF, or would a different approach be better?

**Payment thresholds**

3.19 Payment thresholds for new indicators are based upon NICE recommendations and knowledge of practice performance, for example, as a result of previous activity. In the light of the wider changes to QOF, we have again agreed to defer for 2019/20 only the QOF threshold increases which were due to be implemented in 2014. During 2020, we will undertake further work on the optimal approach to threshold setting, for implementation in 2021/22. This will take account of 2019/20 experience of the personalised care adjustment.

**Further development of QOF**

3.20 The changes described represent significant first steps in implementing the recommendations of the QOF Review. *NHS England and GPC England have agreed to an ongoing programme of indicator review in key priority areas, including heart failure, asthma and COPD care in 19/20, and mental health in 2020/21 for any subsequent changes to be implemented as soon as possible.*

3.21 Through the new testbed programme described in section 9 of this agreement, **we will also aim to develop and test a pipeline of further potential indicators and Quality Improvement modules for national roll-out.** We would welcome additional contributions to developing new QI modules, especially from national voluntary sector organisations.

3.22 Some of these could become available for potential use in the last four years of this five-year agreement. **We have agreed to prioritise development of**
potential QI modules that if well-designed and supported would support the seven service specifications set out in chapter 6.

3.23 Furthermore, an extensive, well-evidenced array of further proven enhancements to QOF could also help position us to make the case for an additional funding boost for primary care in the second five years of the NHS Long Term Plan, based on funding additional QOF points. This would need to be considered as part of future negotiations, alongside other investment choices.
4. **Introducing the Network Contract DES**

4.1 Joint working between practices is nothing new. Recent GP interest has focused on joint provision through GP federations or Primary Care Networks (PCNs). This draws on successful past experience: notably, the out-of-hours GP co-operative movement, which rapidly flourished after the 1995 national contract deal.

4.2 In *The NHS Long Term Plan*, Primary Care Networks (PCNs) become an essential building block of every Integrated Care System, and under the *Network Contract DES*, general practice takes the leading role in every Primary Care Network. This will mean much closer working between PCNs and their Integrated Care System, not just their Clinical Commissioning Group. CCGs are becoming leaner, more strategic organisations, with commissioning arrangements simplified and this will typically involve a single CCG for each ICS area.

4.3 This chapter focuses primarily on the Network Contract DES for general practice, but the Primary Care Network concept is wider. It is intended to dissolve the historic divide between primary and community health services. PCNs are about provision not commissioning, and are not new organisations.

**Purpose**

4.4 By October 2018, 88% of practices in England had chosen to join or lead a Primary Care Network, based on CCG returns. Motivations vary and include:

- **stability.** Many practices have faced increased pressure and being part of a Primary Care Network may be able to help avoid a practice closure, obviating the need to consider alternative provision, including possible procurement. We intend the PCN model as a way of helping GP partnerships survive and evolve over the coming decade, and provide a means of mutual support for better workload management;

- **different roles.** It is easier to create more varied GP and nurse roles for 30-50,000 patients than 8,000. Large enough to run a full multi-disciplinary team, the Primary Care Network still operates on a human scale, with clinicians able to know each other;

- **investment.** By creating the Primary Care Network as a dedicated joint investment and delivery vehicle, the profession is able to offer services that the NHS couldn’t reasonably ask of every individual practice;

- **better health and care.** The Primary Care Network is the natural unit for integrating most NHS care. Collective general practice can become the footprint on which other NHS community-based services can then dock. And by serving a defined place, the Primary Care Network brings a clear geographical locus for improving health and wellbeing; and
• **community leadership.** Primary Care Network Clinical Directors will provide strategic and clinical leadership to help support change across primary and community health services.

**A new Network Contract DES for Primary Care Networks**

4.5 Initial investment in Primary Care Networks has been variable, uncertain, and modest. That changes with the Network Contract. It goes live from 1 July 2019. Network resources are set over a five year funding period of the *NHS Long Term Plan.* By 2023/24, the Network Contract is expected to create national entitlements worth £1.799 billion, or £1.47 million for a typical network covering 50,000 people, in return for phased and full implementation of all relevant *NHS Long Term Plan* commitments. Of this £1.235 billion is new investment. The remaining £564 million is a combination of enhanced access, the extended hours DES, and £1.50 a head support in cash rather than in kind. The £1.799 billion is before adding supplementary local CCG investment for integrated primary and community care.

4.6 **The Network Contract will be a very large Directed Enhanced Service (DES).** As a DES, it is an extension of the core GP contract, not literally a separate contract. It is established in accordance with Directions given to NHS England. This compels CCGs (through delegated functions from NHS England) or NHS England to offer the Network Contract DES to all practices. The commissioner of the Network Contract DES is therefore the CCG in nearly all instances.

4.7 Eligibility applies to all existing and future holders of in-hours (essential) primary medical services contracts. This includes General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS).

4.8 **The Network Contract DES has three main parts:**

- first, the national **Network Service Specifications.** These sections set out what all networks have to deliver. National investment and services grow in tandem;

- second, the national schedule of **Network Financial Entitlements,** akin to the existing Statement of Financial Entitlements for the practice contract. National entitlement increases financial certainty for everyone. Alongside these entitlements come clear transparency requirements, including for subcontracting arrangements;

- third, the **Supplementary Network Services.** CCGs and Primary Care Networks may develop local schemes, and add these as an agreed supplement to the Network Contract, supported by additional local resources.
Preparatory work to go live in July 2019

4.9 GPC England and NHS England are committed to 100% geographical coverage of the Network Contract DES by the Monday 1 July 2019 ‘go live’ date. Close working is needed between Clinical Commissioning Groups and Local Medical Committees to help ensure this goal is met.

Registering for the Network Contract DES

4.10 To be eligible for the Network Contract DES, a Primary Care Network needs to submit a completed registration form to its CCG by no later than 15 May 2019, and have all member practices signed-up to the DES. The form is attached at Annex C. It asks for six factual pieces of information:

(i) the names and the ODS codes of the member practices;

(ii) the Network list size, i.e. the sum of its member practices’ registered lists as of 1 January 2019;

(iii) a map clearly marking the agreed Network area;

(iv) the initial Network Agreement signed by all member practices;

(v) the single practice or provider that will receive funding on behalf of the PCN; and

(vi) the named accountable Clinical Director.

4.11 Many PCNs will find it easy to meet these requirements. For others, significant discussion may be needed during the first quarter of 2019.

4.12 CCGs are responsible for confirming that the registration requirements have been met by no later than Friday 31 May 2019. For the small number of CCGs without delegated primary care commissioning, the task remains with the NHS England local team. As part of confirming its support, the CCG must secure an explicit pledge of support from the leadership of the local Integrated Care System/Sustainability and Transformation Partnership. NHS England Regional teams will need to agree departures from the requirements in exceptional circumstances.

4.13 Rather than approve each Network Contract one at a time, all the Network Contracts within a single CCG will be confirmed at the same time. This is to ensure that both: (a) every constituent practice of a CCG, and (b) 100% of its geographical area, are included with Primary Care Networks. Taken together, the Network boundaries within a CCG must always fully cover the CCG’s own boundary.
4.14 Once the registration requirements are met and GMS/PMS/APMS contracts have been varied to include the DES, the Primary Care Network can start receiving national investment from 1 July 2019.

Timetable for introduction

4.15 The timetable for introducing the Network Contract DES is set out in table 3 below:

**TABLE 3: TIMETABLE FOR NETWORK CONTRACT DES INTRODUCTION**

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-Apr 2019</td>
<td>PCNs prepare to meet the Network Contract DES registration requirements</td>
</tr>
<tr>
<td>By 15 May 2019</td>
<td>All Primary Care Networks submit registration information to their CCG</td>
</tr>
<tr>
<td>By 31 May 2019</td>
<td>CCGs confirm network coverage and approve variation to GMS, PMS and APMS contracts</td>
</tr>
<tr>
<td>Early Jun</td>
<td>NHS England and GPC England jointly work with CCGs and LMCs to resolve any issues</td>
</tr>
<tr>
<td>1 Jul 2019</td>
<td>Network Contract DES goes live across 100% of the country</td>
</tr>
<tr>
<td>Jul 2019-Mar 2020</td>
<td>National entitlements under the 2019/20 Network Contract start:</td>
</tr>
<tr>
<td></td>
<td>• year 1 of the additional workforce reimbursement scheme</td>
</tr>
<tr>
<td></td>
<td>• ongoing support funding for the Clinical Director</td>
</tr>
<tr>
<td></td>
<td>• ongoing £1.50/head from CCG allocations</td>
</tr>
<tr>
<td>Apr 2020 onwards</td>
<td>National Network Services start under the 2020/21 Network Contract DES</td>
</tr>
</tbody>
</table>

(i) Member practices

4.16 The success of a Primary Care Network will depend on the strength of its relationships, and in particular the bonds of affiliation between its members and the wider health and social care community who care for the population. The main reason NHS England and GPC England are backing Primary Care Networks now is because they have emerged from a practice-led process.

4.17 Equally, an entirely ‘bottom-up’ Primary Care Network formation may not generate a solution that works for absolutely every practice, right across the country. In some CCGs, marginal adjustment to PCN membership and boundaries may prove necessary. We do not want a ‘two-tier’ system, and this would be contrary to NHS England’s wider duties. We cannot leave a small
number of practices and their patients behind, excluded from joining a Primary Care Network and the benefits of investment and new services.

4.18 **Practice rights, plus CCG obligations, will help generate 100% coverage.** Every practice will have the right to join a Primary Care Network in its CCG and have a right to participate in the Network Contract DES. Akin to an additional service, a *Network Participation Practice Payment* will start in 2019 and will be a practice entitlement. A typical practice will receive over £14,000 each year from April 2019, in return for their initial and then continued active participation in a Primary Care Network as demonstrated by signing up to the Network Contract DES by 1 July 2019 and their subsequent participation. CCGs, working with LMCs, must ensure all practice lists are covered by a Primary Care Network in their area for the provision of network services.

4.19 In the highly unlikely event that a practice doesn’t want to sign-up to the Network Contract DES, its patient list will nonetheless need to be added into one of its local Primary Care Networks. That PCN then takes on the responsibility of the Network Contract DES for the patients of the non-participating practice through a locally commissioned agreement. For those patients, it receives all the Network Financial Entitlements, and it delivers the Network Service Specifications as well as Supplementary Network Services.

4.20 The arrangement described in paragraph 4.19 is a necessary backstop. We neither expect nor wish to see it widely used. GPC England and NHS England will work together to support Local Medical Committees and Clinical Commissioning Groups resolve difficult issues.

(ii) **Network list size**

4.21 **A Primary Care Network will typically serve a population of at least 30,000 people.** It needs critical mass to do its job. Low population density across a large rural and remote area could be a legitimate reason for a slightly smaller network list size. That is likely to be the only permissible exception to the 30,000 population rule.

4.22 **A Primary Care Network will not tend to exceed 50,000 people.** Operating on a small-enough scale to make relationships work is an essential facet of the ‘Primary Care Home’ sites38, whose experiences have informed these plans. 50,000 is a suggested upper level, not a strict requirement. Some individual practices are already bigger. If a large ‘super-practice’ (of say 200,000 patients) meets all the other registration requirements, it can serve as a single very large Primary Care Network. In reality, it will be organising itself into say 4 separate neighbourhood teams, each covering a mean of 50,000 people. But it would create extra bureaucracy to require each of these internal teams to register as a separate network.

(iii) **The ‘Network Area’**
4.23 Each Primary Care Network must have a boundary that makes sense to: (a) its constituent practices; (b) to other community-based providers, who configure their teams accordingly; and (c) to its local community, given it marks the extent of PCN accountability for the health and wellbeing of a defined place. While it is possible that a single geography could be served by more than one PCN (building on current multi-practice arrangements) most areas are likely to have a single PCN. Through the registration process, all the ‘Network Areas’ will be agreed with the local CCG at the same time. The CCG does this on behalf of, and with the agreement of, the local Integrated Care System (ICS) or Sustainability and Transformation Partnership (STP). Subsequent changes to network areas will require CCG approval. Boundaries will require active support from both the local CCG and NHS England.

4.24 Normally a practice will only join one network. It is likely that most network areas will not overlap, but this is not an absolute rule: for example a large town of 100,000 population could have two different 50,000 networks operating on exactly the same footprint. They would have to collaborate together on wider place-based goals. And a practice’s catchment area may continue to span more than one network, just as it can currently span across more than one CCG (or across into Wales or Scotland).

4.25 The establishment of networks could have implications for the existing rules for example on practice boundaries, list closure and ‘patient assignment’. NHS England and GPC England will consider further in 2019.

(iv) The Network Agreement

4.26 All Primary Care Networks will have a Network Agreement, even those with one large practice. This is because the Network Agreement is both the means by which the Primary Care Network sets out its collective rights and obligations as well as how it will partner with non-GP practice stakeholders. It is needed for the PCN to claim its financial entitlements (collectively, rather than as individual practices) and deliver national and local services to its whole Network list and area. Delivery and achievement of the contract requirements will depend on collaborative working by network members.

4.27 The Network Agreement strengthens the collaboration between all constituent practices. Like the partnership agreement in a GP practice, it is the vehicle under which constituent members agree how they work together and share resources and responsibilities. In order to meet the terms of the Network Participation Practice Payment, all practices must be active participants.

4.28 The Network Agreement is also the formal basis for working with other community-based organisations. A Primary Care Network cannot exist without its constituent practices, but it membership and purpose goes much wider. The NHS Long Term Plan sets out a clear ambition to deliver the ‘triple integration’ of primary and specialist care, physical and mental health services, and health with social care. The Primary Care Network is a foundation of all
Integrated Care Systems; and every Integrated Care System will have a critical role in ensuring that PCNs work in an integrated way with other community staff such as community nurses, community geriatricians, dementia workers, and podiatrists/chiropodists. Collaboration arrangements with other local organisations including community health providers will form a distinct part of every Network Agreement.

4.29 The Network Agreement must be signed by all constituent GP practices. A national template version will be mandated to reduce avoidable legal and transaction costs. Jointly developed by GPC England and NHS England, it will be available by March 2019. It will include a patient data-sharing requirement, in order to support safe and effective delivery of patient care. The network will also be required to share its non-clinical data within the network and its CCG, to support network analysis or assessment of compliance of the requirements of the contract.

4.30 Performance of the contract requirements will depend on collaborative working between all practices in a network, just as the introduction of QOF in 2004 called for collaborative working between all clinicians in a practice. A core duty of every network will be to deliver all network services equally effectively across all constituent practices, so that no patients are disadvantaged. To this end, every practice will need to meet any local network protocols that are developed and included in the Network Agreement.

(v) Delivery model for the Network Contract DES

4.31 Under the Network Contract DES, only the individual GMS, PMS and APMS contract holders (offering essential services) have the legal right to sign up, but it is the PCN as a whole that becomes responsible for delivery.

4.32 It is for each PCN to decide its delivery model for the Network Contract DES. It could be through a lead practice, GP federation, NHS provider or social enterprise partner.

4.33 Payment systems will be amended to take account of the Network Contract DES for 20/21, but some manual claims processes will be required for 19/20.

4.34 A CCG cannot register itself to be, or host, one or more Primary Care Networks.

(vi) The Clinical Director

4.35 A Primary Care Network must appoint a Clinical Director as its named, accountable leader, responsible for delivery.

4.36 Together, the Clinical Directors will play a critical role in shaping and supporting their Integrated Care System. They will help ensure the full engagement of primary care in developing and implementing local system plans to implement the NHS Long Term Plan. These local plans will go much further than the
national parts of the Network Contract DES in addressing how each ICS will achieve the triple integration.

4.37 In recognition of the importance of this role and as a contribution to the costs, we have agreed that each Network will receive an additional ongoing entitlement to the equivalent of 0.25 FTE funding per 50,000 population size. The amount will vary in proportion to network list size. The legal entitlement under the Network Contract DES starts from 1 July 2019.

Primary Care Network support

4.38 Primary Care Networks will benefit from five categories of external support:

(i) Clinical Director support funding as described above;

(ii) Primary Care Networks will also be guaranteed a cash payment of £1.50 per registered patient. From 1 July 2019, this will become a Network Financial Entitlement and will be based on the agreed network list size (based on practices’ registered lists) as of 1 January each year. This payment is a recurrent extension of the existing £1.50 per head support scheme, which was set out in the December 2018 NHS planning guidance\(^\text{39}\). It is a contribution to network effectiveness. As they do now, CCGs will continue to fund this out of their general CCG allocations, rather than the specific NHS England primary medical care allocation. Taken with the Clinical Director together, the two funds combine to create a £2.19 per head fund each year (£2.01 in 19/20), equating to over £109,000 for a typical 50,000 population network each year;

(iii) many CCGs also provide support in kind for their Primary Care Networks, e.g. through seconding and paying for staff to help with particular functions. Devolved support to PCNs is likely to increase as CCGs evolve, and this local help and assistance will be an important factor in their success;

(iv) during 2019, NHS England will establish a significant new national development programme for PCNs, working with Integrated Care System leaders and national bodies including GPC England, the Royal College of GPs, the National Association of Primary Care and the NHS Confederation Community Network; and

(v) the new NHS Chief People Officer will ensure there is a strong focus on supporting and developing future generations of Primary Care Network Clinical Directors as part of the national work on NHS leadership development.
5. Going ‘digital-first’ and improving access

IT infrastructure

5.1 NHS England will continue to ensure and resource IT infrastructure for general practice via the GP IT Operating Model\(^40\). The next version will be developed with GPC England and the Joint General Practitioners Information Technology Committee (JGPITC) by March 2019. It will include: (i) ‘GP2GP’ functionality; (ii) system standards; (iii) standards for digitisation of care records; (iv) cyber security; and (v) that investment decisions take account of CCG-led ‘maturity assurance’ of digital primary care.

5.2 **GP IT Futures** will replace the current GP Systems of Choice (GPSoC) framework from December 2019. GP IT Futures has four goals:
- to provide clinically safe and useful digital and data services for patients and general practice;
- to provide real-time and secure access to data for patients and NHS users;
- to allow interoperability between systems, underpinned by common standards;
- to allow better comparison of activity and outcomes.

5.3 Through their Integrated Care Systems, NHS England will also ensure that predictive analytical tools are available to Primary Care Networks. These will help them identify those groups of people who are most at risk of adverse health outcomes and increasingly predict which individuals are most likely to benefit from different health and care interventions. This is an important enabler for the new Anticipatory Care requirements outlined in chapter 6.

5.4 Additional annual global sum funding of £20 million for the next three years will support practices to manage Subject Access Requests. This recognises loss of charging income and the additional burdens arising from the introduction of the General Data Protection Regulations. The extra funding ends in 2022, by when three changes will have happened that remove the burden on subject access requests: (i) the digitalisation of Lloyd-George paper records is completed; (ii) patients have access to these full digital records; and (iii) DHSC guidance makes clear that patients or their representatives can now access all the necessary information directly.

5.5 In addition, CCGs will be responsible for offering a Data Protection Officer (DPO) function to practices in addition to their existing DPO support services, whether by the CCG directly or through its commissioning support service. Appointing a DPO remains a practice’s legal responsibility, but this arrangement will be more efficient for the NHS as a whole.
Introducing digital-first primary care across England

5.6 The best way of digitising primary care is to help existing practices. That’s why The NHS Long Term Plan announced that a new centrally-funded programme will create a framework for digital suppliers to offer their platforms on standard NHS terms. The framework will be available for use in 2021. Programme details will be developed in 2019.

5.7 All patients should have access to digital primary care services, as rapidly as possible. The new national support programme will help. A number of different digital models are rapidly emerging across England, and are being well received by practices and patients alike. Used well, these can also help alleviate workload challenges facing practices. For example, digital consultations can be more efficient for certain patients, thus helping free up time for more complex patients. Some digital models also offer practices the opportunity to buy-in additional clinical capacity.

5.8 Digital primary care has the potential to improve access, quality and outcomes, including through better data, more accurate diagnosis, and support tools for patients. For many patients, digital will become their channel of choice when interacting with the NHS. This is likely to be particularly true of 16-25 year olds. Increasingly they forgo traditional GP appointments. Progress on digital delivery will be important to maintain social solidarity behind the general practice model, and contract requirements will be updated annually as part of wider contract negotiations, to reflect advances in technology and delivery of the support promised in this agreement.

5.9 NHS England will work with Universities UK on developing digital primary care support for students. We will include a focus on mental health.

Specific digital improvements

5.10 NHS England and GPC England have agreed eight specific improvements, backed by agreed contract changes, in areas where it is realistic to make early progress, given available functionality:

(i) all patients will have the right to online and video consultation by April 2021;

(ii) all patients will have online access to their full record, including the ability to add their own information, as the default position from April 2020, with new registrants having full online access to prospective data from April 2019, subject to existing safeguards for vulnerable groups and third party confidentiality and system functionality;

(iii) all practices will be offering and promoting electronic ordering of repeat prescriptions and using electronic repeat dispensing for all patients for whom it is clinically appropriate, as a default from April 2019;
(iv) all practices will ensure at least 25% of appointments are available for online booking by July 2019. This is staging post towards a shared ambition that all patients should have the maximum possible access to online appointment booking. NHS England will launch a public campaign in 19/20 to raise awareness of the ability to book appointments online. Subject to systems capability, where patients wish, and as part of concluding the NHS 111 call, NHS 111 could book into these appointments on their behalf where that is appropriate, rather than requiring patients to do so in a separate process;

(v) whilst a practice leaflet remains important, to recognise the changing habits of patients, all practices will need by April 2020 to have an up-to-date and informative online presence, with key information being available as standardised metadata for other platforms to use (for example the Access to Service Information (A2SI) Directory of Services Standard);

(vi) all practices will be giving all patients access online to correspondence by April 2020, as the system moves to digital by default (with patients required to opt-out rather than in);

(vii) by April 2020, practices will no longer use facsimile machines for either NHS or patient communications; and

(viii) from October 2019, practices will register a practice email address with MHRA CAS alert system and monitor the email account to act on CAS alerts where appropriate; notify the MHRA if the email address changes to ensure MHRA distribution list is updated; and register a mobile phone number (or several) to MHRA CAS to be used only as an emergency back up to email for text alerts when email systems are down.

5.11 With appropriate governance in place recognising patients’ preferences, practices will be expected to share data for digital services as outlined in the NHS Long Term Plan, like the NHS App and including contributing data to Local Health and Care Record initiatives as they come online to support information sharing with other services, in line with LHCR expectations for timeliness of data sharing.

5.12 As a critical enabler of the Personalised Care service specification outlined in chapter 6, practices will also have the critical role in creating and updating care plans for all appropriate patients, in as near to real-time as possible, to the Summary Care Record and to Local Health and Care Records when they are available. This will enable patients, their carers and professionals involved in their care are able to see the same information.

Fair payment for digital-first delivery
5.13 A founding principle of the NHS is patient choice of practice with which to register. Funding follows, as a patient moves from one practice to another. The emergence of digital-first providers, who directly register patients, raises the question of whether the consequential redistribution of the general practice funding pot is fair. In July 2018, NHS England started a public engagement process on this by asking some specific questions to inform subsequent contract discussions with GPC England\(^41\).

5.14 **Practice funding will be revised to improve fairness.** As first steps, two changes will be made in 2019/20 to the distribution of primary care resources:

(i) the rurality index payment will be amended to apply to patients living within a practice catchment area only, rather than to all patients. This is to better reflect costs; and

(ii) the London adjustment will be amended to apply to patients resident in London, rather than registered in a London-based practice.

5.15 These changes are not intended to reduce funding nor determine overall funding levels. NHS England and GPC England will not make any further changes to the Carr-Hill funding formula in 2019-20 to provide stability to practices.

5.16 **In 2019 NHS England will further analyse and review the current 46% year one premium for registering new patients, for potential change in 2020/21.**

5.17 **In 2019, NHS England will also undertake a wider review of out-of-area registration arrangements and patient choice of digital-first primary care.** The out-of-area rules were originally set up to allow a relatively small number of patients to choose to register with a practice in a more convenient location than their home address (for example, for commuters to register near where they work). But the rules were not designed with digital registration in mind, and they need to be revisited.

5.18 In undertaking the review, NHS England will work closely with patients, interested providers, and GPC England. The review has four goals:

(i) to ensure that digital-first models can have appropriate links with other local services;

(ii) to develop appropriate mechanisms for allowing patient choice of digital-first practices and meet *The Long Term Plan* commitment that all patients will have a new right to choose a digital-first provider;

(iii) to avoid reducing flexibility for those patients who benefit from the current rules; and
to maintain the integrity of essential NHS systems including financial allocations to CCGs.

Protecting the comprehensive model of NHS primary care

5.19 This agreement reaffirms our commitment that primary medical care will always remain a fully comprehensive NHS service, free at the point of use. And so from 2019 it will no longer be legal for any NHS GP provider – either directly or via proxy to advertise or host private paid for GP services that fall within the scope of NHS-funded primary medical services. NHS England will consult on expanding this specific ban on the provision of paid-for GP services to other providers of mainly NHS services.

Joining-up the urgent care system

5.20 In parallel with digital access, the emergence of Primary Care Networks provides an opportunity to bring more coherence to the way extended access is currently provided.

5.21 By April 2021 we intend that the funding for the existing Extended Hours Access DES and for the wider CCG commissioned extended access service will fund a single, combined access offer as an integral part of the Network Contract DES, delivered to 100% of patients including through digital services like the NHS App.

5.22 NHS England will work with stakeholders including GPC England to evolve and implement a single coherent access offer that PCNs will make, for both physical and digital services. This will deliver convenient appointments ‘in hours’, reduced duplication and better integration between settings such as 111, urgent treatment centres and general practice. The review will start in 2019, for full implementation by 2021/22 but we expect local Integrated Care Systems and their Primary Care Networks to go faster and we encourage them to do so. An expanded role for PCNs in running urgent care in the community will be made easier by the flexibility for CCGs to add Supplementary Network Services to the new Network Contract, on a voluntary basis, described in section 4. It could also see networks benefit from payments reflecting their impact on A&E attendances, as part of the new Network Investment and Impact Fund described in chapter 6.

5.23 The access review has four goals:

(i) learn from the existing GP extended hours and enhanced access schemes, including evidence of the costs of service provision;

(ii) take account of The NHS Long Term Plan commitments to improve urgent care in the community and ensure it is joined up, including for example how PCNs work with Urgent Treatment Centres and GP streaming services provided in A&E;
(iii) seek to improve patient reported access and reduce variation in experience of long waits; and

(iv) take account of digital advances, so that physical and digital access are considered together including by delivering via services such as the NHS App.

5.24 The funding available through the Network Contract DES for improving access amounts to £454 million a year in 2021/22, in addition to £30m added to global sum recurrently through the practice contract. The £454m comprises £367m from the Improving Access to General Practice programme42, and £87m transferred in from the Extended Hours Access DES.

5.25 Many of the enhanced access services are currently provided across more than one PCN. Their transfer into the Network Contract DES will need joint working across PCNs to deliver at the right scale. Transition will begin on 1 July 2019. Instead of allowing the Extended Hours Access DES to draw to a close, removing £87m a year from general practice contract funding, we have agreed to transfer the Extended Hours Access DES requirements and existing funding to the Network Contract DES from July 2019 until it becomes part of the funding for the combined access offer in April 2021. The DES requirements will be delivered to 100% patients in every PCN, rather than those of the 75.7% of practices currently participating so that an average network with a population of 50,000 would need to provide 25 hours extended access per week, shared between morning, evening and weekends. All extended hours slots would, as now, need to be delivered by the constituent practices of the network.

5.26 To reflect the increased population coverage of the extended hours access requirements, funding will also increase accordingly. We have agreed that this takes the form of recurrent investment of £30m per annum (in 2019/20) in the practice global sum, which also recognises the introduction of 111 direct booking.

Joining up with 111

5.27 The NHS Long Term Plan commits to joining up the NHS urgent care system so that it works better for everyone. The North-East 111 pilot has shown that many patients who would normally be advised to attend general practice for minor ailments, or urgent repeat medicines, can be successfully diverted to community pharmacies43. NHS England will now explore how these services can be rolled out nationwide as rapidly as possible, as part of negotiations led by the Department of Health and Social Care with the Pharmaceutical Services Negotiating Council (PSNC) on the Community Pharmacy Contractual Framework (CPCF). These potential changes, if implemented, will have an impact in helping to reduce in-hours and out-of-hours workload for GPs. In parallel, NHS England will also test models of redirecting
patients who present in general practice to community pharmacy, described in *The NHS Long Term Plan* as a ‘pharmacy connection scheme’.

5.28 111 also ensures that only patients who genuinely need to attend A&E or use the ambulance service are advised to do so, directing patients to other healthcare settings where this is clinically appropriate. This includes in a small number of cases directly booking into a patient’s own GP for continuity. Over 40% of practices are already involved. NHS England and GPC England have agreed that for 2019/20 this will be at the level of 1 practice appointment per day, per 3,000 patients, with a minimum of 1 appointment per practice per day. The number of appointments required will rise in increments of 3,000 patients. For example, a practice with a list size of 7,500 patients would need to provide a minimum of 2 appointment slots per day, whilst a practice with a list size of 9,000 patients would provide a minimum of 3 appointment slots per day. This becomes a core GP contract requirement. Taken with the intended pharmacy scheme, we anticipate that 111 could be directing more patients away from general practice to pharmacists, than are directly booked into general practice.

*Understanding of GP activity level and waiting times*

5.29 **Clearer recording and collection of data on access to general practice will be essential over the next five years.** It will help us assess adoption of new digital approaches, measure workload pressure more accurately, evaluate the impact of workforce diversification and also to measure patient experience of primary care services. Over the period to 2021 we will develop a comprehensive and structured dataset describing access to general practice based on better and more consistent recording via standards defined in consultation with the Joint General Practitioners Information Technology Committee in 2019/20 and reported through practice systems. Practices will be expected to ensure that data is captured accurately and in a timely manner to enable real time reporting on activity, capacity and waiting times. We will also create a new transparent measure of patient reported satisfaction with access. The aim is to end up with published robust activity and waiting time data at individual practice and PCN level no later than 2021, to allow time for systems to embed this properly alongside the equivalent hospital data, as part of a combined set of statistics.
6. Delivering new network services

Meeting NHS Long Term Plan commitments

6.1 By 2021, Integrated Care Systems will cover the whole country. Primary Care Networks will be a fundamental building block of every Integrated Care System, essential to achieving Integrated Care System goals.

6.2 The NHS Long Term Plan made the major decision to guarantee primary medical and community health services a bigger share of total NHS resources, on the grounds that this will prove the best answer for patients and the NHS itself.

6.3 In turn, the crux of this agreement between NHS England and GPC England is that in return for major investment over the next five years, four things will happen:

- general practice will be able to implement the relevant NHS Long Term Plan commitments in a phased way, thanks to investment in workforce (chapter 1), the indemnity solution (chapter 2), and the creation of Primary Care Networks (chapter 3);

- general practice will deliver specific improvements, such as better support for care homes, or CVD case finding, which will be implemented nationwide. This isn’t only because there is enough capacity, but also because the commitments themselves are evidence-based, and command professional and patient support. NHS England and Integrated Care Systems will also help by supplying analytical tools and data on comparative performance, identifying best practice, and encouraging peer assistance and quality improvement activity;

- in so doing, we will be able to point to impact achieved and demonstrate clear sufficient quantified benefits for patients, the NHS as a whole, and value for money for the taxpayer;

- as a result, we will create a virtuous circle and make a strong investment case for the second five years of the Plan.

Seven national service specifications

6.4 The increase in investment under this agreement includes the introduction of seven specific national service specifications under the Network Contract DES. These seven specifications give effect to most of the specific NHS Long Term Plan goals for primary care, not already covered through the improvements to QOF, access and digital. We encourage PCNs to make early progress in each of these areas ahead of formal introduction of the
requirements and will work to provide early detail of the evolving service specifications to facilitate that.

6.5 The seven are focused on areas where Primary Care Networks can have significant impact against the ‘triple aim’:

- improving health and saving lives (for example from strokes, heart attacks and cancer);

- improving the quality of care for people with multiple morbidities (for example through holistic and personalised care and support planning, structured medication reviews, and more intensive support for patients who need it most including care home residents);

- and helping to make the NHS more sustainable (for example, by helping to reduce avoidable hospital admissions).

6.6 During 2019 and 2020, NHS England will develop the seven specifications and seek to agree these with GPC England as part of annual contract changes. They will also be agreed with Government to ensure value for money from the overall contract deal. All seven specifications will set out standard processes, metrics, and intended quantified benefits for patients. The annual funding increase under the Additional Roles Reimbursement Scheme will be tied to agreeing the service specifications nationally, and their subsequent delivery. This will also be reflected in the wording of the Network Contract DES.

6.7 NHS England will use the primary care testbed programme to test and improve the draft contract specifications, for example on hypertension case-finding. To assist with implementation, and we will also prioritise the early development of potential QOF Quality Improvement modules in these areas, for example on cancer diagnosis. Every Integrated Care System will be developing its own local delivery plan to implement The NHS Long Term Plan, aided by its Primary Care Network Clinical Directors closely engaging with LMCs. In these local ICS plans, delivery and impact of the seven service specifications will be important markers of success.

6.8 The seven national service specifications are:

(i) **Structured Medications Review and Optimisation**;

(ii) **Enhanced Health in Care Homes**, to implement the vanguard model;

(iii) **Anticipatory Care requirements** for high need patients typically experiencing several long term conditions, joint with community services;

(iv) **Personalised Care**, to implement the NHS Comprehensive Model;
(v) Supporting Early Cancer Diagnosis;

(vi) CVD Prevention and Diagnosis; and

(vii) Tackling Neighbourhood Inequalities.

6.9 Much work is already underway in primary care in these areas. The national service specifications build on that energy, and simply create a set of national minimum requirements that must be delivered everywhere. We encourage PCNs to make early and strong progress. This will help them maximise their potential income from the new Investment and Impact Fund. The pace will reflect the phased expansion in Primary Care Network workforce capacity:

- none of the formal contract specifications start in 2019/20;

- the new national structured medication review and care homes requirements apply in full from 2020/21 onwards;

- personalised care, anticipatory care and supporting early cancer diagnosis requirements commence in 2020/21 and develop over the subsequent years; and

- the CVD and inequalities requirements will start in 2021/22, following development and testing of the best delivery models. The specifications will develop over time, for example as diagnostic capacity expands in primary care (e.g. echocardiography to aid early detection of heart failure and valve disease) and secondary care.

6.10 NHS England will work with the full range of relevant stakeholders in developing the draft specifications, prior to formal contract discussions with GPC. This includes for example the RCGP, relevant voluntary sector partners, patients, care home providers, and local system leaders. The specifications will be published in draft before being finalised.

(i) Structured Medications Review and Optimisation

6.11 The new Structured Medication Review requirements will be directly enabled by the expansion of clinical pharmacists working in networks. It will directly tackle over-medication of patients including inappropriate use of antibiotics, supporting the government’s antimicrobial resistance strategy, withdrawing medicines no longer needed and through NHS England led-programmes such as low priority prescribing, as well as support medicines optimisation more widely. Up to 10% of hospital admissions in the elderly population are medicines-related. Research shows that as many as 50% of patients do not take their medicines as intended. Through structured reviews, clinical pharmacists will support patients to take their medicines to get the best
from them, reduce waste and promote self-care. Digital technology will also help.

6.12 In line with *The NHS Long Term Plan* commitments, this service will have a dedicated focus on particular priority groups, including but not limited to: (i) asthma and COPD patients; (ii) the Stop Over Medication for People with learning disabilities or autism programme (STOMP)\(^48\); (iii) frail elderly; (iv) care home residents; and (v) patients with complex needs, taking large numbers of different medications. We will expect a particular focus on tackling inequalities. PCNs will be assisted by analytical tools to help identify the right patients for whom the service should be offered.

*(ii) The Enhanced Health in Care Homes Service*

6.13 **Enhanced Health in Care Homes requirements** will support implementation of the delivery model tested in the six care home vanguards between 2014/15 and 2017/18. This comprises a structured set of evidence-based interventions, and is already being widely implemented across the country, supported by CCGs. They also reduced ambulance conveyances, over-medication, and improved the quality of care for residents\(^49\).

6.14 **The Enhanced Health in Care Homes requirements** will ensure that all care homes are supported by a consistent team of multi-disciplinary healthcare professionals delivering proactive and reactive care, led by named GPs and nurse practitioners, organised by the Primary Care Network. Typically this involves a comprehensive weekly visit. This will be more efficient for practices as well as avoiding care homes having multiple different practices making uncoordinated visits. Care home residents will also get regular clinical pharmacist-led medicine reviews. Primary Care Networks will be responsible for working with emergency services to provide emergency support, including where advice or support is needed out-of-hours. It includes effective care planning including for residents nearing the end of their lives. The model also includes helping care homes ensure their residents have good oral health, stay hydrated and well-nourished, and that they are supported in their recovery following ill-health, by speech and language therapists. This last part of the service specification requires input from wider community services as part of the wider Primary Care Network. NHS England will also help enable social care partners to communicate effectively and securely with Primary Care Networks using NHSmail and other digital tools such as video consultations.

6.15 Many CCGs already have local enhanced services for some form of care home support supplementing funding that is already provided to practices with whom each care resident is registered. Through this national Network Service, we will now achieve 100% coverage of the full model, which goes much further than most local schemes.

6.16 **Every care home in England will benefit from this comprehensive service, provided free by the NHS**, delivered by their Primary Care Network under the
Network Contract DES. In return, NHS England and the Government will work with care homes providers to maximise the contribution they can also make to improving the health and wellbeing of their residents.

(iii) Anticipatory Care

6.17 *The NHS Long Term Plan set out an ambition to dissolve the historic divide between primary and community medical services.* The Anticipatory Care requirements are central to that goal.

6.18 By working on 30-50,000 patient footprints, and by joining up GP services with other community and hospital based staff, the new care models programme showed it is possible to improve outcomes and value for the NHS by introducing more proactive and intense care for patients assessed as being at high risk of unwarranted health outcomes including patients receiving palliative care. GPs are already using the Electronic Frailty Index to routinely identify people living with severe frailty. Based on individual needs and choices, under the Anticipatory Care Service, people identified as having the greatest risks and needs will be offered targeted support for both their physical and mental health needs, which include musculoskeletal conditions, cardiovascular disease, dementia and frailty. Typically, this involves a structured programme of proactive care and support in which patients with multi-morbidities will have greater support— including longer GP consultations where appropriate - from the wider multidisciplinary team.

6.19 Anticipatory care is not something that either community providers or GP practices can deliver in isolation. As integration supplants competition as the NHS’s dominant rulebook, general practice will no longer go it alone. Instead, the Anticipatory Care Service can only be delivered by a fully integrated primary and community health team. This involves input from community providers, general practice, social care and hospitals. Accordingly, from July 2019, community providers are being asked to configure their community teams on PCN footprints.

6.20 *The full requirements will be developed across the country by Integrated Care Systems, and commissioned by CCGs from their Networks.* It will involve bringing together pre-existing teams and resources, supplemented by additional funding from *The NHS Long Term Plan* funding guarantee for community health and primary medical services. Community health teams and primary medical care are being funded to make this happen between them. Delivery of the requirements will only be possible through excellent working relationships and close collaboration with community partners.

6.21 Through the national requirements in the Network Contract DES, general practice will also need to play its part in partnership with community services. Working with Integrated Care Systems, **NHS England will develop the national requirements for the essential contribution required under the Network Contract DES, to form part of the wider service that Integrated**
Care Systems will be organising. As part of this work, we will also design the core national primary care contribution for the new community-led urgent response and reablement service promised in *The NHS Long Term Plan*. As funding increases over time, so the specifications will extend.

(iv) Personalised Care

6.22 *The NHS Long Term Plan* committed to the full roll out of the *NHS Comprehensive Model for Personalised Care*\(^5\). This model has been developed and tested over the past three years, and it will now be delivered in full by Primary Care Networks under the Network Contract DES by 2023/24.

6.23 In England, general practice is based on traditions that are partly psycho-social as well as bio-medical. Consistent with that heritage, **this service specification is intended to avoid over-medicalising care**, and ensure patients are asked by the primary care team “*What matters to you?*”, not just “*What's the matter with you?*”.\(^5\)\(^2\) It is about engaging people fully, sharing control, and connecting them to wider societal support. The model partly reflects the wider movement led by doctors for ‘rethinking medicine’.

6.24 NHS England is publishing its plans for implementing the Comprehensive Model in January 2019, following close working with over 50 different organisations including the RCGP. This sets out the full array of different delivery support actions that will be taken nationally to ensure effective implementation. **The Comprehensive Model of Personalised Care has six main evidence based components:** (i) shared decision-making; (ii) enabling choice, including legal rights to choice; (iii) personalised care and support planning; (iv) social ‘prescribing’ and community-based support; (v) supported self-management; and (vi) personal health budgets and integrated personal budgets. The elements have been proven to improve health and wellbeing outcomes, increase patient satisfaction as well as reducing the direct costs of care (for example of continuing healthcare packages, and through social prescribing reducing GP attendances and wider NHS use).\(^5\)\(^3\)

6.25 A significant cost barrier for general practice in being able to implement the Comprehensive Model is the cost of additional social prescribing link workers, and that is why under this agreement 100% of their cost will now be reimbursed. **As with the Anticipatory Care requirements, the minimum national activity levels for all elements of the model will increase gradually over time in line with increases in capacity.** The Comprehensive Model is expected to benefit 2.5 million people by 2023/24, including over 900,000 referrals for social prescribing. For both the complex care and personalised care service specifications, requirements and expectations will increase over the following three years in line with workforce expansion. As part of the national requirements, a Primary Care Network will need to contribute to their ICS plan, and the ICS will also need to set out what it is doing locally, given
some of the services are best delivered within a framework of wider local coordination and support.

**(v) Supporting Early Cancer Diagnosis**

6.26 The Global Burden of Disease study point to the further significant scope for the NHS to improve early cancer diagnosis at stage 1 and 2\(^{54}\). These patients have the best chance of curative treatment and long term survival. The national ambition in *The NHS Long Term Plan* is that by 2028, the proportion of cancers diagnosed at stage 1 and stage 2 will rise from about half now to three-quarters of cancer patients. It is also vital that patients receive care that is tailored to their individual needs so that their experience of care is on a par with clinical outcomes. *The NHS Long Term Plan* commits to delivering personalised care to all cancer patients by 2021, ensuring that every person with cancer has the best possible care, quality of life and system resources are utilised effectively. **Primary Care Networks will have a responsibility for doing their part, alongside the Cancer Alliances and other local partners, and this will be reflected in the service specification.**

6.27 Cancer screening programmes will be critical in diagnosing cancer earlier, including for bowel cancer using FIT, and HPV primary screening. Sir Mike Richards is leading a national review of current arrangements, which concludes in summer 2019. **Practices are likely to have a key role in helping ensure high and timely uptake of screening and case finding opportunities within their neighbourhoods.** We expect to make early progress by 2020 with agreed changes arising from the review to be implemented via the core practice contract.

6.28 **Primary Care Networks will have a key role in helping to ensure that all their GPs are using the latest evidence-based guidance to identify people at risk of cancer; recognise cancer symptoms and patterns of presentation; and make appropriate and timely referrals for those with suspected cancer.** A typical network with a patient population of 50,000 will have approximately 270-280 new diagnoses of cancer a year, of which only about half are currently diagnosed at stage 1 and 2\(^{55}\). **We will develop a QOF Quality Improvement module for national use in 2020/21 to help practices and networks understand their own data, and work through what they can do to achieve earlier diagnosis.** This might for example include direct engagement with particular local groups of their community where there is the greatest opportunity for making a difference; all staff to play a role in raising awareness of symptoms and the importance of screening; changes in clinical practice e.g. referrals; as well as working with their local ICS to tackle diagnostic bottlenecks. **Alongside the QI module, we will start the Network Specification by 2020/21.**

**(vi) Cardiovascular disease prevention and diagnosis**
6.29 Better prevention, diagnosis and management of cardiovascular disease is the biggest single area where the NHS can save lives over the next ten years, through fewer strokes and heart attacks. Primary Care Networks have the critical role in realising this NHS Long Term Plan ambition, principally through secondary prevention, building on the progress already made through the Quality and Outcomes Framework.

6.30 In 2019/20 we will make significant further progress in CVD management through the QOF changes on blood pressure control, and the review of the heart failure domain for any subsequent changes to be implemented as soon as possible.

6.31 Too many patients are still living with undetected and under-treated high risk conditions such as high blood pressure, raised cholesterol, and atrial fibrillation. 80% of heart failure is currently diagnosed in hospital, despite 40% of patients having symptoms that should have triggered an earlier assessment. We will confirm the scale of the opportunity nationally, and what this means for an individual network. A new CVD national prevention audit for primary care will support continuous improvement, potentially through a QI module. This will be supported through a benchmarking tool. Through a testbed cluster, NHS England will also test the most promising approaches to detecting hitherto undiagnosed patients, including through local pharmacies, as well as managing patients with high risk conditions who are on suboptimal treatment. The initial network service specification will be introduced by 2021/22.

(vii) Inequalities

6.32 The seventh service specification funded nationally will cover the challenge of tackling inequalities in health and healthcare. We will develop this through a testbed cluster, involving Primary Care Networks with high levels of inequalities. This testbed could benefit from significant national and local partnering. Drawing on the existing evidence and programme, some of which is summarised in Chapter 2 of the NHS Long Term Plan and its annex on wider social goals, the cluster will seek to work out what practical approaches have the greatest impact at the 30-50,000 neighbourhood level and can be implemented by Primary Care Networks. The service specification will include good practice can be adopted everywhere, tailored to reflect the specific context of their neighbourhood and agreed with their CCG. An initial service specification will developed in 2020, to start by 2021/22.

6.33 NHS England has continued to target a higher share of overall CCG funding towards geographies with high health inequalities. The primary care component of the funding formula includes the greatest weighting for inequalities, given evidence of the inverse care law. And so for areas with the highest inequalities, NHS England expects that CCGs will be using some of their additional funding for inequalities to boost primary care capacity and access. All Integrated Care Systems will need to set out how they will reduce inequalities by 2023/24, with Primary Care Networks playing their part.
Vaccination and Immunisation Review

6.34 A review of Vaccination and Immunisation procurement, arrangements and outcomes will take place in 2019 with its output implemented through the 2020 and 2021 contracts. The review’s purpose is to reduce complexity, improve value and increase impact and not cut practice income. As part of the review, NHS England will consider how screening and vaccination programmes could be designed to support a narrowing of health inequalities.

6.35 NHS England will apply the same collaborative and co-design approach deployed as part of the recent QOF review and we plan to use this review to:

- ensure the system incentivises achievement of appropriate uptake rates for immunisations in line with national public health uptake rates;
- reduce the administrative burden on general practices by simplifying the system if possible;
- clarify what is expected on call/recall for all S7a immunisations;
- address anomalies in the system that directly incentivise some vaccines but not others;
- look at how we deal with outbreaks and catch-up programmes;
- consider whether we extend the list of chargeable travel vaccines.

6.36 It will also be the forum for developing proposals on changes to the GP payments system to reflect a potential central flu vaccine procurement route, including any revised arrangements to improve the rate of uptake. It is possible that in the future some vaccination programmes could be delivered more efficiently at network level rather than at individual practice level, freeing up time for GPs and practice staff to undertake other activities.

Network Dashboard

6.37 From April 2020, every network will be able to see the benefits it is achieving for its local community and patients. It will see its relative progress on key metrics contained a comprehensive new national Network Dashboard.

6.38 The dashboard will include population health and prevention, urgent care and anticipatory care, prescribing and hospital use. It will also cover metrics for all the new national service specifications.
**Investment and Impact Fund**

6.39 A major new national network Investment and Impact Fund will start in 2020 as a means of supporting Integrated Care System delivery of *The NHS Long Term Plan*, with funding rising from £75 million in 2020/21, to a minimum expected £300 million in 2023/24.

6.40 The purpose of the Investment and Impact Fund is to help PCNs plan and achieve better performance against metrics in the network dashboard. NHS England will develop national rules and guidance. The Scheme will be overseen by Integrated Care Systems. Networks will need to agree with their Integrated Care System how they spend any monies earned from the Fund. These are intended to increase investment for workforce expansion and services, not boost pay.

6.41 Part of the Fund on wider NHS utilisation will be dedicated to *The NHS Long Term Plan* commitment to the principle of ‘shared savings’. NHS England anticipates that this will eventually cover five elements:

(i) **avoidable A&E attendances**, which Primary Care Networks will increasingly be able to impact through the changes described in Chapter 5 including 111 direct booking;

(ii) **avoidable emergency admissions**, which will particularly be impacted through the Anticipatory Care Service and Enhanced Health in Care Homes

(iii) **timely hospital discharge**, helped by the development of integrated primary and community teams;

(iv) **outpatient redesign.** This will be aided by the national ambition set out in the *NHS Long Term Plan* to redesign outpatients services using digital technology to avoid up to 30 million outpatient appointments a year. Primary Care Networks will have a critical role in supporting this ambition, whilst also increasing referrals for cancer, e.g. direct access diagnostics;

(v) **prescribing costs.** NHS England will review past and existing prescribing incentive schemes in 2019 to develop a standard national model.

6.42 This wider NHS utilisation part of the fund will be introduced in a phased way. And unlike many shared savings schemes, the utilisation part of Investment and Impact Fund will not create unfunded risk for either CCGs or hospital contracts. Instead, the funding is pre-identified and capped. The exception to this is the prescribing element, which will be funded through the existing primary care drugs budget and the savings opportunity on prescribing
is not therefore capped but will depend on the extent to which networks can achieve greater efficiencies than those already planned by their CCGs.

6.43 The Fund will be linked to performance and its design will be agreed with Government. We envisage access to the Fund being a network entitlement from 2020/21. NHS England will also consider whether the CCG Quality Premium scheme should be subsumed into the Impact and Investment Fund. This could add additional funding.
7. Guaranteeing investment

7.1 *The NHS Long Term Plan* committed to increase investment in primary medical and community health services as a share of total NHS revenue spend across the five years from 2019/20 to 2023/24. This means that spending on these services will be at least £4.5 billion higher in five year’s time. This is the first time in the history of the NHS that real terms funding for primary medical and community services is guaranteed to grow faster than the rising NHS budget overall.

7.2 This chapter now confirms how much of this flows through national GP contract, via the practice contract and its extension through the Network Contract DES. It gives general practice five-year funding clarity and certainty for the first time. Beyond contract funding, investment worth hundreds of millions of pounds will continue to be made in central programmes benefiting general practice.

Funding for the Practice Contract

7.3 Funding for the core practice contract (i.e. excluding the network DES) is now agreed and fixed for each of the next five years, and increases by £978 million in 2023/24.

<table>
<thead>
<tr>
<th>TABLE 4: PRACTICE CONTRACT FUNDING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2018/19</strong></td>
</tr>
<tr>
<td>Practice contract baseline</td>
</tr>
<tr>
<td>Cumulative increase</td>
</tr>
<tr>
<td>% annual increase</td>
</tr>
</tbody>
</table>

7.4 This settlement covers all aspects of practice income and expenses and incorporates:

(i) the agreed adjustment of global sum as part of the indemnity settlement (paragraph 2.7);

(ii) £105m payable as a network participation payment, which includes 1% pay for staff in general practice, deferred from 2018/19 and incorporated here;\(^{58}\)

(iii) the transfer out of the Extended Hours DES to network level as part of the access changes (paragraph 5.26) and subject access request costs (paragraph 5.4).
Pay

7.5 As a result of fixing the practice contract funding for the next five years, GPC England and NHS England have agreed that DDRB will not make recommendations on GP partner net income.

7.6 Under this agreement, GPC England is recommending that practice staff, including salaried GPs, receive at least a 2.0% increase in 2019/20, but the actual effect for individuals will depend on how indemnity cover is currently funded within practices.

7.7 NHS and GPC have asked the government to ask the DDRB not to make recommendations for salaried GPs for the 2019 pay round. We have further asked the Government to continue to include recommendations on the pay of salaried GPs in the DDRB remit from the 2020 pay round onwards. Recommendations will need to be informed by affordability and in particular the fixed contract resources available to practices under this deal and will inform decisions by GP practices on the pay of salaried GPs. We have asked the Government to ensure that DDRB continues, as usual, to recommend on GP trainees, educators and appraisers. As now, the Government will decide how to respond to DDRB recommendations.

7.8 A new Balancing Mechanism will, if required, adjust between the practice level global sum and the network level Additional Roles Reimbursement Sum depending on levels of real terms partner NHS earnings. It will enable global sum adjustment equally in either direction. The mechanism is intended to provide confidence to the profession and taxpayers alike, by protecting against unexpectedly large increases in either inflation or partner drawings. The effect would also be to increase or decrease number of extra staff funded through the Network Contract DES. The balancing mechanism will be designed in 2019 by NHS England and GPC England to commence from 2020/21, taking account of the most recent available data, and it will be agreed with Government.

7.9 As a corollary of major investment, and to safeguard public trust in the GP partnership model, pay transparency will increase. GPs with total NHS earnings above £150,000 per annum will be listed by name and earnings in a national publication, starting with 2019/20 income. The Government will look to introduce the same pay transparency across other independent contractors in the NHS at the same time.

Funding for the Network Contract DES

7.10 Table 5 shows how the new Network Contract DES will rise over the five years to be worth up to £1,799 billion in 2023/24. It comprises four different funding components:
the new Additional Roles Reimbursement Scheme. Whether or not the whole £891 million of funding is spent will depend on the extent to which networks draw down their entitlement;

(ii) network support, through a combination of the existing recurrent £1.50/head and the new 0.25 WTE contribution for the Clinical Director, which equates to £2.01/head in 2019/20. From July 2019 these will be minimum funding requirements. Many CCGs provide additional financial support, as well as support in kind from CCG staff;

(iii) access, through a combination of the transferred Extended Hours Access DES and the £6/head CCG-commissioned enhanced access arrangements. These become a combined legal entitlement in 2021/22 in return for implementing the revised and more joined-up access requirements that will arise from the access review; and

(iv) the new Investment and Impact Fund. If agreed with GPC England, access to the fund becomes an entitlement, in line with national rules. The level of funding will relate to the level of achievement.

TABLE 5: NETWORK FUNDING

<table>
<thead>
<tr>
<th>£millions</th>
<th>2019/20</th>
<th>2020/21</th>
<th>2021/22</th>
<th>2022/23</th>
<th>2023/24</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Additional Roles Scheme</td>
<td>110</td>
<td>257</td>
<td>415</td>
<td>634</td>
<td>891</td>
</tr>
<tr>
<td>2. Network Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>£1.50 per head from CCG general allocation</td>
<td>90</td>
<td>90</td>
<td>91</td>
<td>91</td>
<td>92</td>
</tr>
<tr>
<td>GP PCN leadership (0.25 WTE per PCN, starts July 2019)</td>
<td>31</td>
<td>42</td>
<td>43</td>
<td>44</td>
<td>45</td>
</tr>
<tr>
<td>Subtotal</td>
<td>121</td>
<td>132</td>
<td>134</td>
<td>135</td>
<td>137</td>
</tr>
<tr>
<td>3. Access</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extended Hours Access DES</td>
<td>66</td>
<td>87</td>
<td>87</td>
<td>87</td>
<td>87</td>
</tr>
<tr>
<td>Improving Access to General Practice at £6 per head</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td>66</td>
<td>87</td>
<td>454</td>
<td>463</td>
<td>472</td>
</tr>
<tr>
<td>4. Investment and Impact Fund</td>
<td>0</td>
<td>75</td>
<td>150</td>
<td>225</td>
<td>300</td>
</tr>
<tr>
<td>TOTAL PCN FUNDING</td>
<td>296</td>
<td>552</td>
<td>1,153</td>
<td>1,457</td>
<td>1,799</td>
</tr>
</tbody>
</table>

7.11 GPC England and NHS England have agreed that we do not expect additional national money for practice or network contract entitlements, taken together, until 2024/25.

7.12 The Premises Review will be published by March 2019. The NHS Long Term Plan committed to its implementation.
Local enhanced services

7.13 This national agreement covers national contract funding. It does not cover additional CCG funding for primary medical care. CCGs in discussion with LMC(s), will need to review their local enhanced services in the light of the new Network Contract DES, so that their additional local funding for general practice secures services that go beyond national contractual requirements. Most local contracts for enhanced services will normally be added to the Network Contract DES. The total funding for primary medical and community services will rise by £4.5 billion by 2023/24. This is a floor level that is being nationally guaranteed, that local CCGs and ICSs are likely to supplement further.

Centrally-funded programmes

7.14 Primary care also benefits from support provided free to practices and networks, because they are met from within a separate NHS England central budget allocation. Some of these funds are devolved to regions or ICSs. They include a range of GP Forward View programmes such as practice nurse development, international GP recruitment, as well as estates and technology transformation, practice resilience, the Time for Care programme, the online consultations programme, and the GP mental health service.

7.15 This agreement also commits NHS England to new centrally-funded support:

(i) the new framework to offer digital-first platforms to all Primary Care Networks, on top of the existing GP IT futures programme which replaces GP Systems of Choice;

(ii) a significant national Primary Care Network development and support programme;

(iii) the new primary care fellowship programme and training hubs;

(iv) provision for expected indemnity costs; and

(v) support for the new testbeds programme.
8. Supporting research and testing future contract changes

Research

8.1 The NHS Long Term Plan emphasises the importance of research. NHS England will work to increase the number of people registering to participate in health research to 1 million by 2023/24, and Primary Care Networks will be able to help with this goal.

8.2 Research participation within general practice has many additional benefits: quality improvement, professional development, and generating income, amongst others. Working with the Royal College of General Practitioners, the National Institute of Health Research and the Clinical Practice Research Datalink, we will use the opportunity created by Primary Care Networks to increase general practice research participation levels. During 2019, we will develop a way of helping networks to do this, embedding approaches such as the RCGP Research Ready quality assurance model. We welcome also the National Institute of Health Research’s intention to prioritise an expansion in academic research capacity into primary care.

A new national development and testing programme

8.3 In addition to traditional academic research and evaluation, The NHS Long Term plan committed to expanding the current NHS England ‘Test beds’. Expanding this commitment and translating it into primary care, NHS England will create a dedicated development and testing programme in 2019 for specific planned contract changes.

8.4 This five year framework enables us to construct a clearer pipeline of future potential contract changes. We will work out which would benefit from a more formal development and testing process, in advance on contract implementation, to improve the quality of implementation.

8.5 Rather than commission a fixed number of ongoing test bed practices or networks, NHS England envisages the test sites being selected purely on a topic by topic basis.

8.6 Each topic will have a cluster of distinct test bed sites, whether practices, or PCNs, or whole Integrated Care Systems. We will aim for a representative sample of different practices or PCNs drawn from different parts of the country. Test bed sites would be funded by topic, rather than to pursue their own local interests. The programme will be nationally managed and is likely to involve rapid-cycle development and evaluation.

8.7 It will develop and test the seven new sets of network requirements, QI modules and QOF indicators. The programme could extend to developing other specific changes such as a practice-level version of Helpforce, which is developing NHS
volunteering at scale and has hitherto focused on hospitals. Another example would be to test general practice demand management initiatives such as the pharmacy connect scheme outlined in *The NHS Long Term Plan*. We will consider the precise scope and design of the programme in 2019.
9. **Schedule of future contract changes and development work**

9.1 This agreement marks the expansion of a major programme of development work by NHS England with GPC England and other stakeholders over the next five years. This chapter summarises the major changes and future work between 2019/20 and 2021/22.

### 2019/20

<table>
<thead>
<tr>
<th><strong>Key changes and development work</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Network</strong></td>
<td></td>
</tr>
<tr>
<td>• Network Contract DES goes live</td>
<td></td>
</tr>
<tr>
<td>• Network participation practice payment starts</td>
<td></td>
</tr>
<tr>
<td>• Design of new national network service specifications starts</td>
<td></td>
</tr>
<tr>
<td><strong>Workforce</strong></td>
<td></td>
</tr>
<tr>
<td>• Additional Roles Reimbursement Scheme launched, starting with clinical pharmacists and social prescribing link workers</td>
<td></td>
</tr>
<tr>
<td>• Design of primary care fellowship programme</td>
<td></td>
</tr>
<tr>
<td><strong>Indemnity</strong></td>
<td></td>
</tr>
<tr>
<td>• New centrally, funded Clinical Negligence Scheme for General Practice starts</td>
<td></td>
</tr>
<tr>
<td><strong>QOF reform</strong></td>
<td></td>
</tr>
<tr>
<td>• 28 indicators retired; 15 new indicators; introduction of personalised care adjustment and Quality Improvement domain</td>
<td></td>
</tr>
<tr>
<td>• Review of heart failure, asthma and chronic obstructive pulmonary disease QOF domains</td>
<td></td>
</tr>
<tr>
<td><strong>Testbeds</strong></td>
<td></td>
</tr>
<tr>
<td>• New primary care testbed programme launched</td>
<td></td>
</tr>
<tr>
<td><strong>Digital</strong></td>
<td></td>
</tr>
<tr>
<td>• New digital improvement requirements introduced including access by patients online to full record</td>
<td></td>
</tr>
<tr>
<td>• Revisions to rurality index payment and London adjustment</td>
<td></td>
</tr>
<tr>
<td>• Review of premium for registering new patients</td>
<td></td>
</tr>
<tr>
<td>• Review of out of area registration and choice of digital-first registration</td>
<td></td>
</tr>
<tr>
<td>• Requirement for Electronic ordering of repeat prescriptions and using electronic repeat dispensing for all patients for whom it is clinically appropriate as a default from April 2019</td>
<td></td>
</tr>
<tr>
<td>• All practices will ensure at least 25% of appointments are available for online booking by July 2019</td>
<td></td>
</tr>
<tr>
<td><strong>Advertising</strong></td>
<td></td>
</tr>
<tr>
<td>• Ban on GP providers advertising or hosting paid-for GP services that fall within the scope of NHS funded primary medical services</td>
<td></td>
</tr>
<tr>
<td><strong>Access</strong></td>
<td></td>
</tr>
<tr>
<td>• Extended Hours Access DES requirements introduced across all practices in every network (until March 2021)</td>
<td></td>
</tr>
<tr>
<td>• NHS111 direct appointment booking into practices introduced nationally</td>
<td></td>
</tr>
<tr>
<td>• Review of wider access arrangements</td>
<td></td>
</tr>
</tbody>
</table>
## Key changes and development work

### Networks
- New Dashboard to monitor progress on network metrics
- National Network Investment and Impact Fund launched
- Anticipatory care requirements (with community services) start
- Enhanced health in care home requirements start
- Structured Medication review requirements start for priority groups
- Personalised care requirements start
- Early cancer diagnosis support requirements start

### Workforce
- Additional Roles Reimbursement Scheme extended to include physician associates and first contact physiotherapists
- Primary care training hubs established

### QOF reform
- Further changes introduced - post review of heart failure, asthma, and COPD domains
- Review of mental health domain
- New QI modules

### Digital
- Requirement for online presence, to give patients access online to correspondence and to no longer be using facsimile machines for either NHS or patient communications;
- Potential out of area registration reform – post review

### Vacs and Imms
- Changes to vaccination and immunisation arrangements – post review

### Access
- Start of transition to new access arrangements – post review

### 2021/22

## Key changes and development work

### Networks
- Cardio-vascular disease case finding requirements start
- Prevention and inequalities requirements start

### Workforce
- Additional Roles Reimbursement Scheme extended to include community paramedics

### QOF
- Further changes introduced, including new QI modules

### Digital
- New digital-first support offer
All patients will have the right to online and video consultations by April 2021

New access arrangements fully implemented - post review
Patient reported access & waiting times data published monthly

Engagement in 19/20

9.2 NHS England and GPC England will hold a series of roadshows and webinars to communicate the new contract. Further details about these events will be communicated in due course. In addition, both GPC England and NHS England will publish supporting guidance on their websites.
Annex A: QOF indicator changes

Indicators to be retired in 19/20

1. 28 indicators worth 175 points in total will be retired from April 2019 as detailed in table 1.

Table 1: Indicators to be retired

<table>
<thead>
<tr>
<th>Indicator ID</th>
<th>Indicator wording</th>
<th>Points</th>
<th>Rationale for retirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD002</td>
<td>The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less</td>
<td>17</td>
<td>Replacement with more clinically appropriate targets</td>
</tr>
<tr>
<td>CON001</td>
<td>The contractor establishes and maintains a register of women aged 54 or under who have been prescribed any method of contraception at least once in the last year, or other clinically appropriate interval e.g. last 5 years for an IUS</td>
<td>4</td>
<td>Simple collection of prescribing data. No link to any other indicators</td>
</tr>
<tr>
<td>CON003</td>
<td>The percentage of women, on the register, prescribed emergency hormonal contraception one or more times in the preceding 12 months by the contractor who have received information from the contractor about long acting reversible contraception at the time or within one month of the prescription</td>
<td>3</td>
<td>Small numbers of patients at practice level leading to reliability issues. Achievement has plateaued.</td>
</tr>
<tr>
<td>COPD004</td>
<td>The percentage of patients with COPD with a record of FEV₁ in the preceding 12 months</td>
<td>7</td>
<td>Not required on an annual basis to guide care coupled with issues with access to annual spirometry in general practice</td>
</tr>
<tr>
<td>COPD005</td>
<td>The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 12 months, with a record of oxygen saturation value within the preceding 12 months</td>
<td>5</td>
<td>Not in line with NICE guidance</td>
</tr>
<tr>
<td>CS001</td>
<td>The contractor has a protocol that is in line with national guidance agreed with the NHS CB for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate sample rates</td>
<td>7</td>
<td>Core professional responsibility</td>
</tr>
<tr>
<td>CS002</td>
<td>The percentage of women aged 25 or over and who have not attained the age</td>
<td>11</td>
<td>Replacement with indicators in line</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Value</td>
<td>Notes</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>CS004</td>
<td>The contractor has a policy for auditing its cervical screening service and performs an audit of inadequate cervical screening tests in relation to individual sample takers at least every 2 years</td>
<td>2</td>
<td>Core professional responsibility</td>
</tr>
<tr>
<td>DEM005</td>
<td>The percentage of patients with a new diagnosis of dementia recorded in the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded between 12 months before or 6 months after entering on to the register</td>
<td>6</td>
<td>Small numbers at a practice level leading to reliability issues.</td>
</tr>
<tr>
<td>DM002</td>
<td>The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less</td>
<td>8</td>
<td>Replacement with indicators in which treatment targets are stratified according to whether the patient has moderate or severe frailty</td>
</tr>
<tr>
<td>DM003</td>
<td>The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>DM004</td>
<td>The percentage of patients with diabetes, on the register, in whom the last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>DM007</td>
<td>The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>DM008</td>
<td>The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>DM009</td>
<td>The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>HYP006</td>
<td>The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less</td>
<td>20</td>
<td>Replacement with more clinically appropriate targets</td>
</tr>
<tr>
<td>MH007</td>
<td>The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months</td>
<td>4</td>
<td>Replacement with an indicator focused upon BMI recording</td>
</tr>
<tr>
<td>MH008</td>
<td>The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective</td>
<td>5</td>
<td>Small numbers at a practice level leading to</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Count</td>
<td>Notes</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------------------------------------</td>
<td>-------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>MH009</td>
<td>The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months</td>
<td>1</td>
<td>Small numbers at a practice level leading to indicator reliability issues. Also double payment of CS002.</td>
</tr>
<tr>
<td>MH010</td>
<td>The percentage of patients on lithium therapy with lithium levels in the therapeutic range in the preceding 4 months</td>
<td>2</td>
<td>Small numbers at a practice level leading to reliability issues. Indicator timing not in line with clinical guidance.</td>
</tr>
<tr>
<td>OST002</td>
<td>The percentage of patients aged 50 or over, and who have not attained the age of 75, with a fragility fracture on or after 1 April 2012, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone sparing agent</td>
<td>3</td>
<td>Small numbers at a practice level leading to reliability issues. Concerns about over-treatment.</td>
</tr>
<tr>
<td>OST005</td>
<td>The percentage of patients aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis, who are currently treated with a bone sparing agent</td>
<td>3</td>
<td>Small numbers at a practice level leading to reliability issues. Concerns about over-treatment.</td>
</tr>
<tr>
<td>PAD002</td>
<td>The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less</td>
<td>2</td>
<td>Significant overlap with other CVD areas therefore not a priority for ongoing incentivisation.</td>
</tr>
<tr>
<td>PAD003</td>
<td>The percentage of patients with peripheral arterial disease with a record in the preceding 12 months that aspirin or an alternative anti-platelet is being taken</td>
<td>2</td>
<td>Issues with indicator assurance. Greater potential gain through a QI approach.</td>
</tr>
<tr>
<td>PC002</td>
<td>The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed</td>
<td>3</td>
<td>Core professional practice</td>
</tr>
<tr>
<td>SMOK003</td>
<td>The contractor supports patients who smoke in stopping smoking by a strategy which includes providing literature and offering appropriate therapy</td>
<td>2</td>
<td>Replacement with more clinically appropriate targets</td>
</tr>
<tr>
<td>STIA003</td>
<td>The percentage of patients with a history of a stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>
The percentage of patients with a stroke or TIA (diagnosed on or after 1 April 2014) who have a record of a referral for further investigation between 3 months before or 1 month after the date of the latest recorded or stroke or the first TIA

2. New indicators in 19/20

We are introducing 15 more clinically appropriate indicators from April 2019 as detailed in Table 2.

Table 2: New Indicators

<table>
<thead>
<tr>
<th>Indicator ID</th>
<th>Indicator wording</th>
<th>Points</th>
<th>Payment thresholds</th>
<th>Rationale for inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>CS005 (NICE ID NM154)</td>
<td>The proportion of women eligible for screening and aged 25-49 years at the end of reporting period whose notes record than an adequate cervical screening test has been performed in the preceding 3 years and 6 months</td>
<td>7</td>
<td>45-80%</td>
<td>To achieve alignment with screening committee guidelines</td>
</tr>
<tr>
<td>CS006 (NICE ID NM155)</td>
<td>The proportion of women eligible for screening and aged 50-64 years and the end of reporting period whose notes record that an adequate cervical screening test has been performed in the previous 5 years and 6 months</td>
<td>4</td>
<td>45-80%</td>
<td></td>
</tr>
<tr>
<td>COPD008 (NICE ID NM47)</td>
<td>The percentage of patients with COPD and Medical Research Council (MRC) dyspnoea scale ≥3 at any time in the preceding 12 months, with a subsequent record of an offer of referral to a pulmonary rehabilitation programme</td>
<td>2</td>
<td>40-90%</td>
<td>High impact intervention for patients with COPD</td>
</tr>
<tr>
<td>DM019 (NICE ID NM159)</td>
<td>The percentage of patients with diabetes without moderate or severe frailty, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less.</td>
<td>10</td>
<td>38-78%</td>
<td>Suite of changes to reduce the potential for over-treatment and iatrogenic harm to patients with moderate or severe frailty and to</td>
</tr>
<tr>
<td>DM020 (NICE ID NM157)</td>
<td>The percentage of patients with diabetes without moderate or severe frailty, on the register, in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months.</td>
<td>17</td>
<td>35-75%</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>ID</td>
<td>Description</td>
<td>Target</td>
<td>Tbc</td>
</tr>
<tr>
<td>--------</td>
<td>-------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------</td>
<td>------</td>
</tr>
<tr>
<td>DM021</td>
<td>(NICE ID</td>
<td>The percentage of patients with diabetes with moderate or severe frailty, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months.</td>
<td>10</td>
<td>52-92%</td>
</tr>
<tr>
<td></td>
<td>NM158</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM022</td>
<td>(NICE ID</td>
<td>The percentage of patients with diabetes aged 40 years and over, with no history of CVD and without moderate or severe frailty, who are currently treated with a statin. (excluding patients with type 2 diabetes and a CVD risk score of &lt;10% recorded in the preceding 3 years)</td>
<td>4</td>
<td>50-90%</td>
</tr>
<tr>
<td></td>
<td>NM162</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM023</td>
<td>(NICE ID</td>
<td>The percentage of patients with diabetes and a history of CVD (excluding haemorrhagic stroke) who are currently treated with a statin.</td>
<td>2</td>
<td>50-90%</td>
</tr>
<tr>
<td></td>
<td>NM163</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HYP003</td>
<td>(NICE ID</td>
<td>The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90mmHg or less.</td>
<td>14</td>
<td>Tbc</td>
</tr>
<tr>
<td></td>
<td>NM53</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HYP007</td>
<td>(NICE ID</td>
<td>The percentage of patients aged 80 years and over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90mmHg or less.</td>
<td>5</td>
<td>Tbc</td>
</tr>
<tr>
<td></td>
<td>NM54</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH006</td>
<td>(NICE ID</td>
<td>The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months</td>
<td>4</td>
<td>50-90%</td>
</tr>
<tr>
<td></td>
<td>NM16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHD008</td>
<td>(NICE ID</td>
<td>The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90mmHg or less.</td>
<td>12</td>
<td>Tbc</td>
</tr>
<tr>
<td></td>
<td>NM68</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHD009</td>
<td>(based on</td>
<td>The percentage of patients aged 80 years or over with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90mmHg or less.</td>
<td>5</td>
<td>Tbc</td>
</tr>
<tr>
<td></td>
<td>NICE ID NM86</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STIA010</td>
<td>(NICE ID</td>
<td>The percentage of patients aged 79 years or under with a history of stroke or TIA in whom the last blood pressure reading</td>
<td>3</td>
<td>Tbc</td>
</tr>
<tr>
<td></td>
<td>NM69</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. We will also be introducing a new QOF Quality Improvement domain from 19/20. For 19/20, the two Quality Improvement Modules will be end of life care and prescribing safety. Further detail on the modules will be included in the QOF implementation guidance.

Changes to the Indicators No Longer incentivised in QOF (INLIQ) extraction

4. Minor changes are proposed to the INLIQ extraction as a result of the current retirements and indicators reintroduced from INLIQ described above. These are detailed in Table 3 and 4.

5. These changes represent a net decrease in the number of indicators supported through INLIQ from 25 to 23.

Table 3: Indicators to be added to INLIQ

<table>
<thead>
<tr>
<th>Indicator ID</th>
<th>Indicator wording</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH007</td>
<td>The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months.¹</td>
</tr>
<tr>
<td>MH008</td>
<td>The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years.</td>
</tr>
<tr>
<td>PAD002</td>
<td>The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.</td>
</tr>
<tr>
<td>PAD003</td>
<td>The percentage of patients with peripheral arterial disease with a record in the preceding 12 months that aspirin or an alternative anti-platelet is being taken.</td>
</tr>
</tbody>
</table>

Table 4: INLIQ indicators where data collection may cease

<table>
<thead>
<tr>
<th>Indicator ID</th>
<th>Indicator wording</th>
</tr>
</thead>
<tbody>
<tr>
<td>CON002</td>
<td>The percentage of patients, on the register, prescribed an oral or patch contraceptive method in the preceding 12 months who have also received information from the contractor about long acting reversible methods of contraception in the preceding 12 months.</td>
</tr>
<tr>
<td>DEP001</td>
<td>The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have had a</td>
</tr>
</tbody>
</table>

¹ Swapped with INLIQ indicator MH006
biopsychosocial assessment by the point of diagnosis. The completion of the assessment is to be recorded on the same day as the diagnosis is recorded.

<table>
<thead>
<tr>
<th>DM016</th>
<th>The percentage of male patients with diabetes, on the register, who have a record of erectile dysfunction with a record of advice and assessment of contributory factors and treatment options in the preceding 12 months.</th>
</tr>
</thead>
<tbody>
<tr>
<td>HYP004</td>
<td>The percentage of patients with hypertension aged 16 or over and who have not attained the age of 75 in whom there is an assessment of physical activity, using GPPAQ, in the preceding 12 months.</td>
</tr>
<tr>
<td>HYP005</td>
<td>The percentage of patients with hypertension aged 16 or over and who have not attained the age of 75 who score ‘less than active’ on GPPAQ in the preceding 12 months who also have a record of a brief intervention in the preceding 12 months.</td>
</tr>
<tr>
<td>STIA004</td>
<td>The percentage of patients with a stroke or TIA who have a record of total cholesterol in the preceding 12 months.</td>
</tr>
</tbody>
</table>
Annex B: QOF Quality Improvement

Prescribing safety

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>QI001. The contractor can demonstrate continuous quality improvement activity focused upon prescribing safety as specified in the QOF guidance.</td>
<td>27</td>
<td>NA</td>
</tr>
<tr>
<td>QI002. The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity as specified in the QOF guidance. This would usually include participating in a minimum of two peer review meetings.</td>
<td>10</td>
<td>NA</td>
</tr>
</tbody>
</table>

End of life care

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>QI003: The contractor can demonstrate continuous quality improvement activity focused on end of life care as specified in the QOF guidance</td>
<td>27</td>
<td>NA</td>
</tr>
<tr>
<td>QI004: The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity as specified in the QOF guidance. This would usually include participating in a minimum of two network peer review meetings.</td>
<td>10</td>
<td>NA</td>
</tr>
</tbody>
</table>

Rationale for inclusion of a QI domain

This is a new domain which seeks to fulfil the recommendation in the Report of the Review of QOF\(^2\) to introduce a quality improvement domain. The aim of this domain is to provide support for contractors and their staff to recognise areas of care which require improvement, and take steps to address this through the development and implementation of a quality improvement plan and sharing of learning across their network. Being skilled in quality improvement has been recognised as a key role for healthcare professionals in the Shared View of Quality\(^3\).

NHS England and GPC (England) have worked with the Royal College of General Practitioners, NICE and the Health Foundation to develop the topic specific guidance included here. This guidance sets specific objectives for each topic which contractors are expected to work towards and provides advice on potential quality improvement actions. Within the parameters set out in this guidance, contractors are encouraged to understand where they have the potential to make quality improvements and then to design and implement bespoke quality improvement plans, including improvement targets to address these. There are no deadlines given for the completion of the

---

\(^2\) QOF Review
\(^3\) Shared View of Quality
diagnostic activities, the subsequent plan or the network meetings. However, contractors are advised that they are expected to be working on these improvement activities throughout the QOF year.

The two topic areas identified for 2019/20 are prescribing safety and end of life care. These topics will change on an annual basis. Through practice engagement with these and future modules we expect to see measurable improvement in the quality of care and patient experience at a national level against the areas of focus described in the individual modules.

The focus of the indicators and associated points is on contractor engagement and participation in the quality improvement activity both in the practice and through sharing of learning across their network. This is to recognise that not all quality improvement activity will be successful in terms of its immediate impact upon patient care. If a contractor does not achieve the targets which they have set themselves this would not in itself be a reason to withhold QOF points and associated payments, unless they have also failed to participate in the activities described in the guidance.

All the supporting information and resources referred to in this guidance will be made available on NHS England’s website by end of March 2019. Further information as to how to undertake quality improvement activities is available from a number of sources including:

NHS England Sustainable Improvement Team (https://www.england.nhs.uk/sustainableimprovement/) - this is a national resource to support quality improvement activity in primary care and includes training, practical advice and support from quality improvement specialists.

NHS Improvement (https://improvement.nhs.uk/improvement -hub) - resources including improvement tools and case studies.

RCGP QI resources (www.rcgp.org.uk/qi) - resources including the RCGP QI Guide for General Practice and other quick guides to the use of quality improvement tools and techniques. These are available to both members and non-members.

Health Foundation (https://www.health.org.uk/publications/quality-improvement-made-simple) - an easy to read and practical guide to undertaking QI


Institute for Health Improvement [http://www.ihi.org/] – a US site with a range of resources to support QI activity.
Prescribing safety

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>QI001. The contractor can demonstrate continuous quality improvement activity focused upon prescribing safety as specified in the QOF guidance.</td>
<td>27</td>
<td>NA</td>
</tr>
<tr>
<td>QI002. The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity as specified in the QOF guidance. This would usually include participating in a minimum of two peer review meetings.</td>
<td>10</td>
<td>NA</td>
</tr>
</tbody>
</table>

Rationale

Medicines prevent, treat or manage many illnesses or conditions and are the most common intervention in healthcare (NICE, 2015). The number of prescribed medicines supplied in primary care in England has been increasing year on year. The Health Survey for England 2016 (NHS Digital, 2017) reported that 1,104 million prescription items were dispensed in 2016, an increase of 1.9% (20.5 million additional items) on the number dispensed in 2015. The average number of prescription items per head of the population in 2016 was 20.0, compared with 19.8 items in the previous year.

As primary care staff will be aware, the number of people with multiple conditions is increasing; 25% of all people in England live with 2+ conditions and 8% live with 4+ conditions (Health Foundation, 2018). Over a 2-year period, people with 4+ conditions visited their GP almost 25 times for face to face consultations and were prescribed over 20 different medications.

In May 2012, the GMC published its report Investigating the prevalence and causes of prescribing errors in general practice which found that 1 in 20 prescriptions contained an error in terms of medication or monitoring. Most were graded as mild or moderate severity but 1 in 550 was a severe error. Many such errors relate not just to a prescriber’s clinical knowledge but also to communication between primary and secondary care, communication with patients and carers, and safety monitoring systems in practices.

Through these QOF indicators practices are being encouraged to help meet the WHO challenge to reduce medication-related harm by 50% by December 2022 (Medication Without Harm, Third Global Patient Safety Challenge, WHO, 2017) and recently announced five year action plan to reduce antimicrobial resistance (Tackling antimicrobial resistance 2019-2024, HM Government 2019).

Overview of the QI module

The overarching aim of these QI indicators is to lead to improvements in the following aspects of prescribing safety:

- Reduce the rate of potentially hazardous prescribing, with a focus upon the safer use of non-steroidal anti-inflammatory drugs (NSAIDs) in patients at significant risk of complications such as gastro-intestinal bleeding.
• Better monitoring of potentially toxic medications and the creation of safe systems to support drug monitoring through a focus upon lithium prescribing (or another agreed medication if no patients on the registered list are currently being prescribed lithium).

• Better engagement of patients with their medication through a focus upon valproate and pregnancy prevention.

• Improve collaboration between practices, networks and community pharmacists to share learning and improve systems to reduce harm and improve safety.

Practices will need to:

i. Evaluate the current quality of their prescribing safety and identify areas for improvement – this would usually include an baseline assessment of current prescribing (QI001)

ii. Identify quality improvement activities and set improvement goals to improve performance in the three identified areas – see below (QI001)

iii. Implement the improvement plan (QI001)

iv. Participate in a minimum of 2 network peer review meetings (QI002)

v. Complete the QI monitoring template in relation to this module (QI001 + QI002)

The following section includes further detail on the types of things practices could do to deliver this module. These are suggestions only and the decision about what to include in the QI plan and which QI methodologies to use should be made by practices and shared with their peers through the network meetings.

Detailed contractor guidance

1. Identifying areas for improvement

All practices should undertake an audit of the current quality of their prescribing in relation to the following measures:

• Patients at significant risk of gastrointestinal adverse effects who have been prescribed a nonselective nonsteroidal anti-inflammatory drug (NSAID) without co-prescription of a proton-pump inhibitor (PPI) in the preceding 6 months.

• Patients receiving lithium and being monitored in primary care who have not had a recorded check of their lithium concentrations, estimated glomerular filtration rate, urea and electrolytes, serum calcium and thyroid function in the previous 6 months.

• Girls and women of childbearing potential currently being prescribed valproate have had an annual specialist medication review and are taking this in compliance with the pregnancy prevention programme as documented by a specialist in the annual risk acknowledgement form. This standard applies equally to unlicensed use for pain, migraine and other conditions.

Where practices do not have any patients being prescribed lithium they may select an alternative medication to focus on based on their prescribing data and professional judgement. It is recommended that the medication chosen reflects similar issues to lithium prescribing e.g. a requirement for systematic toxicity monitoring. Suggested alternatives include the appropriate monitoring of amiodarone, phenobarbital or methotrexate. As this is a quality improvement exercise, this should not lead to the removal of locally agreed shared care protocols, including any
associated funding to deliver the activity. Any alternative to lithium should be agreed between the contractor and the commissioner.

Even if a practice does not have any girls of any age or women of childbearing potential who are currently prescribed valproate, they should ensure their practice has a robust system in place to identify and refer for annual specialist review any new at-risk patients being prescribed valproate and should ensure continuous measurement of this measure. The inclusion of valproate prescribing and monitoring seeks to further promote health care professional awareness of the appropriate monitoring actions whilst awaiting the report of the Independent Medicines and Medical Devices Safety Review, chaired by Baroness Cumberlege.

These medications have been selected as they are linked to significant potential harm if prescribed and managed inappropriately. At a national level, progress against these measures will be monitored and used to inform any evaluation of this QI module.

BOX 1. How to do a prescribing audit

A prescribing audit is considered to have five steps:
1. Choose a relevant topic (such as NSAID prescribing)
2. Derive some standards from good quality guidelines (eg NICE)
3. Measure your prescribing practice (through searches in the clinical system) and compare how you do against your chosen standards
4. Plan any actions needed to make improvements or sustain good practice and implement them, setting clear goals to achieve
5. Repeat the measurement of your prescribing practice against the standards to assess the impact of the changes you have made. Continue repeated cycles of these steps as you judge necessary.

An audit function is available on all GP software systems to identify and recall all women and girls being prescribed valproate who may be of child bearing potential. Contractors should use this tool in preference to developing their own bespoke searches.

Practices may also find it useful to undertake a reflective group meeting and complete a SWOT (strengths, weaknesses, opportunities, threats) analysis. Guidance as to how to do this can be found in the RCGP guide How to get started in QI (link). Understanding and sharing individual learning experiences and promoting reflective practice as individuals and in groups helps in the creation of a culture of learning and continuous improvement and the ultimate success of any quality improvement activity.

2. Identifying quality improvement activities and setting improvement goals

Following the initial baseline assessment, practices should develop a quality improvement plan which describes the actions they are going to take to address the prescribing safety improvements they are going to make. Evidence based improvement quality activities include:

- Audit of current prescribing against validated measures
- Review of patients identified as potentially at risk through the audit
- Review of practice systems to address organisational factors which contribute to medication related harm
- Ongoing measurement to demonstrate the impact of any changes [ref – PINCER, BG work]

Objectives to support these plans should be SMART (Specific, Measurable, Achievable, Relevant and Time-bound). See Box 2 for examples. Practices should set their own targets for improvement based upon their baseline audit results. These should be challenging but realistic and recognise that it may be easier to make larger improvements when starting from a modest baseline. These should be validated by network peers as part of the initial network review meeting.

Factors to consider when setting these targets include:
- The severity level of identified clinical risk to patients
- The urgency of the timescale to review patients and reduce the risk
- The availability and training of appropriate practice staff to review patients

Quality improvement activities can involve the whole practice team and specialist advice as necessary. In relation to prescribing safety, practices are encouraged to work with clinical and community pharmacists to consider potential improvements and how these may be realised.

There are many aspects of prescribing safety which would be suitable for quality improvement work, but practices should as a minimum address the aspects listed above. A number of external resources are available to support practices with improving prescribing safety such as the RCGP Patient Safety toolkit. In addition, the Academic Health Sciences Network (AHSNs) are implementing the PINCER intervention between now and 2020. Practices are encouraged to engage with their AHSN to access this support.
Box 2: Examples of SMART objectives

**Objective 1:**
Baseline practice prescribing analysis identifies patients on regular NSAID prescriptions with a recorded contraindication.
SMART outcome: Repeat analysis after 3 months (and repeated at 3monthly interval thereafter) shows NO PATIENTS with a recorded contraindication have been prescribed NSAIDS.

**Objective 2:**
Baseline practice prescribing analysis shows only 5% of patients obtaining a regular (repeat) NSAID have had a clinical safety risk assessment clearly documented within the last 12months.
SMART outcome: Increase from 5% to X% over the next 6 months (practice to decide) and X-Y% over the 6-12 months (practice to decide) of people prescribed NSAIDs regularly have a documented clinical safety risk assessment (as part of their medication review) as per NICE advice within the preceding 12months.

**Objective 3:**
Baseline practice prescribing analysis shows 50% of patients prescribed lithium for more than one year and suitable (as per NICE guidance) for 6 monthly checks had had a recorded serum lithium level checked within the last 6 months.
SMART outcome: At a repeat analysis 6 months after the baseline analysis there is an increase from 50% to X% (practice to decide) of patients prescribed lithium for greater than a year who are suitable for 6 monthly checks who have a recorded serum lithium level within the last 6 months.

**Objective 4**
Baseline practice prescribing analysis shows no girls or women of childbearing potential are currently prescribed valproate without a highly effective pregnancy prevention plan in place as per MHRA guidelines. However no practice system is in place to routinely identify new potential at risk patients.
SMART outcome: Within one month the practice can demonstrate an appropriate repeated monthly search of the clinical system to identify all girls or women of childbearing potential who have been recommended to start valproate medication have had a clinical review to ensure compliance with the pregnancy prevention programme as recommended by the MHRA.
Guidance on specific elements of the quality improvement activity

NSAID prescribing

*NICE Clinical Knowledge Summary (CKS) on NSAID prescribing* (revised August 2018) provides advice on this topic including how to reduce harm from gastrointestinal side effects such as ulcer, perforation, obstruction or bleeding. Nonsteroidal anti-inflammatory drugs (NSAIDs) must not be prescribed to people with:

- active gastrointestinal (GI) bleeding, or active GI ulcer
- history of GI bleeding related to previous NSAID therapy, or history of GI perforation related to previous NSAID therapy
- history of recurrent GI haemorrhage (two or more distinct episodes), or history of recurrent GI ulceration (two or more distinct episodes).

The CKS advice also sets out how to assess risk of harm from NSAIDs in patients and then what appropriate prescribing decisions to take. This advice can be used as evidence-based standards against which to assess a practice’s current prescribing.

Examples of the audit standards which practices could adopt are:

- No patients with a current clinical contraindication are currently being prescribed an NSAID medication.
- 100% of patients with an NSAID medication on regularly receiving a repeat prescription have had a documented clinical safety risk review in the last 12 months.
- 100% of patients identified as high risk and requiring ongoing treatment have been prescribed a selective NSAID.
- 100% of patients identified as moderate risk and requiring ongoing treatment have been prescribed an appropriate NSAID with proton pump inhibitor unless contraindicated.

Practices should then demonstrate the action they have taken to reduce risk to these patients, and the system or process they will continue to use to maintain safe NSAID prescribing.

**Monitoring or potentially toxic medications – Lithium** - *NICE guidance Bipolar disorder: assessment and management*, NICE (2014) clearly sets out the requirements for monitoring lithium once a patient has been returned from secondary to primary care.

Analysis of the practice’s prescribing data and searches within the practice’s electronic clinical system will be able to identify individual patients prescribed lithium who are not being managed in line with NICE guidance. Practices are encouraged to review their process for following up a person who has not responded to invitations for monitoring or fails to order or collect prescriptions to ensure concordance with treatment plans and avoid clinical deterioration and crisis.

Practices can use the QI approach to ensure their processes for lithium monitoring are robust and comply with NICE guidance and take action to identify and reduce any risks to individual patients.
Valproate and pregnancy prevention programme – MRHA alert April 2018, updated October 2018

(see also Drug Safety Update volume 11 issue 10; May 2018)

During 2018, all practices and individual GPs will have been sent a pack of information advising them of the need to identify any girl or woman of childbearing potential (this is defined as a pre-menopausal woman who is capable of becoming pregnant) currently being prescribed valproate and setting out a series of actions for health professionals including GPs. Valproate use in pregnancy is associated with an increased risk of children with congenital abnormalities and developmental delay. Valproate is contraindicated in women of childbearing potential unless the conditions of the valproate pregnancy prevention programme are fulfilled. Whilst the rates of prescribing of valproate continue to decline slowly there are wide geographical variations in prescribing.

Clear actions have been set for general practices to identify and recall existing patients, provide them with a copy of the Patient Guide, to check they have had a specialist review in the last year and to have systems in place to identify and appropriately manage new patients who are prescribed valproate and are of child bearing potential.

The pregnancy prevention programme requires GPs to:

- Ensure continuous use of highly effective contraception* in all women of childbearing potential (consider the need for pregnancy testing if not a highly effective method).
- Check that all patients have an up to date, signed, Annual Risk Acknowledgment Form each time a repeat prescription is issued.
- Ensure the patient is referred back to the specialist for review, annually.
- Refer back to the specialist urgently (within days) in case of unplanned pregnancy or where a patient wants to plan a pregnancy.

* The Summary of Product Characteristics for valproate states that ‘Women of childbearing potential who are prescribed valproate must use effective contraception without interruption during the entire duration of treatment with valproate. These patients must be provided with comprehensive information on pregnancy prevention and should be referred for contraceptive advice if they are not using effective contraception. At least one effective method of contraception (preferably a user independent form such as an intra-uterine device or implant) or two complementary forms of contraception including a barrier method should be used. Individual circumstances should be evaluated in each case when choosing the contraception method, involving the patient in the discussion to guarantee her engagement and compliance with the chosen measures. Even if she has amenorrhea she must follow all the advice on effective contraception.’

For children or for patients without the capacity to make an informed decision, provide the information and advice on highly effective methods of contraception and on the use of valproate during pregnancy to their parents/ caregiver/ responsible person and make sure they clearly understand the content.
The practice should regularly use the audit function on their clinical system to identify at risk patients and ensure timely recall for clinical review in line with the MHRA alert. Such continuous measurement can be used to demonstrate compliance with the MHRA alert.

This improvement programme offers general practice a further opportunity to ensure these actions have been completed and that ongoing systems to protect patients from harm have been put in place.

3. Implementing the plan

Practices should implement the improvement plan developed to support their objectives. It is recommended that these plans and associated improvement activities should involve the whole practice team and practices are encouraged to engage with colleagues in community pharmacy where practicable.

Practices should undertake continuous improvement cycles to achieve the outcomes they have set themselves. These should focus upon necessary changes to practice systems and processes, staff roles, methods of recording and sharing information as well as reviewing care for individual patients.

Continuous measurement is recommended to demonstrate the impact of the changes being tested. The audit cycle should be closed by repeating the audit and clarifying the outcomes achieved.

Example case studies will be made available on the NHS England at the end of March 2019.

4. Network Peer review meetings

A key objective of the network peer review meetings is the establishment of a system to enable shared learning across Primary Care Networks. The aim of this is to share best practice in prescribing safety.

Contractors should participate in a minimum of two network peer review discussions unless there are exceptional and unforeseen circumstances which impact upon a contractor’s ability to participate. Whilst these meetings would usually be face to face, networks are able to explore other mechanisms to facilitate real time peer learning and sharing including virtual meetings.

The peer review group will usually be the Primary Care Network of which the practice is a member. Where the practice is not part of a network their peer review group should be agreed with the commissioner. Suggested discussion points for these meetings are made in Box 3.

The network clinical lead or their nominated deputy should facilitate these meetings and maintain a record of attendance. It is for the network to determine the timing of these meetings but we would recommend that the first meeting takes place early in the QI activity and the second towards the end.
5. Reporting and verification

The contractor will complete the QI monitoring template in relation to this module and self-declare that they have completed the activity described in their QI plan. The contractor will also self-declare that they have attended a minimum of two peer review meetings as described above, unless there are exceptional and unforeseen circumstances which impact a contractor’s ability to participate. In these circumstances contractors are expected to make efforts to ensure alternative participation in peer review.

Verification – Commissioners may require contractors to provide a copy of the QI monitoring template as written evidence that the quality improvement activity has been undertaken. Commissioners may require the network clinical lead to provide written evidence of attendance at the peer review meetings. If a contractor has been unable to attend a meeting due to exception and unforeseen circumstances then they will need to demonstrate other active engagement in peer learning as review.

Box 3. Suggested peer review meeting discussion points

The first peer review meeting should take place early in the QI process and focus upon:

- Sharing of the outputs of diagnostic work to understand the issues associated with prescribing safety
- Validation of practice improvement targets

Discussion points could include:

1. What relevant evidence-based guidance / quality standards can the group use?
2. What data has each practice used to inform its review of current performance?
3. Has the right focus been chosen by each practice based on their current performance?
4. Has each practice set a clear aim with a challenging but realistic local target, and agreed an appropriate measurement to monitor impact?
5. What ideas for changes is each practice planning to try in an improvement cycle?
6. How are practices ensuring the whole practice team (including other clinical colleagues and patients and carers) are engaged in the proposed QI activity?

The second peer review meeting should take place towards the end of the QI process and should focus upon:

- Celebrating successes and sharing of key changes made in practice.
- How these changes can be embedded into practice.

Discussion points could include:

1. What results have each practice seen in their QI activity testing?
2. What changes have been adopted in each practice?
3. How will these changes be sustained in the future?
4. What new skills have staff developed and how can they be used next?
5. What further QI activity prescribing safety is planned in each practice?
6. What further actions may need to take place (e.g. at network or CCG level) to support the changes in practices?
The reporting template is available below.

**QI module documentation: Safe prescribing**

It is anticipated that the responses noted here should total 1 A4 sides in Arial font size 11.

<table>
<thead>
<tr>
<th>Practice name and ODS code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Diagnosing the issues**

<table>
<thead>
<tr>
<th>What issues did the practice identify with prescribing safety?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What changes did the practice make to try to address issues identified with prescribing safety?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Results**

<table>
<thead>
<tr>
<th>What did the practice achieve?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What changes will/ have been embedded into practice systems to ensure prescribing safety in the future?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How did the network peer support meetings influence the practice’s QI plans and understanding of prescribing safety?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Please attach the results of both prescribing audits (as appendices)

**End of life care**
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>QI003: The contractor can demonstrate continuous quality improvement activity focused on end of life care as specified in the QOF guidance</td>
<td>27</td>
<td>NA</td>
</tr>
<tr>
<td>QI004: The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity as specified in the QOF guidance. This would usually include participating in a minimum of two network peer review meetings.</td>
<td>10</td>
<td>NA</td>
</tr>
</tbody>
</table>

**Rationale**

In 2015 the National Palliative and End of Life Care Partnership published *Ambitions for palliative and end of life care: a national framework for local action 2015-2020*. This quality improvement activity is designed to support practices to respond to those ambitions and to build the foundations needed to provide excellent, holistic and individualised care for all.

Identifying patients in need of end of life care, assessing their needs and preferences, and proactively planning their care with them are key steps in the provision of high quality care at the end of life in general practice. There is evidence to suggest that there is the potential for the quality of this care to be improved. Increased use of healthcare services during this time also occurs often with limited clinical effectiveness and poor experiences for people. Better identification of people in the last year of their life followed by appropriate care planning and support for them are recognised as key elements of good medical practice as set out by the General Medical Council (*Treatment and care towards the end of life: good practice in decision making*, 2010).

Involving, supporting and caring for all those important to the dying person is also recognised as a key foundation of good end of life care. As well as being individuals facing impending loss and grief, they often provide a key caring role for the dying person.

**Overview of the QI module**

The overarching aim of these QI indicators is to lead to improvements in relation to the following aspects of care:

1. **Early identification and support for people** with advanced progressive illness who might die within the next twelve months.
2. **Well-planned and coordinated care** that is responsive to the patient’s changing needs with the aim of improving the experience of care.

---

3. **Identification and support for family / informal care-givers**, both as part of the core care team around the patient and as individuals facing impending bereavement.

Practices will need to:

- vi. Evaluate the current quality of their end of life care and identify areas for improvement – this would usually include a retrospective death audit (QI003)
- vii. Identify quality improvement activities and set improvement goals to improve performance (QI003)
- viii. Implement the improvement plan (QI003)
- ix. Participate in a minimum of 2 GP network peer review meetings (QI004)
- x. Complete the QI monitoring template in relation to this module (QI003 + QI004)

The following section includes further detail on the types of things practices could do to deliver this module. These are suggestions only and the decision about what to include in the QI plan and which QI methodologies to use should be made by practices and shared with their peers through the network meetings.

**Detailed contractor guidance**

1. **Identifying areas for improvement**

All practices should start with an assessment of the current quality of care they provide for patients and their families at the end of life. This would usually include the completion of a retrospective baseline audit analysis of deaths unless this has been completed in the previous 3 months. Box 1 provides further information about how to do this. The purpose of this is to understand firstly, the numbers of people who had been identified on the palliative care register and therefore deaths which had been anticipated and secondly, how many patients had care plans in place. If the practice already has well-established end of life care processes then this baseline audit analysis could focus upon other aspects of care such as:

- Priority care goals achieved e.g. is preferred place of death recorded and achieved?
- Quality of care plans including treatment escalation and advance care plans e.g. legal status of Power of Attorney and advance Directives, and emergency treatment preferences such as recording of decision on cardiopulmonary resuscitation (note evidence suggests that this should be part of the care planning process and not done in isolation).
- Main carer is identified with offer of assessment and support
- Anticipatory medicines are available in the place of care

We encourage practices, particularly those with well-established end of life care processes to seek the views of family members / informal carers which for example could be done through a **survey of carers** or a **structured interview with one carer or patient every six months** to evaluate how well the practice meets their needs and what improvements could be made.
Practices may also find it useful to undertake a reflective group meeting and complete a SWOT (strengths, weaknesses, opportunities, threats) analysis. Guidance as to how to do this can be found in the accompanying RCGP guide How to get started in QI (link). Understanding and sharing individual learning experiences and promoting reflective practice as individuals and in groups helps in the creation of a culture of learning and continuous improvement and the ultimate success of any quality improvement activity.

2. Identifying quality improvement activities and setting improvement goals

The identification of quality improvement activities should be informed by the results of the retrospective death baseline audit and analysis. Practices should focus their QI activities on delivering improvement across the following four measures:

1. An increase in the proportion of people who die from advanced serious illness who had been identified in a timely manner on a practice ‘supportive care register’, in order to enable improved end of life care, reliably and early enough for all those who may benefit from support.

2. An increase in the proportion of people who died from advanced serious illness who were sensitively offered timely and relevant personalised care and support plan discussions; documented and shared electronically (with appropriate data sharing agreements in place) to support the delivery of coordinated, responsive care in and out of hours with key cross-sector stakeholders.

3. An increase in the proportion of people who died from advanced serious illness where a family member / informal care-giver / next-of-kin had been identified; with an increase in those who were offered holistic support before and after death, reliably and early enough for all those who may benefit from support.

4. A reliable system in place to monitor and enable improvement based on timely feedback of the experience of care from staff, patients and carer perspectives.

These measures will be used at a national level to assess the impact of the module. Identification and care planning should be addressed in parallel. Improvement activity should focus on impact, and may include a dedicated focus on specific areas or patient groups e.g. the practice may perform well in relation to supporting patients
with cancer at the end of life, but could improve in relation to other patient groups e.g. those with respiratory disease, children with life limiting illnesses or people with learning disabilities.

Practices may also wish to review the RCGP and Marie-Curie Daffodil standards: core Standards for advanced serious illness and end of life care in general practice (www.rcgp.org.uk/daffodilstandards_in_Spring_2009) and the NICE Quality Standards for End of Life Care in Adults (QS13) and Care of dying adults in the last days of life (QS144) for further suggestions of appropriate quality improvement activities.

For each of the measures, practices should identify and agree their own objectives which are SMART (Specific, Measurable, Achievable, Relevant and Time-bound). See Box 2 for examples of SMART outcomes. Practices should set their own targets for improvement based upon their baseline audit results. These should be challenging but realistic and recognise that it may be easier to make larger improvements when starting from a modest baseline. These should be validated by network peers as part of the initial network review meeting.
Implementing the plan

Practices should implement the improvement plan they have developed to support the objectives they have identified. It is recommended that these plans and associated improvement activities should involve the whole practice team and practices are encouraged to engage with colleagues in community and related services (such as district nurses, hospice services, and community pharmacy) where practicable. Where possible, patients and their family members and informal care givers should be involved in continuous quality improvement around people affected by advanced serious illness and end of life care. This is especially the case in relation to measures 3 and 4.

Box 2: Examples of SMART outcomes for each measure

Measure 1:
Baseline analysis from retrospective audit – 20% of people affected by serious illness and end of life care who died, had already been identified on a practice ‘supportive care register’.
SMART outcome: Increase from 20% to X% of people affected by serious illness and end of life care who died, to be identified on a practice ‘supportive care register’, over the next 6 months.

Measure 2:
Baseline analysis from retrospective audit – 10% of people affected by serious illness and end of life care who died, had been sensitively offered timely and relevant personalised care and support plan discussions and these were documented and shared electronically.
SMART outcome: Increase from 10% to X% over the next 6 months (practice to decide) and X-Y% over the 6-12 months (practice to decide) of people affected by serious illness and end of life care who died, to be sensitively offered timely and relevant personalised care and support plan discussions and have these documented and shared electronically.

Measure 3:
Baseline analysis from retrospective audit – 10% of family members / informal care-givers/ next-of-kin identified on a practice ‘supportive care register’ were contacted and offered information on dealing with grief and bereavement within 1 month of the person on the register dying.
SMART outcome: Increase from 10% to X% (practice to decide) of family members / informal care-givers/ next-of-kin identified on the practice ‘supportive care register’ to be contacted and offered information on dealing with grief and bereavement within X weeks /months (practice to decide) of the person on the register dying – within a 12-month period.

Measure 4:
SMART outcomes:
To support and reflect on retrospective death audit and practice-relevant QI planning within the 12-month period, achieving a minimum of:
   a) 2-5 family/care-giver or patient interviews (See Appendix 1) e.g. semi-structured discussion, using an agreed template or annual carer survey relevant to EOLC needs.

Optional and additional SMART OUTCOMES could include:

3. Implementing the plan

Practices should implement the improvement plan they have developed to support the objectives they have identified. It is recommended that these plans and associated improvement activities should involve the whole practice team and practices are encouraged to engage with colleagues in community and related services (such as district nurses, hospice services, and community pharmacy) where practicable. Where possible, patients and their family members and informal care givers should be involved in continuous quality improvement around people affected by advanced serious illness and end of life care. This is especially the case in relation to measures 3 and 4.
Practices should undertake continuous improvement cycles to achieve the outcomes they have set for themselves in relation to the measures they are focusing on. Example case studies will be made available on the NHS England website by end of March 2019.

4. **GP Network peer review meetings**

A key objective of the network peer review meetings is to enable shared learning across the network. The aim of this is to improve learning from deaths and the provision of best practice end of life care. It is also intended to provide a forum for practices to identify wider system issues impacting upon care quality which may require a collective response.

Contractors should participate in a minimum of two network peer review discussions unless there are exceptional and unforeseen circumstances which impact upon a contractor’s ability to participate. Whilst these meetings would usually be face to face, networks are able to explore other mechanisms to facilitate real time peer learning and sharing including virtual meetings.

The peer review group will usually be the Primary Care Network of which the practice is a member. Where the practice is not part of a network their peer review group should be agreed with the commissioner. Suggested discussion points for these meetings are made in Box 3.

The network clinical lead or their nominated deputy should facilitate these meetings and maintain a record of attendance. It is for the network to determine the timing of these meetings but it is recommended that the first meeting takes place early in the QI activity and the second towards the end.
Box 3: Suggested peer review meeting discussion points

The first peer review meeting should take place early in the QI activity and focus on:
- Sharing the outputs of the diagnostic work to understand the issues for each practice about end of life care.
- Validation of practice improvement targets.

Discussion points could include:
1. What relevant evidence-based guidance / quality standards can the group use?
2. What data has each practice used to inform its review of current performance?
3. Has the right focus been chosen by each practice based on their current performance?
4. Has each practice set a clear aim with a challenging but realistic local target, and agreed an appropriate measurement to monitor impact?
5. What ideas for changes is each practice planning to try in an improvement cycle?
6. How are practices ensuring that the whole practice team (including other clinical colleagues and patients and carers) are engaged in the proposed QI activity?

The second peer review meeting should take place towards the end of the QI activity and focus on:
- Celebrating success and sharing of key changes made in practice.
- Encouraging a compassionate, no-blame and active learning culture.
- How these changes have been embedded and will be sustained.

Discussion points could include:
1. What results have each practice seen in their QI activity testing?
2. What changes have been adopted in each practice?
3. How will these changes be sustained in the future?
4. What new skills have staff developed and how can they be used next?
5. What further QI activity in end of life care is planned in each practice?
6. What further actions may need to take place (e.g. at network or CCG level) to support the changes in practices?

5. Reporting and verification

The contractor will need to complete the QI monitoring template in relation to this module and self-declare that they have completed the activity described in their QI plan. The contractor will also self-declare that they have attended a minimum of two peer review meetings as described above, unless there are exceptional and unforeseen circumstances which impact upon a contractor’s ability to participate. In these circumstances contractors are expected to make efforts to ensure alternative participation in peer review.

Verification - Commissioners may require contractors to provide a copy of the QI monitoring template as written evidence that the quality improvement activity has been undertaken. Commissioners may require the network clinical lead to provide written evidence of attendance at the peer review meetings. If a contractor has been unable to attend a meeting due to exceptional circumstances then they will need to demonstrate other active engagement in network peer learning and review.

The reporting template is below.
<table>
<thead>
<tr>
<th>QI module documentation: End of life care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>It is anticipated that the responses noted here should total approx. 1 A4 side in Arial font size 11.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practice name and ODS code</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosing the issues</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>What issues did the practice identify with current end of life care?</td>
<td></td>
</tr>
<tr>
<td>What SMART outcomes did the practice set for each measure?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Results</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>What did the practice achieve?</td>
<td></td>
</tr>
</tbody>
</table>

| What changes will/ have been embedded into practice systems to ensure improved quality end of life care in the future? |  |
| How did the GP network peer support meetings influence the practice’s QI plans and understanding of end of life care? |  |

| Please attach the results of both end of life care audits (as appendices), including identified SMART outcomes for each objective. |  |
Annex C: Network Contract DES Registration Form

This registration form sets out the information required by the commissioner for any Primary Care Networks (member practices) signing-up to the Network Contract Directed Enhanced Service.

The completed form is to be returned to [add name] by no later than the 15 May 2019.

**PCN members and ODS code**

<table>
<thead>
<tr>
<th>Network Member Practices</th>
<th>ODS code</th>
<th>Practice’s registered list size (as at 1 January 2019)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Network list size**

[This is the sum of member practice’s list sizes as at 1 January 2019]

**Name of Clinical Director**

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
<th>Practice/organisation</th>
<th>Contact Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Details for network’s nominated payee**

Name of single nominated practice or provider (‘nominated payee’):

<table>
<thead>
<tr>
<th>Name of bank account (if different to above)</th>
<th>Account number</th>
<th>Sort code</th>
</tr>
</thead>
</table>
Appendix A: Initial Network Agreement

Note: A revised version of the Network Agreement may be required immediately prior to the contract variation to provide information that may not have been confirmed on initial registration.
Annex D: Additional detail on main 2019/20 contract changes

Main Contractual changes

Additional Services
1. From April 2019, contraception services will no longer be an Additional Service under the Regulations but will become part of Essential Services. There will be no opt-out or reduction of global sum payments as a result.

Network Practice Participation Payment
2. From April 2019 practices will be able to claim a Network Participation Practice Payment for being an active member of a Primary Care Network through signing up to the Network Contract DES, which will be introduced from 1 July 2019.

Ban on advertising and hosting of private GP services
3. To safeguard the model of comprehensive NHS primary medical care, from 2019 it will no longer be possible for any GP provider either directly or via proxy to advertise or host private paid-for GP services that fall within the scope of NHS-funded primary medical services. NHS England will consult in 2019 on expanding this ban on private GP services to other providers of mainly NHS services.

Changes to the FP10 form
4. For all future prescriptions, where the medication is for a Sexually Transmitted Infection (STI), the prescriber will write SH as an endorsement on the FP10 form. The requirement for the endorsement will be added to the GMS Regulations to make the requirement explicit as it is with other endorsements (Regulation 61). This will only be a temporary solution until EPS4 functionality is available.

Data Requirements
5. Practices will be required to provide data in support of delivering the contract requirements set out in this document through new contract requirements, including on any practice not participating in the Network DES providing data to facilitate the provision of network services to their list.

Digital
6. All patients will have online access to their full record, as the default position from April 2020, with new registrants having full online access to prospective data from April 2019.

7. All practices will be offering and promoting electronic ordering of repeat prescriptions and using electronic repeat dispensing for all patients for whom it is clinically appropriate, as a default from April 2019.

8. All practices will ensure at least 25% of appointments are available for online booking by July 2019.
9. Practice funding will be revised to avoid unwarranted redistribution to digital-first models from other practices. In 19/20:
   i. the rurality index payment will be amended to apply to patients living within a practice catchment area only, rather than to all patients; and
   ii. the London adjustment will be amended to apply to patients’ resident in London, rather than registered in a London-based practice.

**Direct booking from NHS111**

10. From 2019/20, where the functionality exists, practices will allow the direct booking of clinician-assessed patient appointments from the NHS111 service into the practice.

11. NHS England and GPC England have agreed that practices will make available one appointment per whole 3,000 patients per day for direct booking from NHS111. If a practice has a registered list of less than 3,000 patients, the practice will make one appointment available per day for direct booking from NHS111. If those appointments are not taken up, they will be available to the practice to use in good time.

12. When the appointment is offered and made, it will be made clear to the patient that they are not being booked into automatically seeing a GP at that time. They must plan to attend the practice at that time. But they may be contacted by the practice prior to the appointment time, to confirm if:
   - they will see the GP at the practice; or
   - they will have a telephone appointment with the GP; or
   - they will see another healthcare professional at the practice.
   If they do not hear from the practice they must attend at the appointed time.

13. Clear post-event information will be automatically added to the patient record along with the appointment, so that the practice can easily see the reason for the appointment and any relevant clinical summary or why the practice decided the appointment was inappropriate. NHS England will provide guidance for practices and NHS 111 outlining how system configuration can be optimised to make this information as clear and accessible as possible.

14. Practices can then decide (as above) whether to accept a GP appointment at the appointed time, contact the patient to arrange a phone appointment with a GP, or contact the patient to arrange an appointment with another healthcare professional.

15. Commissioners will work with practices [and LMCs] to review the efficacy of direct booking arrangements both from a clinical audit and a logistical perspective.

**Duty of Co-operation**

16. The existing Duty of Co-operation requirements will be amended to facilitate data sharing between providers to support integrated provision of services.

**Marketing campaigns**

17. From 2019-20 NHS England and GPC England have agreed that GP practices will be required to support six national NHS marketing campaigns on an annual basis.
basis, where the GP contractor will be required to put up and display in their premises, campaign display materials six times every 12 months. NHS England will produce the campaign materials and will share with each practice for them to display.

18. NHS England and GPC England will to develop a formal process for agreeing which campaigns GP Practices will be asked to support.

MHRA Central Alerting System (CAS)
19. The Central Alerting System (CAS) which is the national system for issuing patient safety alerts, important public health messages and other safety critical information to all providers, including GP practices, is being updated. NHS England will be able to send alerts directly to practices by email or mobile phone (when functionality is available) which will improve public safety.

20. From October 2019, there will be a contractual requirement for practices to:
   - register a practice email address with MHRA CAS alert system and monitor the email account to act on CAS alerts where appropriate.
   - notify the MHRA if the email address changes to ensure MHRA distribution list is updated.
   - register a mobile phone number (or several) to MHRA CAS to be used only as an emergency back up to email for text alerts when e-mail systems are down.

QOF changes

Payment to reflect changes to medical records movement
22. As part of the 2017/18 contract settlement, £2m was included in global sum to recognise the additional work arising from a change to medical records movement. We agreed that the funding would remain in global sum until this additional payment is no longer required. This funding continued to be included in global sum for 2018/19 and we have agreed that this £2m should remain in global sum as a non-recurrent element for 2019/20. However, we expect that this funding will not be included next year, subject to review at the time. The £2m released will be available for reinvestment in the contract.

Use of the NHS Logo
23. From October 2019, where GPs choose to apply the NHS primary care logo in relation to their NHS provided services, they will be required to adhere to the NHS Identity guidelines and apply the NHS primary care logo to all information and materials about their NHS services.

Shared parental leave
24. Legislation now allows parents to share parental leave on the birth of a child. To support GPs who wish to do this, NHS England will reimburse the cost of locum cover for GPs taking shared parental leave in the same way that is done for those taking maternity leave.
Transparency

25. GPs with total NHS earnings above £150,000 per annum – including salaried GPs - will be listed by name and earnings in a national publication, starting with 2019/20 income. The Government will look to introduce the same pay transparency across other independent contractors in the NHS at the same time.

Vaccinations and Immunisations

26. The item of service (IoS) fees for the following three programmes will be uplifted to £10.06 from April 2019:
   - childhood seasonal influenza
   - pertussis
   - seasonal influenza and pneumococcal polysaccharide

27. IoS uplifts for future years to be included in the wider review of vaccinations and immunisations.

Influenza vaccine

28. From April 2019, care home and social care staff will be added to the categories of people entitled to a flu vaccine on the NHS under the Influenza and Pneumococcal Immunisation Scheme at an IoS fee of £10.06.

29. The Influenza and Pneumococcal Immunisation Scheme DES specification will be revised to explicitly underline that in order for practices to receive payment for the vaccination and reimbursement for the vaccine, they need to use the flu vaccine recommended in NHSE guidance.

HPV vaccine

30. The current Human Papillomavirus (HPV) programme is provided in schools and is for girls aged 14-18. Contractors can already vaccinate women above age 18, based on clinical judgement. We have agreed to amend the SFE from April 2019 so that any vaccination of women aged over 18 and up to 25 years will be paid at an IoS rate of £10.06.

31. The HPV for boys programme will begin as part of the HPV vaccine programme (including girls and boys going forward) from September 2019. NHS England, GPC England and PHE have agreed that the catch-up element for boys will not need to be delivered through GP practices in 2019/20. Any boys who miss the initial doses from September 2019 to March 31, 2020 will be offered another appointment via the school based programme. We anticipate that boys will be added to the HPV catch-up scheme in general practice from April 2020.

MMR catch up for 10 and 11 year olds

32. From April 2019 NHS England and GPC England have agreed an item of service payment of £5 per patient for the extra cost of a catch-up campaign for the Measles, Mumps and Rubella (MMR) vaccine for 10 and 11-year olds in the light of the current measles outbreaks. Payment will be made for each child recorded as unvaccinated.

33. In return for receiving payment practices will be expected to:
i. Check patient paper/electronic records (Electronic Patient Record) and if necessary correct computerised record

ii. Confirm that patient is still in the area - if not, remove from list and inform the local Child Health Information Service (CHIS)

iii. Actively invite all those missing one or both doses of MMR to have the MMR vaccine at a vaccination clinic held in the practice or to make an appointment – priority should be given to patients missing both doses as this is where most clinical value /value for money can be gained

iv. Invites should be by letter, email, phone call, text or digital personal child health record ‘red book’ as appropriate. NHS England expect as a minimum three invites per payment per patient and a record of practice activity to go local teams:

- First invite can simply offer appointment
- Second invite - offer appointment, confirm receipt and/or check if parent/guardian has record of vaccination already e.g. Personal Child Health Record
- Third contact should be a practice healthcare professional discussion, either face-to-face or via telephone, with the parent or guardian - with the expectation that all staff participating are adequately trained. Practices to make use of the Public Health England (PHE) designed resources to aid call/recall discussions if required to support informed choice and improved uptake and coverage. (https://www.gov.uk/government/collections/immunisation#measles,-mumps-and-rubella-(mmr) At this point also check – offer/update any other childhood immunisations missing.

v. Ensure that those parents/guardians of patients who need second dose are invited and attend for the second dose (three invites);

vi. Continue to follow-up, recall and update computerised records for patients who do not respond or fail to attend scheduled clinics or appointments and offer opportunistically as and when

vii. If there is no response after the following the process outlined above, practices to notify school nursing service to follow up/offer at school

viii. Inform local team of outcome.

Non-contractual changes

Digital

34. NHS England and GPC England expect practices to make progress in 2019-20 towards the digital changes that will become contractual requirements from April 2020 and April 2021. These are:

i. all practices will be offering online consultations by April 2020 at the latest;

ii. all patients will have online access to their full record, as the default position from April 2020, subject to existing safeguards for vulnerable groups and third party confidentiality and system functionality;

iii. all practices will need by April 2020 to have an up-to-date and informative online presence, with key information being available as metadata for other platforms to use;
iv. all practices will be giving all patients access online to correspondence by April 2020, as the system moves to digital by default (with patients required to opt-out rather than in);

v. by April 2020, practices will no longer use facsimile machines for either NHS or patient communications;

vi. all practices will be offering consultations via video by April 2021 at the latest.

**Freedom to Speak Up Guardian**

35. The National Guardian’s office will begin developing a proposal for ‘Freedom To Speak Up’ guardianship in primary care during 2019, taking account of emerging PCNs. We will keep under review any potential contract implications.

**Over the Counter Medicine**

36. NHSE has agreed to provide a letter to provide assurance that practices they will not be at risk of breaching their contract when following OTC prescribing guidance. The letter can be read here: [https://www.england.nhs.uk/publication/letter-to-gp-practices-routine-prescribing-of-medicines-which-are-available-over-the-counter/](https://www.england.nhs.uk/publication/letter-to-gp-practices-routine-prescribing-of-medicines-which-are-available-over-the-counter/)

**Temporary residents**

37. NHS England and GPC to issue guidance to CCGs and practices to facilitate local solutions around temporary residents. This guidance will set out the flexibilities that exist to support practices who have faced a significant increase or decrease in the numbers of unregistered patients requiring treatment and how to apply appropriate temporary patient adjustment funding accordingly.

**Debt and mental health conditions**

38. NHS England, GPC England and Government have a shared concern about the impact that financial debt has on the mental health of many people. Following a Government review, the credit sector has amended its code of practice to minimise the instances in which it is deemed necessary to seek input from GPs via the Debt and Mental Health Evidence Form. NHS England, GPC England and Government will continue to work with relevant groups to maximise use of self-certification and alternative evidence by patients with mental health conditions or carers/families of patients, with the patient’s consent, when seeking debt relief. In exceptional situations where a self-certificated declaration requires validation or when patients are not in a position to self-certify, we will explore how this could be done by any appropriate health and social care professional or support worker known to the patient, reducing as far as possible the need for GP practice involvement. In the remaining circumstances where GP practice input is needed, we believe that this should be done without charge to the patient. NHS England and GPC England will therefore work with Government to amend regulations so that GP certification of a Debt and Mental Health Evidence Form much simplified from the version produced in 2012 is free of charges. Should banks or other lenders require further medical evidence in addition to the simplified initial validated statement of diagnosis, this would need to be sought directly from the practice for an appropriate fee which should be paid by the company not the patient.
Annex E: Network Contract DES Workforce Role Descriptions and Outputs

This Annex provides information on the core role requirements for the five workforce roles for which investment is being made via the new Network Contract DES. It is not a comprehensive list and Primary Care Networks will determine the job description for their staff ensuring they reflect these core requirements and enable delivery of the Network Service Specifications.

1. Workforce roles beginning from 2019/20

1.1. Network Clinical Director

Description of role/core responsibilities

Each network will have a named accountable Clinical Director, responsible for delivery. They provide leadership for networks strategic plans, through working with member practices and the wider Primary Care Network to improve the quality and effectiveness of the network services.

Together, the Clinical Directors will play a critical role in shaping and supporting their Integrated Care System (ICS), helping to ensure full engagement of primary care in developing and implementing local system plans to implement the NHS Long Term Plan. These local plans will go much further than the national parts of the Network Contract DES in addressing how each ICS will integrate care.

The role of the clinical lead will vary according to the particular characteristics of the network, including its maturity and local context, but the key responsibilities may include:

- providing strategic and clinical leadership to the network, developing and implementing strategic plans, leading and supporting quality improvement and performance across member practices (including professional leadership of the Quality and Outcomes Framework Quality Improvement activity across the network).
- Influencing, leading and supporting the development of excellent relationships across the network to enable collaboration for better patient outcomes
- providing strategic leadership for workforce development, through assessment of clinical skill-mix and development of network workforce strategy.
- supporting network implementation of agreed service changes and pathways, working closely with member practices, the wider PCN and the commissioner to develop, support and deliver local improvement programmes aligned to national and local priorities.
- developing relationships and working closely with other network Clinical Directors, clinical leaders of other health and social care providers, local commissioners and Local Medical Committees (LMCs).
- facilitating practices within the network to take part in research studies and will act as a link between the network and local primary care research networks and research institutions.
• representing the network at CCG-level clinical meetings and the ICS/STP, contributing to the strategy and wider work of the ICS.

The Clinical Director would not be solely responsible for the operational delivery of services. This will also be a collective responsibility of the network.

As outlined in section 4, each Network will receive an additional ongoing entitlement to the equivalent of 0.25\textsuperscript{5} WTE funding per 50,000 population size. This entitlement is a contribution towards the costs and not a reflection of the time commitment required to undertake the role.

1.2. Clinical pharmacists

Description of role/core responsibilities

• Indicative Agenda for Change Band 7-8a

Clinical pharmacists will have a key role in supporting delivery of the new Network Contract DES Service specifications. For the new Structured Medications Review and Optimisation requirements this will include tackling over-medication of patients, including inappropriate use of antibiotics, withdrawing medicines no longer needed through NHS-led programmes such as low priority prescribing and medicines optimisation more widely. For Enhanced Health in Care Homes residents will benefit from regular clinical-pharmacy led medicines reviews.

The following sets out the key role responsibilities\textsuperscript{6} for clinical pharmacists:

a. Clinical pharmacists will work as part of a multi-disciplinary team in a patient facing role to clinically assess and treat patients using their expert knowledge of medicines for specific disease areas.

b. They will be prescribers, or training to become prescribers, and will work with and alongside the multi-disciplinary team across a Primary Care Network. They will take responsibility for the care management of patients with chronic diseases and undertake clinical medication reviews to proactively manage people with complex polypharmacy, especially the elderly, people in care homes, those with multiple long term conditions (in particular COPD and asthma) and people with learning disabilities or autism (through STOMP - Stop Over Medication Programme).

c. They will provide specialist expertise in the use of medicines while helping to address both the public health and social care needs of patients in the network\textsuperscript{7} and help in tackling inequalities.

d. Clinical pharmacists will provide leadership on person centred medicines optimisation (including ensuring prescribers in the practice conserve antibiotics in line with local antimicrobial stewardship guidance) and quality improvement, while contributing to the quality and outcomes framework and enhanced

\textsuperscript{5} 0.15 WTE for network size of 30,000 or 0.2 WTE for network size of 40,000

\textsuperscript{6} See: RPS – practice based pharmacists job specification

services. Through structured medication reviews, clinical pharmacists will support patients to take their medications to get the best from them, reduce waste and promote self-care.

e. Clinical pharmacists will have a leadership role in supporting further integration of general practice with the wider healthcare teams (including community and hospital pharmacy) to help improve patient outcomes, ensure better access to healthcare and help manage general practice workload. The role has the potential to significantly improve quality of care and safety for patients.

f. They will develop relationships and work closely with other pharmacists across networks and the wider health system.

g. Clinical pharmacists will take a central role in the clinical aspects of shared care protocols, clinical research with medicines, liaison with specialist pharmacists (including mental health and reduction of inappropriate antipsychotic use in people with learning difficulties) and anticoagulation.

1.3. Social Prescribing Link Workers

Description of role/core responsibilities

- Up to indicative Agenda for Change Band 5

Social prescribing empowers people to take control of their health and wellbeing through referral to non-medical 'link workers' who give time, focus on 'what matters to me' and take a holistic approach, connecting people to community groups and statutory services for practical and emotional support. Link workers support existing groups to be accessible and sustainable and help people to start new community groups, working collaboratively with all local partners.

Social prescribing can help to strengthen community resilience and personal resilience, and reduces health inequalities by addressing the wider determinants of health, such as debt, poor housing and physical inactivity, by increasing people’s active involvement with their local communities. It particularly works for people with long term conditions (including support for mental health), for people who are lonely or isolated, or have complex social needs which impact on wellbeing.

Social prescribing link workers will have a key role in supporting delivery of the Comprehensive Model of Personalised Care.

The following sets out the key role responsibilities for social prescribing links workers:

a. They will in 2019/20 take referrals from the network’s members, expanding from 2020/21 to take referrals from a wide range of agencies\(^8\). Primary Care Networks that already have social prescribing link workers in place, or who have access to social prescribing services may take referrals from other agencies prior to 2020/21

b. They will:

\(^8\) These agencies include but are not limited to: the network’s members, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations and voluntary, community and social enterprise (VCSE) organisations.
• provide personalised support to individuals, their families and carers to take control of their wellbeing, live independently and improve their health outcomes;
• develop trusting relationships by giving people time and focus on ‘what matters to them’;
• take a holistic approach, based on the person’s priorities, and the wider determinants of health;
• co-produce a simple personalised care and support plan to improve health and wellbeing, introducing or reconnecting people to community groups and statutory services; and
• evaluate the individual impact of a person’s wellness progress.

c. The role will require social prescribing link workers to manage and prioritise their own caseload, in accordance with the needs, priorities and any urgent support required by individuals on the caseload. Where required and as appropriate, the social prescribing link workers will refer people back to other health professionals within the network.

d. Social prescribing link workers will draw on and increase the strengths and capacities of local communities, enabling local VCSE organisations and community groups to receive social prescribing referrals. They will ensure those organisations and groups are supported, have basic safeguarding processes for vulnerable individuals and can provide opportunities for the person to develop friendships, a sense of belonging, and build knowledge, skills and confidence.

e. Social prescribing link workers will work together with all local partners to collectively ensure that local VCSE organisations and community groups are sustainable and that community assets are nurtured, by making them aware of small grants or micro-commissioning if available, including providing support to set up new community groups and services, where gaps are identified in local provision.

f. Social prescribing link workers will have a role in educating non-clinical and clinical staff within the network on what other services and support are available within the community and how and when patients can access them. This may include verbal or written advice and guidance.

2. Workforce roles beginning from 2020/21

2.1. Advanced Practice Physiotherapists

Description of role/core responsibilities

• Indicative Agenda for Change Band 7-8a

Advanced Practice Physiotherapist have advanced skills to assess, diagnose, treat and manage musculoskeletal (MSK) problems and undifferentiated conditions. This will involve seeing patients, without prior contact with their GP, to establish a rapid and accurate diagnosis and management plan, thus streamlining pathways of care. They can work independently and do not require supervision, thus helping to release workload currently undertaken by GPs. Patients can either self-refer or be referred by the network’s members.
Advanced Practice Physiotherapists will have a key role in supporting delivery of the new Network Contract DES Service specifications.

The following sets out the key role responsibilities for FCP physiotherapists:

a. They will work as part of a multi-disciplinary team in a patient facing role, using their expert knowledge of Musculoskeletal (MSK) issues, to create stronger links for wider MSK services.

b. They will assess, diagnosis, triage and treat patients either via patient self-referrals or referrals from a professional within network, and take responsibility for managing a complex caseload (including patients with long term conditions, comorbidities and multi-factorial needs). Practice physiotherapists will progress and request investigations (such as x-rays and blood tests) to facilitate diagnosis and choice of treatment regime.

c. They will develop integrated and tailored care programmes in partnership with patients and provide a range of treatment options, including self-management, exercise groups or individual treatment sessions. These programmes will facilitate behavioural change, optimise patient’s physical activity and mobility, support fulfilment of personal goals and independence and reduce the need for pharmacological interventions.

d. They will develop and make use of their scope of practice and clinical skills, including those relating to independent prescribing, injection therapy and imaging referral rights (where qualified/experienced).

e. They will provide learning opportunities for the whole multi-professional team within primary care. They will also work across the multi-disciplinary team to develop more effective and streamlined clinical pathways and services.

f. They will liaise with secondary care MSK services, as required, to support the management of patients in primary care.

g. Using their professional judgement, they will take responsibility for making and justifying decisions in unpredictable situations, including in the context of incomplete/contradictory information.

h. They will manage complex interactions, including working with patients with particular psychosocial and mental health needs and with colleagues across primary care teams, sectors and setting.

i. They will be accountable for decisions and actions via Health and Care Professions Council (HCPC) registration, supported by a professional culture of peer networking/review and engagement in evidence-based practice.

2.2. Physician Associates

Description of role/core responsibilities

- Indicative Agenda for Change Band 7

A physician associate is a trained healthcare professional who works directly under the supervision of a doctor as part of the medical team. They are usually generalists with broad medical knowledge, but can develop expertise/specialisms in a particular

---

Job descriptions should be in line with those provided by respective professional bodies (these key responsibilities are reflective of these job descriptions).
field. The responsibilities\textsuperscript{10} of the role include direct patient contact through assessment, examination, investigation, diagnosis and treatment.

Physician Associates will have a key role in supporting delivery of the new Network Contract DES Service specifications.

The following sets out the key role responsibilities for a physicians’ associate:

a. They provide first point of contact for patients presenting with undifferentiated, undiagnosed problems
b. Taking comprehensive patient histories and providing physical examinations, they will establish a working diagnosis and management plan (in partnership with the patient).
c. They will deliver integrated patient centred-care through appropriate working with the wider primary care and social care networks.
d. They will undertake home visits and clinical audits.

3. Workforce roles beginning from 2021/22

3.1. Paramedics – Advanced Paramedic Practitioners

Description of role/core responsibilities

- Indicative Agenda for Change Band 6

Advanced paramedic practitioners work autonomously within the community, using their enhanced clinical assessment and treatment skills, to provide first point of contact for patients presenting with undifferentiated, undiagnosed problems relating to minor illness or injury, abdominal pains, chest pains and headaches.

Advanced Paramedic Practitioners will have a key role in supporting delivery of the new Network Contract DES Service specifications.

The following sets out the key role responsibilities\textsuperscript{11} for advanced paramedic practitioners:

a. They will assess and triage patients, including same day triage, and as appropriate provide definitive treatment (including prescribing medications following policy, patient group directives, NICE (national) and local clinical guidelines and local care pathways) or make necessary referrals to other members of the primary care team.
b. They will advise patients on general healthcare and promote self-management where appropriate, including signposting patients to other community or voluntary services.
c. They will be able to:


\textsuperscript{11} Job descriptions should be in line with those provided by respective professional bodies (these key responsibilities are reflective of these job descriptions). See here for national job profile
• perform specialist health checks and reviews;
• perform and interpret ECGs;
• perform investigatory procedures as required, and
• undertake the collection of pathological specimens including intravenous blood samples, swabs etc.

d. They will support the delivery of ‘anticipatory care plans’ and lead certain community services (e.g. monitoring blood pressure and diabetes risk of elderly patients living in sheltered housing)
e. They will provide an alternative model to urgent and same day GP home visit for the network and undertake clinical audits.
f. They will communicate at all levels across organisations ensuring that an effective, patient-centered service is delivered.
g. They will communicate proactively and effectively with all colleagues across the multi-disciplinary team, attending and contributing to meetings as required. They will maintain accurate and contemporaneous health records appropriate to the consultation, ensuring accurate completion of all necessary documentation associated with patient health care and registration with the practice.
Glossary of Terms

A2SI  Access to service information
A&E  Accident and Emergency
AfC  Agenda for Change
AHP  Allied Health Professional
AHSNs  Academic Health Science Networks
APMS  Alternative Provider of Medical Services
BMA  British Medical Association
CAS alert  Central Alerting System
CCG  Clinical Commissioning Group
COPD  Chronic Obstructive Pulmonary Disease
CPCF  Community Pharmacy Contractual Framework
CVD  Cardiovascular Disease
DDRB  Doctors’ and Dentists’ Review Body
DES  Directed Enhanced Service
DHSC  Department of Health and Social Care
DPO  Data Protection Officer
EEA  European Economic Area
FIT  Faecal Immunochemical Test
GMS  General Medical Services
GP  General Practitioner
GPC (England)  General Practitioner’s Committee in England
GPSoC  GP System of Choice
IAPT  Increasing Access to Psychological Therapies
HPV  Human Papilloma Virus
ICS  Integrated Care System
JGPITC  Joint General Practice IT Committee
LHCR  Local Health and Care Record
LMC  Local Medical Committee
MHRA  Medicines and Healthcare Products Regulatory Agency
NHS  National Health Service
NICE  National Institute for Health and Care Excellence
ONS  Office for National Statistics
PCNs  Primary Care Networks
PINCER  Pharmacist-led information technology intervention for medication errors
PMS  Personal Medical Services
PSNC  Pharmaceutical Services Negotiating Committee
QI  Quality improvement
QOF  Quality and Outcomes Framework
RCGP  Royal College of General Practitioners
S7a  Section 7a
STOMP  Stopping Over Medication of People with a learning disability, autism or both
STP  Sustainability and Transformation Partnership
WTE  Whole Time Equivalent
Reference List


37 NHS England internal analysis


NHS England internal analysis


NHS England calculations based on incidence projections provided by CRUK and numbers of patients registered with general practice as recorded by NHS Digital in mid 2018


NHS England Board Paper, 31 January 2019


## Dudley Clinical Commissioning Group
### GLOSSARY - APRIL 2018

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>#NOF</td>
<td>Fractured Neck of Femur</td>
</tr>
<tr>
<td>£K</td>
<td>£1,000 equivalent</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
</tr>
<tr>
<td>ACO</td>
<td>Accountable Care Organisation</td>
</tr>
<tr>
<td>ACS</td>
<td>Acute Coronary Syndrome</td>
</tr>
<tr>
<td>ACSs</td>
<td>Ambulatory Care Sensitive Conditions</td>
</tr>
<tr>
<td>AD</td>
<td>Assistant Director</td>
</tr>
<tr>
<td>A&amp;C</td>
<td>Agenda for Change</td>
</tr>
<tr>
<td>AGM</td>
<td>Annual General Meeting</td>
</tr>
<tr>
<td>AHSN</td>
<td>Academic Health Science Networks</td>
</tr>
<tr>
<td>ALE</td>
<td>Auditors Local Evaluation</td>
</tr>
<tr>
<td>ALOS</td>
<td>Average Length of Stay (in hospital)</td>
</tr>
<tr>
<td>AMI</td>
<td>Acute Myocardial Infarction</td>
</tr>
<tr>
<td>AMMC</td>
<td>Area Medicines Management Committee</td>
</tr>
<tr>
<td>AMR</td>
<td>Antimicrobial resistance</td>
</tr>
<tr>
<td>Anti-D</td>
<td>An antibody occurring in pregnancy</td>
</tr>
<tr>
<td>Anti-TNF</td>
<td>Drugs used in the treatment of rheumatoid arthritis and Crohn’s disease</td>
</tr>
<tr>
<td>AQP</td>
<td>Any Qualified Provider</td>
</tr>
<tr>
<td>ARIF</td>
<td>Aggressive Research Intelligence Facility</td>
</tr>
<tr>
<td>ASAP</td>
<td>As soon as possible</td>
</tr>
<tr>
<td>AVE</td>
<td>Advertising Value equivalent</td>
</tr>
<tr>
<td>BACs</td>
<td>Bank Automated Credit</td>
</tr>
<tr>
<td>BAF</td>
<td>Board Assurance Framework</td>
</tr>
<tr>
<td>BCC</td>
<td>Black Country Cluster</td>
</tr>
<tr>
<td>BCF</td>
<td>Better Care Fund</td>
</tr>
<tr>
<td>BCPFT</td>
<td>Black Country Partnership NHS Foundation Trust</td>
</tr>
<tr>
<td>BFT</td>
<td>Behavioural Family Therapy</td>
</tr>
<tr>
<td>BMA</td>
<td>British Medical Association</td>
</tr>
<tr>
<td>BME</td>
<td>Black Minority Ethnic</td>
</tr>
<tr>
<td>BMJ</td>
<td>British Medical Journal</td>
</tr>
<tr>
<td>BPAS</td>
<td>British Pregnancy Advisory Board</td>
</tr>
<tr>
<td>BSCCP</td>
<td>British Society of Colposcopy and Cervical Pathology</td>
</tr>
<tr>
<td>CAB</td>
<td>Citizens Advise Bureau</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Children and Adolescent Mental Health Service</td>
</tr>
<tr>
<td>CAO</td>
<td>Chief Accountable Officer</td>
</tr>
<tr>
<td>CASH</td>
<td>Contraception and Sexual Health</td>
</tr>
<tr>
<td>CCBT (CBT)</td>
<td>Computerised Cognitive Behavioural Therapy</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CCRN</td>
<td>Comprehensive Clinical Research Networks</td>
</tr>
<tr>
<td>CDC</td>
<td>Commissioning Development Committee</td>
</tr>
<tr>
<td>CDiff</td>
<td>Clostridium difficile</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>CETV</td>
<td>Cash Equivalent Transfer Value</td>
</tr>
<tr>
<td>CFO</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>CHADD</td>
<td>The Churches Housing Association of Dudley &amp; District Ltd</td>
</tr>
<tr>
<td>CHC</td>
<td>Continuing Healthcare</td>
</tr>
<tr>
<td>CHD</td>
<td>Coronary Heart Disease</td>
</tr>
<tr>
<td>CIP</td>
<td>Cost Improvement Plan</td>
</tr>
<tr>
<td>CLT</td>
<td>Collaborative Leadership Team</td>
</tr>
<tr>
<td>CMO</td>
<td>Chief Medical Officer</td>
</tr>
<tr>
<td>CNST</td>
<td>Clinical Negligence Scheme for Trusts</td>
</tr>
<tr>
<td>CNT</td>
<td>Community Nursing Team</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-------------</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>COSHH</td>
<td>Control of Substances Hazardous to Health Regulations 2002</td>
</tr>
<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
</tr>
<tr>
<td>CPN</td>
<td>Community Psychiatric Nurse</td>
</tr>
<tr>
<td>CPR</td>
<td>Cardiopulmonary Resuscitation</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>CNO</td>
<td>Chief Quality and Nursing Officer</td>
</tr>
<tr>
<td>CQRHM</td>
<td>Clinical Quality Review Meeting</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation</td>
</tr>
<tr>
<td>CRL</td>
<td>Capital Resource Limit</td>
</tr>
<tr>
<td>CRRT</td>
<td>Community Rapid Response Team</td>
</tr>
<tr>
<td>CSG</td>
<td>Clinical Strategic Group</td>
</tr>
<tr>
<td>CSU</td>
<td>Commissioning Support Unit</td>
</tr>
<tr>
<td>CT scan</td>
<td>Computer Topography</td>
</tr>
<tr>
<td>CVD</td>
<td>Cardiovascular Disease</td>
</tr>
<tr>
<td>D&amp;N</td>
<td>Dudley and Netherton (Locality)</td>
</tr>
<tr>
<td>DACHS</td>
<td>Directorate of Adult Children and Housing Services</td>
</tr>
<tr>
<td>DCS</td>
<td>Dudley Community Services</td>
</tr>
<tr>
<td>DCVS</td>
<td>Dudley Community Voluntary Service</td>
</tr>
<tr>
<td>DES</td>
<td>Directed Enhanced Service</td>
</tr>
<tr>
<td>DiES</td>
<td>Department for Education and Skills</td>
</tr>
<tr>
<td>DGFT</td>
<td>Dudley Group Foundation Trust</td>
</tr>
<tr>
<td>DHR</td>
<td>Domestic Homicide Review</td>
</tr>
<tr>
<td>DHSC</td>
<td>Department of Health and Social Care</td>
</tr>
<tr>
<td>DMO</td>
<td>Designated Medical Officer</td>
</tr>
<tr>
<td>DNA</td>
<td>Did not attend</td>
</tr>
<tr>
<td>DoH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DoLS</td>
<td>Deprivation of Liberty Safeguards</td>
</tr>
<tr>
<td>DoS</td>
<td>Directory of Service</td>
</tr>
<tr>
<td>DPMA</td>
<td>Dudley Practice Managers Alliance</td>
</tr>
<tr>
<td>DPO</td>
<td>Data Protection Officer</td>
</tr>
<tr>
<td>DQOFH</td>
<td>Dudley Quality Outcomes for Health</td>
</tr>
<tr>
<td>DSCB</td>
<td>Dudley Safeguarding Children’s Board</td>
</tr>
<tr>
<td>DTC</td>
<td>Diagnostic and Treatment Centre</td>
</tr>
<tr>
<td>DToC</td>
<td>Delayed Transfer of Care</td>
</tr>
<tr>
<td>DWMHPT</td>
<td>Dudley and Walsall Mental Health Partnership Trust</td>
</tr>
<tr>
<td>DXA</td>
<td>Dual X-ray Absorptiometry (measures bone density)</td>
</tr>
<tr>
<td>E&amp;D</td>
<td>Equality and Diversity</td>
</tr>
<tr>
<td>EAU</td>
<td>Emergency Assessment Unit</td>
</tr>
<tr>
<td>ECA</td>
<td>Extra Care Area</td>
</tr>
<tr>
<td>ECM</td>
<td>Every Child Matters</td>
</tr>
<tr>
<td>ECT</td>
<td>Electroconvulsive Therapy</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>EI</td>
<td>Early Implementer</td>
</tr>
<tr>
<td>EI</td>
<td>Early Intervention</td>
</tr>
<tr>
<td>EIP</td>
<td>Early intervention in Psychosis</td>
</tr>
<tr>
<td>EMI</td>
<td>Elderly Mentally Ill</td>
</tr>
<tr>
<td>EMIS</td>
<td>Education Management Information System</td>
</tr>
<tr>
<td>EoL</td>
<td>End of Life</td>
</tr>
<tr>
<td>EPC</td>
<td>Empowering People and Communities</td>
</tr>
<tr>
<td>EPIC</td>
<td>Enabling Practices to Improve and Change</td>
</tr>
<tr>
<td>EPP</td>
<td>Expert Patients Programme</td>
</tr>
<tr>
<td>EPR</td>
<td>Electronic Patient Record</td>
</tr>
<tr>
<td>EPRR</td>
<td>Emergency, Preparedness, Resilience, Response</td>
</tr>
<tr>
<td>ERT</td>
<td>Enzyme Replacement Therapy</td>
</tr>
<tr>
<td>ESR</td>
<td>Electronic Staff Record</td>
</tr>
<tr>
<td>FCEs</td>
<td>Finished Consultant Episodes</td>
</tr>
<tr>
<td>FED</td>
<td>Forum for Education and Development</td>
</tr>
<tr>
<td>FFT</td>
<td>Friends and Family Test</td>
</tr>
<tr>
<td>FHS</td>
<td>Family Health Services</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>FMC</td>
<td>Facility Management Centre</td>
</tr>
<tr>
<td>FOI</td>
<td>Freedom of Information</td>
</tr>
<tr>
<td>FTE</td>
<td>Full Time Equivalent</td>
</tr>
<tr>
<td>FYE</td>
<td>Full Year Effect</td>
</tr>
<tr>
<td>FYFV</td>
<td>Five Year Forward View</td>
</tr>
<tr>
<td>GDPR</td>
<td>General Data Protection Regulations</td>
</tr>
<tr>
<td>GGI</td>
<td>Good Governance Institute</td>
</tr>
<tr>
<td>GMS</td>
<td>General Medical Services</td>
</tr>
<tr>
<td>GOWM</td>
<td>Government Office for the West Midlands</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>GPAQ</td>
<td>General Practice Assessment of Quality</td>
</tr>
<tr>
<td>GPFV</td>
<td>GP Forward View</td>
</tr>
<tr>
<td>GPwSI</td>
<td>GP with Special Interest</td>
</tr>
<tr>
<td>GU</td>
<td>Genito-urinary</td>
</tr>
<tr>
<td>GUM</td>
<td>Genito-urinary Medicine</td>
</tr>
<tr>
<td>H&amp;QB</td>
<td>Halesowen and Quarry Bank (Locality)</td>
</tr>
<tr>
<td>HCAI</td>
<td>Healthcare Associated Infections</td>
</tr>
<tr>
<td>HCF</td>
<td>Healthcare Forum</td>
</tr>
<tr>
<td>HEE</td>
<td>Health Education England</td>
</tr>
<tr>
<td>HENIG</td>
<td>Health Economy NICE Implementation Group</td>
</tr>
<tr>
<td>HF</td>
<td>Heart Failure</td>
</tr>
<tr>
<td>HFMA</td>
<td>Healthcare Financial Management Association</td>
</tr>
<tr>
<td>HAO</td>
<td>Head of Internal Audit Opinion</td>
</tr>
<tr>
<td>HIC</td>
<td>Health Improvement Centre</td>
</tr>
<tr>
<td>HIS</td>
<td>Health Infrastructure Strategy</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HPA</td>
<td>Health Protection Agency</td>
</tr>
<tr>
<td>HPS/S</td>
<td>Health Promoting Schools / Service</td>
</tr>
<tr>
<td>HPU</td>
<td>Health Protection Unit</td>
</tr>
<tr>
<td>HR</td>
<td>Human Resources</td>
</tr>
<tr>
<td>HSC</td>
<td>Health and Safety Commission</td>
</tr>
<tr>
<td>HSCQCC</td>
<td>Health and Social Care Quality Centre</td>
</tr>
<tr>
<td>HSE</td>
<td>Health and Safety Executive</td>
</tr>
<tr>
<td>HSMC</td>
<td>Health Services Management Centre</td>
</tr>
<tr>
<td>HT</td>
<td>Home Treatment</td>
</tr>
<tr>
<td>HV</td>
<td>Health Visitor</td>
</tr>
<tr>
<td>HWBB</td>
<td>Health and Well-being Board</td>
</tr>
<tr>
<td>IAF</td>
<td>Improvement Assessment Framework</td>
</tr>
<tr>
<td>IAPT</td>
<td>Improved Access to Psychological Therapies</td>
</tr>
<tr>
<td>IC</td>
<td>Infection Control</td>
</tr>
<tr>
<td>ICAS</td>
<td>Independent Complaints Advocacy Service</td>
</tr>
<tr>
<td>ICE</td>
<td>Integrated Commissioning Executive</td>
</tr>
<tr>
<td>ICNA</td>
<td>Infection Control Nurses Association</td>
</tr>
<tr>
<td>ICO</td>
<td>Information Commissioner Office</td>
</tr>
<tr>
<td>ICP</td>
<td>Integrated Care Pathway</td>
</tr>
<tr>
<td>IFR</td>
<td>Individual Funding Request</td>
</tr>
<tr>
<td>IG</td>
<td>Information Governance</td>
</tr>
<tr>
<td>IOSH</td>
<td>Institute of Occupational Safety and Health</td>
</tr>
<tr>
<td>ISAP</td>
<td>Integrated Support Assurance Process</td>
</tr>
<tr>
<td>IT</td>
<td>Information Technology</td>
</tr>
<tr>
<td>IUCD</td>
<td>Intrauterine Contraceptive Device</td>
</tr>
<tr>
<td>JCAB</td>
<td>Joint Clinical Advisory Board</td>
</tr>
<tr>
<td>JCC</td>
<td>Joint Commissioning Committee</td>
</tr>
<tr>
<td>JD</td>
<td>Job Description</td>
</tr>
<tr>
<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
</tr>
<tr>
<td>KAB</td>
<td>Kingswinford, Amblecote and Brierley Hill (Locality)</td>
</tr>
<tr>
<td>KLOE</td>
<td>Key Lines of Enquiry</td>
</tr>
<tr>
<td>KPI</td>
<td>Key Performance Indicators</td>
</tr>
<tr>
<td>LAA</td>
<td>Local Area Agreement</td>
</tr>
</tbody>
</table>
OOH  Out of Hours
OPH  Office of Public Health
OSC  Overview and Scrutiny Committee
OT  Occupational Therapist
PACS  Primary and Acute Care Systems
PAF  Positive Assurance Framework
PALS  Patient Advice and Liaison Service
PAM  Patient Activation Measures
PAS  Patient Administration System
PAU  Paediatric Assessment Unit
PBP  Practice Based Pharmacists
PbR  Payment by Results
PC  Personal Computer
PCCC  Primary Care Commissioning Committee
PCDSG  Primary Care Development Steering Group
PCOG  Primary Care Operational Group
PDF  Portable Document Format
PDR  Personal Development Review
PDS  Personal Dental Services
PDSA  Plan, Do, Study, Act
PDU  Professional Development Unit
PE  Pulmonary Embolism
PEAK  Database holding the main registered details of patients and associated referral, contact, caseload, outpatient, inpatient, MH Act and clinic information.
PEAT  Patient Environment Action Team
PEPP  Pooled Budget External Placement Panel
PFI  Private Finance Initiative
PGD  Patient Group Directives
PHE  Public Health England
PHSO  Parliamentary and Health Service Ombudsman
PICU  Psychiatric Intensive Care Unit
PID  Project Initiation Document
PIN  Prior Information Notice
PMLD  Profound and Multiple Learning Difficulties
PMS  Primary Medical Services
PNA  Pharmaceutical Needs Assessment
POD  Prescription Ordering Direct
POPs  Patient Opportunity Panels
PPA  Prescription Pricing Authority
PPG  Patient Participation Group
PQQ  Pre-Qualification Questions
PSA  Public Service Agreement
PSHE  Personal and Social Health Education
PSIAMS  Personal Social Impact Action Measurement System
PTCA  Percutaneous Transluminary Coronary Angioplasty
Q&A  Questions and Answers
Q&S  Quality & Safety
QA  Quality Assurance
QIB  Quality Improvement Board
QIPP  Quality, Innovation, Productivity and Prevention
QMAS  Quality Management and Analysis System
QOF  Quality and Outcome Framework
QPDT  Quality and Practice Development Teams
RACPC  Rapid Access Chest Pain Clinic
RAG  Red, Amber Green (rating)
RAS  Respiratory Assessment Service
RCA  Root Cause Analysis
RCGP  Royal College of General Practitioners
RES  Race Equality Scheme
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHH</td>
<td>Russells Hall Hospital</td>
</tr>
<tr>
<td>RIDDOR</td>
<td>Reporting of Injuries, Diseases and Dangerous Occurrences Regulations</td>
</tr>
<tr>
<td>RMO</td>
<td>Responsible Medical Officer</td>
</tr>
<tr>
<td>RRL</td>
<td>Revenue Resource Limit</td>
</tr>
<tr>
<td>RTT</td>
<td>Referral to Treatment</td>
</tr>
<tr>
<td>SAP</td>
<td>Single Assessment Process</td>
</tr>
<tr>
<td>SAR</td>
<td>Safeguarding Adult Reviews</td>
</tr>
<tr>
<td>SCG</td>
<td>Sedgley, Coseley and Gornal (Locality)</td>
</tr>
<tr>
<td>SCIE</td>
<td>Social Care Institute for Excellence</td>
</tr>
<tr>
<td>SCR</td>
<td>Serious Case Review</td>
</tr>
<tr>
<td>SDU</td>
<td>Sustainable Development Unit</td>
</tr>
<tr>
<td>SDMP</td>
<td>Sustainable Development Management Plan</td>
</tr>
<tr>
<td>SEPIA</td>
<td>Mental health computer system</td>
</tr>
<tr>
<td>SFBH</td>
<td>Standards for Better Health</td>
</tr>
<tr>
<td>SFI</td>
<td>Standing Financial Instructions</td>
</tr>
<tr>
<td>SI</td>
<td>Serious Incident</td>
</tr>
<tr>
<td>SIC</td>
<td>Statement of Internal Control</td>
</tr>
<tr>
<td>SLA</td>
<td>Service Level Agreement</td>
</tr>
<tr>
<td>SPA</td>
<td>Single Point of Access</td>
</tr>
<tr>
<td>SQPR</td>
<td>Service Quality Performance Review</td>
</tr>
<tr>
<td>SQRM</td>
<td>Safeguarding Quality Review Meeting</td>
</tr>
<tr>
<td>SRE</td>
<td>Sex and Relationship Education</td>
</tr>
<tr>
<td>SRG</td>
<td>System Resilience Group</td>
</tr>
<tr>
<td>SSD</td>
<td>Social Services Department</td>
</tr>
<tr>
<td>SSDP</td>
<td>Strategic Services Development Plan</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Disease</td>
</tr>
<tr>
<td>STP</td>
<td>Sustainability and Transformation Plan</td>
</tr>
<tr>
<td>STRW</td>
<td>Support, Time &amp; Recovery Worker</td>
</tr>
<tr>
<td>SWL</td>
<td>Stourbridge, Wollescote and Lye (Locality)</td>
</tr>
<tr>
<td>SWOT</td>
<td>Strength, Weakness, Opportunity and Threat</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TCT</td>
<td>Transforming Care Together</td>
</tr>
<tr>
<td>TIA</td>
<td>Transient Ischaemic Attack</td>
</tr>
<tr>
<td>TP</td>
<td>Teenage Pregnancy</td>
</tr>
<tr>
<td>TPT</td>
<td>Teenage Pregnancy Team</td>
</tr>
<tr>
<td>TTO</td>
<td>To Take Out</td>
</tr>
<tr>
<td>UCC</td>
<td>Urgent Care Centre</td>
</tr>
<tr>
<td>UHBT</td>
<td>University Hospital Birmingham Trust</td>
</tr>
<tr>
<td>UCSCs</td>
<td>Urgent Care Sensitive Conditions</td>
</tr>
</tbody>
</table>

Vaccs & Imms | Vaccinations and Immunisations |
VSM | Very Senior Manager |
WAN | Wide Area Network |
WCC | World Class Commissioning |
WIC | Walk in Centre |
WMAS | West Midlands Ambulance Service |
WMCA | West Midlands Combined Authority |
WMHTAC | West Midlands Health Technology Advisory Committee |
WMSCG | West Midlands Strategic Commissioning Group |
WMSSSA | West Midlands Specialised Services Agency |
WTE | Whole Time Equivalent |
YHC | Young Health Champion |