NHS
Fylde and Wyre
Clinical Commissioning Group

NHS Fylde and Wyre Primary Care Commissioning Committee meeting

To be held on Tuesday 19 March 2019 at 1.00pm

In the CCG Boardroom, CCG Offices, Derby Road, Wesham, PR4 3AL

Committees in Common meeting with NHS Blackpool Primary Care Commissioning Committee

AGENDA

No.	Item	Purpose and process	Lead
1.	Apologies for absence	Noting Verbal	Chair
2.	Declarations of Interest *A conflict of interest is defined as "a set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.*	Noting/action Verbal	Chair
3.	Fylde Coast GP Enhanced Contract Proposal 2019/20	Decision Attachments and Presentation	Chair
4.	Date, time and of next meeting: • Tuesday 2 April 2019 • 10am to 12noon • Boardroom, Wesham	Noting	Chair

NHS
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PRIMARY CARE COMMISSIONING COMMITTEE

Date of meeting	Tuesday 19 March 2019	**Agenda item number**	Item 3
Title of report	Fylde Coast GP Enhanced Contract Proposal 2019/20		
Paper Presented by:	Nicola Marland, Head of Delivery and Planning		
Paper prepared by:	Nicola Marland, Head of Delivery and Planning		

CCG strategic objective supported by this paper: (please tick ✓)	Develop and maintain an effective organisation	✓
	Commission high quality, safe and cost effective services which reduce health inequalities and improve access to healthcare	✓
	Effectively engage patients and the public in decision making	
	Develop excellent partnerships which lead to improved health outcomes	
	Make the best use of resources	✓

Purpose of report

Attached is a copy of the Fylde Coast GP Enhanced Contract proposal for 2019/20.

Following the success of Years 1 to 3 of the GP Quality Contract within Fylde and Wyre CCG and the GP+ Contract within Blackpool CCG, the CCGs agreed to align the contracts for 2019/20 to reflect the collaborative working arrangements and aims of the Fylde Coast Integrated Care Partnership.

A number of enhancements have been made to the contract to support the delivery of achievements which will continue to maintain and improve quality and also meet the health needs of the population.

A cost pressure was identified as a result of the alignment exercise, as the contracts were previously funded at different levels. This cost pressure was fed into and approved via the Fylde Coast Planning process for 2019/20.

Recommendation

Members of the committee are asked to agree the proposed Fylde Coast GP Enhanced Contract for 2019/20.

Please indicate which Group this has been discussed with (please tick ✓)			
Executive Management Team	✓	Quality Improvement and Governance Cttee	
Clinical Commissioning Committee	✓	Finance and Performance Committee	
Audit Committee		Remuneration Committee	
Council of Members	✓	Primary Care Commissioning Committee	✓
Other/Not Applicable			
Patient and Public Engagement:		N/A	
Equality Impact Assessment:		N/A	
Resource Implication(s)		Yes – confirmed as part of the 2019/20 planning	

	process
Are there any associated risks? **If so, are the risks on the risk register?** **If yes, please include risk descriptor and current risk score**	N/A
For further information please contact:	Nicola Marland

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Fylde Coast CCGs
Enhanced GP Contract

DRAFT

NOT FOR WIDER CIRCULATION

2019/20

CONTENTS

FYLDE COAST ENHANCED GP CONTRACT 2019-20 OVERVIEW

Following the success of Years 1 to 3 of the GP Quality Contract within Fylde & Wyre CCG and the GP+ contract within Blackpool CCG, the CCGs have agreed a number of enhancements to the delivery of achievements which will continue to maintain and improve quality and also meet the health needs of the population.

The Fylde Coast Enhanced GP Contract enhancements will become effective for the period from 1 April 2019 to 31 March 2020.

The contract is coloured coded to support practices in noting the changes;

- PURPLE = from Fylde and Wyre CCG 2018/19 GP Quality Contract
- BLUE = from Blackpool CCG 2018/19 GP Plus contract
- GREEN = from both Fylde and Wyre WCCG and Blackpool CCG 2018/19 respective contracts
- RED = New deliverables/KPIs for 2019/20

Rationale

The aim of the contract continues to be to provide financial stability for practices; to improve quality and to reduce unwarranted variation.

Key Principles

The principles which continue to drive and guide the evolution of the contract are:

- To commission appropriate high-quality care delivered in a timely and effective way in the right place and time for the benefit of all patients
- To ensure fairness and equity across all practices and contract types
- To provide one framework for commissioning from General Practice
- To provide a framework for investing in General Practice
- To create a single reporting mechanism with clear timescales

Support

The CCG will provide a framework of support for practices, which will underpin the implementation of the Fylde Coast Enhanced GP Contract. Practices will be supported via:

- Locally developed templates
- CCG events
- READ codes (SNOMED codes when available) with guidance document
- Executive and Commissioning Lead support

Service Outline

The Fylde Coast Enhanced GP Contract will be mutually dependent upon the “Core” Contract. This means that only a provider currently offering essential primary medical services to a list of patients under either a General Medical Services contract (GMS), Personal Medical Services Agreement (PMS) or Alternative Provider Medical Services (APMS) will be capable of providing the services required under the GP Quality Contract to the same list of patients.

The themes and sub-themes noted in the table below;

Theme	Sub Theme
Enhanced Clinical Delivery	• Long Terms Conditions Management • Diabetes Care • Stroke Prevention • Heart Failure Care • COPD Care • End of Life Care • Mental Health Care • Dementia Timely Diagnosis and Ongoing Care • Cancer Screening and Care • Learning Disability Care • Carers Support • Safeguarding
Prescribing	• Prescribing
Planned Care Resource Utilisation	• Practice Development Sessions • Improving Access in Primary Care • Prevention, Self-Care and Signposting • Digital Access • Workforce monitoring and planning
Secondary Care Resource Utilisation	• Secondary Care Resource Management
Neighbourhood Delivery	• Governance • Council of Members / GP Link • Integrated Neighbourhood Delivery • System Resilience & Emergency Planning

Funding

Reimbursement for achievement of KPIs will be made following the submission of Quarter 4 information.

This contract does not affect the funding for core GMS/PMS services or Directed Enhanced Services commissioned via NHS England.

Similarly this contract does not affect those service commissioned by Lancashire County Council.

Practices will continue to receive the Quality and Outcomes Framework reimbursement over and above the funding detailed.

The CCG has agreed to focus the reimbursement on 4 key priority areas, with 6 reimbursable KPIs.

Each Practice will receive:

- 70% of the total funding; one twelfth per month

- 30% of the total funding will be reimbursed on achievement of the **6** KPI's included across the following four sub themes noted below. 30% will be equally split over the 6 KPIs within these themes.

    - Long Term Conditions (2 x KPIs)
    - Access (1 x KPI)
    - Prescribing (1 x KPI)
    - Managing Demand & Effective Use of Resources (2 x KPIs)

- Practices may opt to be reimbursed for the full 100% contract value, one twelfth per month, with adjustment at year end for any KPI's not achieved.

Contract Monitoring

Please note; contract monitoring arrangements are under developed and will be confirmed prior to final publication of the contract.

Participation

The respective Enhanced GP Contracts commenced on 1 April 2016 up until 31 March 2021. The CCGs will review the effectiveness of the existing themes and key performance indicators on an annual basis. Any variations will be discussed and agreed with practices.

Practices who wish to participate in the Quality Contract will be asked to provide the services required to enable delivery of all themes included within the contract.

End of year review process

The Fylde Coast CCGs will review all practice achievement for the year. Following this review, an end of year report will be sent to each Practice by 30th April 2019.

Practices will receive the appropriate level of reimbursement for the KPIs which have been achieved.

This report will note the KPIs deemed not to have been achieved, highlighting the KPIs which have a financial incentive attached.

Practices will be given the opportunity to submit additional supporting information for the KPIs which have not been achieved, where this additional information is to support the level of achievement. The deadline for submission of additional supporting evidence is no later than the 14th May 2019.

Following receipt of the supporting information, a KPI reconciliation review panel will be convened to review the non-achieved KPIs and supporting evidence. The panel will review the information submitted by each individual practice to determine the outcome of the KPI. The panel will consist of a member of each of the following:

- The Local Medical Council (LMC)
- A lay member associated with Fylde & Wyre CCG
- A member of the Finance team of Fylde & Wyre CCG
- A member of the Quality & Governance team of Fylde & Wyre CCG

- A Clinical Lead associated with the Fylde & Wyre CCG
- The Primary Care lead (from the Transformation & Planning Team) for Fylde & Wyre CCG
- The key data controller for the GP Quality Contract (currently the Transformation & Planning Support Officer)

Practices will be notified of the outcomes by formal communication which will outline the non-achievement or achievement and reimbursement associated together with the rationale.

Practices will have the opportunity to appeal the outcome of the panel in line with the process noted below.

Appeals

Practices wishing to appeal the outcomes of the KPI achievement determined by the KPI Reconciliation review panel should notify Fylde & Wyre CCG. This appeal will need to be made in writing via primarycareenquiries.fyldecoast@nhs.net no later than 30th June following the conclusion of the contract year.

For appeals, supporting evidence which has not previously been submitted will not be considered. Appeals will only be considered where the Practice wishes to contest the review process undertaken by the KPI Reconciliation review panel or of the decision made.

An appeals panel will be convened to review the appeals submitted within 4 weeks following the 30th June closing date.

Disputes

Any disputes in relation to delivery of the KPI's will be dealt with via the CCGs locally agreed disputes resolution procedure.

The delivery of the contract and associated monitoring will be overseen by the Primary Care Commissioning Committee of the CCG.

Summary of key dates for Enhanced GP Contract

Date	Action
Friday, 6th July 2018	Q1 Submission deadline – TBC
Friday, 5th October 2018	Q2 Submission deadline – TBC
Friday, 4th January 2019	Q3 Submission deadline – TBC
Friday, 5th April 2019	Q4 Submission deadline – TBC
Friday, 12th April 2019	Q4 data received from MLCSU
Tuesday, 30th April 2019	Latest date for Practices to be informed of non-achieved KPIs
Tuesday 14th May 2019	Deadline for supporting information for non-achieved KPIs to be supplied by Practices
Friday, 17th May 2019	Report to be sent to KPI Reconciliation Panel
w/c 27th May 2019	KPI Reconciliation Panel meeting to be held
Friday, 7th June 2019	Deadline for report to finance to confirm end of year payment to Practices. Practices to be notified of outcome by letter.
End of June 2019	End of year finances based on KPI achievement to be paid to Practices.
Sunday, 30th June 2019	Deadline for Practices to submit appeals of the outcomes of the KPI reconciliation.
w/c 15th July 2019	Appeals panel to be held
Friday, 9th August 2019	Deadline for report to finance to confirm any additional payments to Practices based on appeals. Practices to be notified of outcome of appeals panel by letter.
End of August 2019	Any additional payments based on appeals to be paid to Practices.

Section 1 - Enhanced Clinical Delivery

1.1 - Long Term Conditions Management

Commissioning Lead/s: Jeannie Hayhurst

Delivery

A range of indicators have been developed for 4 conditions

- Diabetes
- COPD
- AF
- Heart Failure (with Left Ventricular Dysfunction (LVD))

GRASP reports exist for all four conditions and practices are required to utilise these reports to support increasing prevalence and reviewing management:

- The Case Finder report will identify patients whose records contain Read/SNOMED codes that suggest they might have the condition but who are missing from the disease register
- The Care report will help to identify those patients who are not currently receiving evidence based therapies or management.

These reports can also assist in achieving the LTC financial targets.

Practices are required to identify a nominated Lead for GRASP and ensure that this person has attended training on utilising the reports.

To deliver this standard you will be expected to:
Reduce Risk Factors
People identified as high risk of developing a LTC are, where reasonable to do so, assessed/reviewed and, where appropriate, referred/signposted to support services with the purpose of reducing the risk of people identified.

For people identified as having a long-term condition, ongoing treatment and monitoring is provided including lifestyle management advice, referral to activity/patient education programmes (where available), preventative treatment and management of stable co-morbidities and complications.

This should include Very Brief Advice for smoking cessation: ASK, ADVISE,ACT

1. ASK – and record smoking status
2. ADVISE – on the best way of quitting
3. ACT – by offering referral to specialist support, where available, and signpost patients to obtain medication support from Pharmacies if required.

Very Brief Advice training module can be accessed via
http://www.ncsct.co.uk/publication_very-brief-advice.php

KPIs

In addition to lifestyle factors, for many long-term conditions detection of and management of hypertension and cholesterol is fundamental in reducing risk. To align with Blackpools/Fylde Coast Right Care Programme and the Standards for Primary Care delivery across Lancashire and South Cumbria, the following indicators will apply:

- **LTC1 - Primary prevention** - For the primary prevention of cardiovascular

	disease, 70% of people who have a 20% or greater ten year risk of developing cardiovascular disease to be prescribed Atorvastatin 20mg.(Ref: NICE CG181) • **LTC2 - Secondary prevention** – For the secondary prevention of cardiovascular disease, 70% of people with existing cardiovascular disease to be prescribed Atorvastatin 80mg, or the best tolerated Statin if this dosage is not tolerated.(Ref: NICE CG181) **LTC3 - Hypertension prevalence** – practices to have diagnosed and appropriately coded 70% of expected Hypertensive patients, NHS England Primary Care Standard

1.2 – Diabetes Care

Commissioning Lead/s: Jeannie Hayhurst

Delivery	Utilising the Diabetes case finder tool, review the patients who have codes entered onto their records suggestive of a possible /probable diagnosis for Diabetes and add them to the Diabetes register or Pre-Diabetes register as appropriate. (Patients should be added if they have a HBA1C between 42-47) Refer patients coded with Non- Diabetic Hyperglycaemia to the Diabetes Prevention Programme as per referral guidelines Increase the percentage of patients receiving **ALL 8** care processes: • *BMI measurement* • *Albumin: creatinine ratio* • *Foot examination* • *HbA1c measurement* • *Blood Pressure measurement* • *Serum creatinine measurement* • *Record of smoking status* • *Cholesterol measurement* Increase the percentage of patients receiving all 8 processes and meeting targets (Both can be monitored through GRASP Diabetes) Encourage all newly diagnosed patients to attend structured education ensuring that all patients are READ/SNOMED coded as being offered the service (the CCG will issue a list of recommended READ/SNOMED codes) *Link to High Impact Action 9 – Support Self Care* Practices should identify a Diabetes lead (clinical). Practices should participate in the National Diabetes Audit Practices should maintain a Non Diabetic Hyperglycaemia register Practices should initiate injectable therapies for newly diagnosed Diabetic patients or, if the Practice has no skilled staff to deliver this, Practice to commence training for one or more clinicians within the contracting year. Practices should refer eligible patients to the National Diabetes Prevention Programme
KPIs	• **DIA1 -** Practices will improve the delivery of the eight NICE recommended diabetes care processes (noted in the Delivery section) to above the Fylde Coast average as at 1/4/2019

1.3 – Stroke Prevention Commissioning Lead/s: Jeannie Hayhurst	
Delivery	Utilising the GRASP – AF case finder tool, review the patients with 2 or more possible/probable codes for AF entered onto their records Ensure patients in the target group (patients over 65 or with recognised risk factors not currently on the AF register) have their pulse monitored annually, Add patients to the AF register as appropriate Atrial fibrillation - All AF patients at high risk of stroke (CHA2DS2VASc ≥ 2)to be prescribed an anticoagulant therapy as per NICE guidance (June 2014). AF Patients at high risk of stroke and not on anticoagulation as identified by GRASP AF, in particular patients on antiplatelets, to be reviewed with regards to initiating anticoagulation therapy in accordance with NICE guidance June 2014. Where patients decline or treatment is contraindicated an exception code should be recorded and reviewed annually
KPIs	• **STR1** - To have diagnosed 70% of patients at risk of stroke (as per NCVIN/fingertips data) NHS England Primary Care Standard • **STR2 - Either a 2% increase (vs position at 1/4/2019) or 85%** of Practice patients with CHADSVASC score greater than 1 (as identified via GRASP) to be actively prescribed anticoagulation unless this is contraindicated (adverse reactions, contraindications, not tolerated).

1.4 – Heart Failure Care Commissioning Lead/s: Jeannie Hayhurst	
Delivery	Validate your HF register, utilising GRASP-HF case finder tool, and ensure patients are coded appropriately so that they receive evidence based treatments and are recalled in line with NICE guidance (June 2010) Review HF patients with regards to the prescribing and titration of dual therapy and provision of six-monthly reviews as guided by GRASP HF Identify and refer HF patients onto local community based HF rehab programme Consider Care Co-ordination for patients at high risk of admission. Ensure all HF patients are coded correctly and are receiving the maximum tolerated doses of evidence based treatments Ensure all HF patients receive a six-monthly review Increase the number of HF patients referred onto the local community-based HF rehab programme
KPIs	• **HFA1 -** Ensure all HF patients are coded correctly and are receiving the maximum tolerated doses of evidence based treatments • **HFA2 -** Ensure all HF patients receive a six-monthly review

1.5 - COPD Care Commissioning Lead/s: Jeannie Hayhurst	
Delivery	Utilising the COPD case finder tool, review the patients with codes that suggest a possible/probable diagnosis for COPD, that are not currently on the COPD register Increase the % of patients on COPD register who have had inhaler technique checked in the last 12 months Increase the % of patients on COPD Register who have had a Flu vaccination during the latest campaign Consider Care Co-ordination for patients at high risk of admission Where available, ensure patients are referred to Stop Smoking Services Refer patient to Pulmonary Rehabilitation Service ensuring patients are recorded as being offered this services.
KPIs	• **COP1** - Increase the Patients on COPD register who have had inhaler technique checked in the last 12 months to 70%

1.6 – End of Life Care Commissioning Lead/s: Amanda Lomas	
Delivery	People with EPaCCS will have access to an appropriate healthcare professional on the same day Patients with an EPaCCS record are notified of their named accountable GP and care co-ordinator, and how to contact them, within 21 days of the EPaCCS record being created, unless the patient has been informed within the preceding 12 months Relevant care agencies will be notified of the EPaCCS record. Ensure appropriate HCP staff attend End of Life training Following discharge from hospital, patients are contacted by the practice within 3 working days of receipt of discharge summary. Identify a Clinical end of life lead within each practice to improve communications between organisations and facilitate better care for patients at the end of their life and ensure the palliative care register is maintained. Practices and Neighbourhood Care Teams will collaboratively create the practice palliative care register to create, complete and maintain an EPaCCS records for people on the register (Utilising "EMIS Palliative Care Co-ordination (EPaCCS)" template) Practices and Neighbourhood Care Teams will work towards 1% of the practice register having an EPaCCS. It is recognised that 1% of the practice register will not die in year from health-related conditions, however there may be patients that are not in the last year of their life that may benefit from an EPaCCS record being created for them Hold monthly GSF multidisciplinary meetings (GP, relevant neighbourhood hub staff, Trinity Hospice Community specialist palliative care nurse, practice nurse, administrative staff and social services) to improve communications, shared learning from quality improvement (Q1003 & Q1004) and ensure seamless care across settings Complete end of life templates (EPaCCS - already available) to ensure that all elements of care are considered using GSF proactive identification guidance to improve identification of all end of life patients and support advance care planning. Use GSF prognostic indicator guides to improve detection of non-cancer end of life patients to support early planning to "get it right". Searches available on EMIS. End of life care is to be delivered in line with national guidance including NICE, NSF and Gold Standards Framework, where appropriate. Where 1% of the practice population does not have an EPaCCS, the practice will evidence how they work towards the target, including a clinical rationale. Aim to reduce non elective admission for people at the End of Life (Palliative Care QOF

	Register). Practice should review Fylde Coast End of Life Care Strategy changes applied by lead clinician. The EOL lead and relevant staff involved in end of life care to complete regular training on communication skills and DNACPR. Regular is defined as training being completed and updated every three years.
KPIs	• **EOL1** - 100% of patients on Palliative Care Register (QOF) to have an EPaCCs record with a preferred place of care, and all other patients, where it is deemed appropriate by a clinician, who require an EPaCCs record to also have one created. (Aspiration target 1% of total patient population to have an EPaCCs Record, recognising that 1% of practice population may not require EPaCCs). • **EOL2 -** Undertake a case review with learning of the death of 1 patient per year, where the patient was on the practice GSF register, and feedback to the CCG • **EOL3** - 100% of people with an EPaCCS record are contacted within 72hours (3 working days) of receipt discharge summary after being discharged from hospital.

1.7 – Mental Health Care Commissioning Lead/s: Lesley Tiffen	
Delivery	All administrative and clerical staff to complete mental health module on e- learning for health Each practice to identify 2 mental health champions (1 Clerical, 1 Clinical) Practice champions will attend at least one day of mental health champion training (training will be organised by the CCG), monitor e-learning training and evaluation for the clerical team and evidence promotion of mental health, early identification and timely signposting into appropriate support within the practice and along physical health pathways. Support integration of mental health services (Health and Wellbeing service and IAPT within the practice). This includes identifying clinical space within the practice, and inclusion of workers within Practice meetings Deliver physical health checks to people with severe and enduring mental health (Patient cohort is defined as the Mental Health QOF register), to ensure their physical needs are identified and appropriately addressed, utilising the recognised health check template "EMIS Mental Health Physical health Assessment" Ensure that ADHD patients (children and adults) on shared care receive appropriate support Deliver physical health checks to people with severe and enduring mental health to ensure their physical needs are identified and appropriately addressed
KPIs	• **MHE1** - Increase the % of People with Serious Mental Illness (patients on Mental Health QOF register), who have received the complete list of physical checks to 60% by 2018/19 (Baseline 37.2%) • **MHE2** - 100% of administrative and clerical staff in Practice to complete training (recommended eLearning: https://www.e-lfh.org.uk/programmes/mental-health-awareness-programme/ . Alternative in-house training such as Connect 5 can be undertaken, please contact CCG for ratification)

1.8 – Dementia Timely Diagnosis and Ongoing Care Commissioning Lead/s: Lesley Tiffen	
Delivery	Continue to facilitate early identification, timely diagnosis and ongoing support to patients with dementia and their carers
KPIs	• **DEM1** - Minimum 80% (aspiring to 100%) of patients on register to have a high quality review and a proactive care plan undertaken annually (review template to use is "FWCCG Dementia", practices to use own care plan template) • **DEM2** - Maintain the dementia diagnosis rate of two thirds (66.7%) of prevalence and improve post diagnostic care.

1.9 – Cancer Screening and Care

Commissioning Lead/s: Katie Rimmer

Delivery	Cancer care review using the EMIS Macmillan template to be carried out within 6 months of initial diagnosis Practices will be expected to contact women coming up to their 25th birthday either by text, telephone or letter to remind them that they will be eligible for a cervical screening test and to expect an appointment letter. The Practice should submit the names of the following to Primarycareenquiries.fyldecoast@nhs.net : • An administrative 'Cancer Champion' who will act as point of contact for Fylde Coast CCGs • A GP lead for Cancer Implement recommendations of the Fylde Coast Cancer Steering Group in respect of prevention of DNA's Undertake one significant event analysis (SEA) per permanent GP, prioritising patients diagnosed with bowel cancer between 1/4/2017 and 31/3/2019, where a cancer has presented late or as an emergency (not via the 2 week rule). This analysis is to reflect on what could be learnt and implemented within the practice to further support early diagnosis. The findings of each SEA will be discussed at a practice meeting and 3 recommendations will be prioritised. These recommendations should be forwarded to Primarycareenquiries.fyldecoast@nhs.net. Practice to follow up with patients who have not taken up the offer of cervical, breast or bowel screening. This contact could be via any communication method (letter, telephone call, SMS etc) but should be recorded in the patient record. Practice to ensure Bowel cancer screening EMIS pop up alerts are enabled Practice to agree for Practice banners to be used on screening invite letters and update the hubs if any changes occur
KPIs	• **CAN1** – 100% of all women to be contacted 6 months prior of their 25th birthday to remind them that they will be eligible for a cervical screening test and to expect a letter of invitation • **CAN2 –** Forward SEA reports to CCG via Primarycareenquiries.fyldecoast@nhs.net • **CAN3 –** Practice to follow-up with all patients who do not attend Cervical, Breast or Bowel screening and those who do not respond to invite

1.10 - Learning Disability Care Commissioning Lead/s: Tracey Callaghan-Hayes	
Delivery	Establish a Learning Disability Lead (Healthcare professional) Practices are required to participate in the Learning Disability DES commissioned by NHS England Evidence of systems identifying existing and new people (all age) for the Learning Disabilities register. Practices to carry out annual health checks and health action plans. Offer access to screening initiatives, to include easy read information and support for communication difficulties Participate in any LeDeR mortality reviews where primary care records or care are requested to be reviewed within the LeDeR programme. This may for example be in the form of explaining to a review team the care of the individual, engaging in a complex multiagency review investigation. Employ a system that can communicate with other healthcare providers, in primary and secondary care referrals, the need of people with LD and make reasonable adjustments required Awareness training for safeguarding vulnerable adults for all staff - MCA/DOLS training for their appropriate level Awareness training for safeguarding vulnerable adults for all staff - MCA/DOLS training for their appropriate level Make reasonable adjustments for people with LD to increase uptake of services and reduce health inequalities
KPIs	• **LDI1 -** Achieve and evidence 95% for an offer of physical health check for each person on the GP LD register. • **LDI2** - Achieve 65% of completion of annual health checks • **LDI3** - Achieve 50% of health action plans (of those who have had an annual health check)

1.11 – Carers Support Commissioning Lead/s: Amanda Bate	
Delivery	Have a carer's register which is maintained and updated. Ensure that all staff, including receptionists, are "carer aware" and have a basic understanding of the support available. Practices should involve their Patient Participation Groups in communicating with and supporting carers, with identifying support networks. Ensure carers registered at the Practice are recorded on the clinical system and add a patient note to the Practice record. Carers not registered at the Practice should be signposted to their own Practice for inclusion Practices should identify those patients on the carers register who are accessing services i.e. respite, where the Practice is made aware, and also add this to the Patient record.

1.12 – Safeguarding Commissioning Lead/s: Alice Marquis-Carr	
Delivery	Complete the CCG safeguarding standards audit on an annual basis in order to benchmark and highlight areas for support and development. The CCG will provide support where requested by practices Good Quality referrals and reports from Primary Care are submitted into the children safeguarding system Should you require any support or guidance in relation to Safeguarding, please do not hesitate to contact the team via FWCCG.Safeguarding@nhs.net
KPIs	• **SAF1** - Submission of a completed CCG safeguarding standards audit document on an annual basis to FWCCG.Safeguarding@nhs.net • **SAF2** - Action plans detailing progression to full compliance for those areas of non-compliance to FWCCG.Safeguarding@nhs.net

Section 2 – Prescribing

2.1 – Prescribing

Commissioning Lead/s: Melanie Preston & Julie Lonsdale

Delivery

1. **Service provision of Medicines Optimisation**

The service provision of Medicines Optimisation is different in the two CCGs. Therefore this section is only applicable to Blackpool CCG practices. For Fylde and Wyre this element is picked up under the service provision provided by Blackpool Victoria Hospital.

The practice shall provide the service via the practice pharmacist. Any sub-contracting of this service will only be authorised by Fylde Coast CCGs. The provider shall ensure appropriate management and administration of the service is delivered within the scheme and the CCG is kept informed of any changes in post-holder.

Implementation of the Prescribing QIPP initiatives to deliver savings on the CCG prescribing budget. (Implementation is monitored monthly). Non-compliance will be highlighted to practices. QIPP initiatives should be a priority at the start of the financial year in order to maximise cost efficiencies; practices should look to complete all simple medicines switches by the end of June 2019.

The provider will undertake specific pieces of work covering areas consistent with national and local priorities and approved by Fylde Coast CCGs.

The provider may be asked to contribute to the review or re-design of patient clinical pathways where medicines are involved.

The pharmacist will be required to attend update meetings (usually quarterly) held by BCCG to; review progress in year; work planning for following year; receive relevant updates.
Supplementary services may cover areas such as;

- Implementation of new guidance
- Improvement of practice prescribing systems
- Improvement in chronic disease management
- Management of minor ailments
- Review of discharged patients
- Minimisation of prescribing risks
- Improved education of GPs/staff in complex needs reviews
- Improvements in governance

(The above list is illustrative, not definitive)

2. **Specific priority areas**

Budgeting is an essential requirement of CCGs, who have an obligation to remain within their budgets. Practices should engage with the CCG on achieving their individual prescribing budget. The annual action plan should bring each practice within their budget if implemented successfully. Where a practice is overspending they should engage with the CCG and agree an action plan to address the overspend. Practices have a responsibility to maintain an accurate record of their prescribers with the NHS BSA for financial stability for the CCG; this is to avoid a prescriber leaving a practice and the

	practice still picking up their prescribing costs, for instance. **Medicines waste** is high on the agenda for the NHS nationally. It is estimated that £300M of NHS prescribed medicines are wasted each year. This includes an estimated £90M of unused medicines in patient's homes, £110M returned to community pharmacies and £50M disposed of by care homes; representing £1 in every £25 spent in primary care. Practice staff who are involved in the repeat prescription process should be adequately trained and know how to reduce medicines waste. All non-clinical practice staff involved in issuing prescriptions should utilise the e-learning PrescQIPP Medicines Co-ordinator training. This training is broken down into 8 small modules and can be done at a time and pace that suit. All new Practice staff that will be involved in prescription management must have at least started the training by the conclusion of the contracting year. Each practice to nominate a lead medicines co-ordinator as a contact for any information by email that is pectinate to their and colleagues' roles in repeat prescriptions; to support practice staff in their role around repeat prescribing. **Anticoagulants** are reported to be one of the most high-risk medicines used in Primary Care. Across Lancashire audits have shown that there are concerns around the prescribing of DOACs and this is something that a working group is picking up across the ICS footprint. Patients on warfarin should have their INR results from ADAS written into their patient notes and additionally should have a INR result within the previous 3 months before being issued a repeat prescription. **High dose opioid** prescribing is a problem across Lancashire and South Cumbria, and CCGs are outliers nationally. This is a patient safety and prescribing quality concern. There is a proposal for work aiming to reduce prescribing to be done across the ICS. There will also be a work-stream for local implementation of initiatives to review opioid prescribing. **Appropriate antibiotic prescribing** continues to be high profile in order to combat Antimicrobial Resistance. Prescribers should ensure that all prescribing of antibiotics is appropriate and follows the local Fylde Coast formulary. **Near Patient testing** Near Patient Testing to be delivered in line with the Specification embedded below:  NPT 18-19.docx
KPIs	**BLACKPOOL CCG ONLY (KPIs 1 to 6)** • **PRE1** – The provider will implement the CCG's work-plan to meet the agreed annual prescribing budget. • **PRE2** - The pharmacist will work on; meeting or maintaining the target for specified prescribing indicators and any QIPP opportunities to meet the annual prescribing budget. These are subject to annual review by BCCG medicines optimisation lead and may be updated in-year to ensure delivery of the budget.

- **PRE3** - Practice pharmacist to discuss budget reports at neighbourhood meetings and ensure a standing agenda.
- **PRE4** - Metrics for other such work identified will be agreed separately.
- **PRE5** - The Provider shall undertake audit and research work to verify findings and develop best practice and share such to BCCG as requested. This may be additional to current GMS/PMS/APMS requirements.
- **PRE6** – Attendance at Practice Pharmacist meetings recorded. Where there is no engagement from a practice, this will be flagged with the practice manager to rectify.

ALL FYLDE COAST PRACTICES (KPIs 7 to 16)

- **PRE7** - The practice must not be above 15% of the average CCG spend per Average Patient Unit (APU). Action plans are required to bring the practice in line with their budget
- **PRE8** - Practices to maintain an accurate prescriber list with the NHS BSA. Practices to complete the appropriate documentation (in advance of changes) to maintain their prescriber list correctly with the NHS BSA.
- **PRE9** - 100% of current practice staff who are involved with prescriptions to have commenced the PrescQIPP training modules for medicines co-ordinators. To be included in the staff induction pack.
- **PRE10** – The practice has nominated a lead medicines co-ordinator as a contact for any information by email that is pertinent to their and colleagues' roles in repeat prescriptions.
- **PRE11** - 90% of patients on warfarin have 3 monthly records of INRs.
- **PRE12** - Provider to engage with the CCG project plan to reduce the prescribing of high dose opioids. This will include audit and review of patients on high dose opioids and other strategies to improve prescribing. To identify and review all patients on high dose opioids
- **PRE13** - Provider to implement the 'Opioid Pathway' for new patients to improve the management of pain.
- **PRE14** - A X% reduction (or greater) in the number of Trimethoprim items prescribed to patients aged 70 years or greater on baseline data (June15-May16) for 2019/20. In 2019/20 reduction thresholds will be reviewed to ensure targets reflect latest activity and maximise appropriate reduction gains.
- **PRE15** - To progress appropriate prescribing of antibiotics, Items per Specific Therapeutic group Age-Sex Related Prescribing Unit (STAR-PU) must be equal to or below England 2013/14 mean performance value of XXX items per STAR-PU. (Comment: This may need updating with new QP indicators)

	• **PRE16** – Near Patient Testing quarterly reporting to be completed as per the embedded document below: Julie and Melanie to recommend F. Coast KPI (financial consequence)

Section 3 – Primary Care Resource Utilisation

3.1 – Practice Development Sessions

Commissioning Lead: Barbara McKeowen

Delivery

Blackpool Practices will *have monthly development sessions to allow attendance for:

- Bi monthly Collective Learning Set afternoons (2pm – 6.30pm)
- Bi monthly GP Link meetings

Fylde & Wyre Practices will *have a bi monthly option to allow attendance at:

- Collective Learning Set afternoons

*FCMS will provide clinical provision during 2pm – 6.30pm and will be funded by the CCGs however, during the period, practice telephone lines and doors should remain open to allow patients to pick up prescriptions, book appointments etc.

Dates of meeting:

- Wednesday 12th December 2018 – 2pm – 6:30pm (Blackpool and Fylde & Wyre)
- Wednesday 9th January 2019 1.00 - 3.00pm (GP Link Meeting – Blackpool only)
- Wednesday 13th February 2019 – 2pm - 6:30pm (Blackpool and Fylde & Wyre)
- Wednesday 13th March 2019 – 1.00pm – 3.00pm (GP Link Meeting – Blackpool only)
- Wednesday 17th April 2019 – 2pm – 6:30pm (Blackpool and Fylde & Wyre)
- Wednesday 8th May 2019 – 1.00pm - 3.00pm (GP Link Meeting – Blackpool only)
- Wednesday 12th June 2019 – 2pm – 6:30pm (Blackpool and Fylde & Wyre)
- Wednesday 10th July 2019 – 1.00pm – 3.00pm (GP Link Meeting – Blackpool only)
- Wednesday 14th August 2019 – 2pm – 6:30pm (Blackpool and Fylde & Wyre)
- Wednesday 11th September 2019 – 1.00pm – 3.00pm (GP Link Meeting – Blackpool only)
- Wednesday 16th October 2019 – 2 – 6:30pm (Blackpool and Fylde & Wyre)
- Wednesday 13th November 2019 – 1.00pm – 3.00pm (GP Link Meeting – Blackpool only)
- Wednesday 11th December 2019 – 2pm – 6:30pm (Blackpool and Fylde & Wyre)

On Wednesday 17th April 2019 and Wednesday 16th October 2019, practices can close entirely, including telephones lines and doors.

NB: Note that the above must be in accordance with GMS requirements

3.2 - Improving Access in Primary Care

Commissioning Lead: Barbara McKeowen

Delivery	Appropriate clinician is available to see patients as appropriate following triage within GP contracted hours Practices should consider offering longer appointments for patients with Long Term Conditions and multi-morbidities (This may include any clinical appointment). Practices should be open (i.e. reception open and telephones answered) 8am – 6.30pm during weekdays. Exceptions for branch surgeries and or by prior agreement with the CCG Practices are advised to utilise the information below for inclusion on practice telephone answer message (when the practice is closed) to ensure continuity and clarity for patients: *"Hello and thank you for calling [practice name], our opening hours are [include hours] and we are now closed. If you need to make a routine appointment, please call again during opening hours or use the online booking systems available. If you require more immediate medical attention please call 111 where you will receive expert advice"* Pre-bookable appointments 4 weeks in advance should be made available Provide a minimum of 75 contacts per 1000 population per week. Contacts may be provided by a prescribing clinician including GP (including vocational training GP's), Pharmacist, Nurse Practitioner, Pharmacist, or Practice Nurse and may be triage, face to face, online access or by telephone consultation. Practices will be required to utilise the NHS England national capacity reporting tool on release Work with CCGs to develop process for providing directly bookable slots for patients, NHS111 and/or local deflection schemes Practice reception staff should follow a robust triage flowchart to ensure the patient request is dealt with at the first contact and if appropriate signposted to another service Practices should ensure patients are not routinely directed to the Urgent Treatment Centres. Ensure the practice process for routine/unplanned/urgent appointments meet patient requirements for a range of appointments. This can be achieved by regular audit of capacity and demand for appointments and also links to point 10 around new consultation types: a. Face to face b. Telephone c. E mail Practices to work with CCG / STP to explore new consultation types. I.e. E-consultations

	Practices will promote and offer same day clinical assessment to children under 12 years of age, ensuring they are assessed by a clinician and seen on the same day where clinically appropriate. Practices should offer Extended Access appointments as part of the routine appointment offering to increase utilisation of the service (a script/template has been developed to support practices). In addition, practice should promote the service via practice TV screens, practice websites and via practice social media. Practice should actively review DNAs on a monthly basis to identify any needs for additional solutions i.e. easy cancellation; reminders; patient recorded bookings; read-back; report attendances and reducing 'just in case' appointment booking. Temporary resident registrations should be processed the same day and not routinely referred to the UTCs for treatment
KPIs	• **IMP1** - 75 Contacts per 1000 population (financial KPI attached)

3.3 - Prevention, Self-Care and Signposting

Commissioning Lead/s: Barbara McKeowen

Delivery	Practices should nominate 2 representatives from the practice to undertake care navigation training which will provide the skills to train existing and new staff members. Practices are required to code signposting to: - Pharmacies - Voluntary services - weight management - smoking cessation - IAPT Practice are encouraged to review and update their internal processes regards signposting and include new services to ensure maximum utilisation of services and appropriate referral to services Practices are encouraged to work with their Patient Participation Group to support engagement with patients for self-care/signposting Practices are encouraged to participate in vaccinations programmes to support effective rates of Influenza, Childhood Immunisations etc. Practices are required to record Health Care Worker influenza vaccinations on Immform 'PAMS' is a tool that measures how motivated a patient is to change their behaviour. The patient is asked a series of questions that result in a score there are four levels that patients are categorised into this can be repeated at various point to see if their motivations has increased. This tool is used by the Health and Wellbeing workers and can be a useful tool for practices to use when identifying patients that would benefit from Education programmes e.g. DESMOND, Pulmonary Rehab.
KPIs	• **SIG1** – Practices to code any signposting of patients to Pharmacy, Voluntary services, weight management, smoking cessation or IAPT

3.4 – Digital Access

Commissioning Lead/s: Peter Kelly

Delivery	**Electronic Prescribing Services** The new national GP contract (April 2019) says that all practices, by default, will be offering and promoting the electronic ordering of repeat prescriptions and using Electronic Repeat Dispensing for all patients for whom it is clinically appropriate. In order to support continued uptake and previous year's enhanced contracts, the following local targets have been set: • EPS – 75% of all repeat prescriptions to be sent to Pharmacies electronically (this has been lowered from last year's target in acknowledgement of a change in controlled drugs which are currently non-transmittable electronically) • ERD – 30% use of Electronic Repeat Dispensing (for patients for whom it is clinically appropriate) by Dec 2019 • Repeat Prescription Ordering – 25% of repeat prescriptions to be ordered by patients via the iPlato or similar app App by Sept 2019 **Improving Digital Communications** A minimum of 50% of patients with a registered mobile phone number on their record to have downloaded the iPlato or similar app App and Practices use this for patient messaging – by Dec 2019 **GP2GP records transfer** Increase previous year's targets achieved to 85% for sending, receiving and integration of records within 3 days – by October 2019
KPIs	

3.5 – Workforce Monitoring and Planning Commissioning Lead/s: Tracy Riddick/Steve Gornall	
Delivery	Complete quarterly data capture exercise via HENW Practices will engage with the CCG and NHS England to have the APEX insight tool operational/installed and utilised Provide learning/training opportunities within general practice (support available from local Enhanced Training Hub)

Section 4 – Secondary Care Resource Utilisation

4.1 – Secondary Care Resource Management

Commissioning Lead/s: Nicola Marland

Delivery	Practices will be required to act on feedback from the CCG which indicates that telephone and or email advice & guidance systems are not being utilised. Practices should ensure that all referrals are clinically appropriate and are required to have internal processes in place to ensure pathways are followed. The NHS is not obliged to provide every treatment that a patient, or group of patients, may demand. It does, however, have a statutory duty to take into account the resources available to it. Practices should utilise local pathways when considering a referral and refer via the CCG agreed policies for procedures identified on the CCG website Practices should monitor daily admissions and discharges and contact patients who have been admitted (non-elective admissions) and discharged from hospital within 3 working days of discharge. The practice will record evidence of this on clinical systems. Practices should determine if the patient needs a visit and further intervention and offer a primary contact for patients in coordinating their care across primary, secondary and community health care as well as social and mental health care
KPIs	• **SEC1 -** Practice to maintain level of referrals based on 17/18 unless above CCG average. Variation in referrals to be reviewed at Neighbourhood level, based on intelligence in Service Utilisation Report • **SEC2 -** Ensure all referrals for Procedures of Limited Clinical Value are sent through CCG referral triage process and practices refer appropriate patients through available Tier 2 services and not directly to Secondary Care • **SEC3 -** Practice to maintain level of Non-elective admissions. (Maintenance target based on 17/18 unless above CCG average)

Section 5 – Neighbourhood Delivery

5.1 – Governance Commissioning Lead/s: Nicola Marland	
Delivery	Placeholder: this section will be revisited following publication of the Network DES in July 2019
KPIs	

Comment [DB1]: Awaiting Neighbourhood DES before rewording/redesigning

5.2 – Council of Members/GP LINK

Commissioning Lead/s: Nicola Marland

Delivery	**FOR BLACKPOOL CCG PRACTICES ONLY:** Each practice should have 1 named GP representative who will attend the GP Link meetings and be required to identify a deputy (GP) if they are unable to attend. In exceptional circumstances (e.g. single handed practices) the Practice Manager can attend as the deputy practice representative. **FOR FYLDE & WYRE CCG PRACTICES ONLY:** Each practice should have 1 named GP representative who will attend the Council of Members meetings and be required to identify a deputy (GP) if they are unable to attend. In exceptional circumstances (e.g. single handed practices) the Practice Manager can attend as the deputy practice representative, but they will not be able to vote on behalf of the practice Named GP representative (or deputy as above) to attend Council of Members meetings and feedback to staff within practice
KPIs	**FOR BLACKPOOL CCG PRACTICES ONLY:** • **GPL1** – Ensure Clinical representation at GP link meetings with Practice Manager representation if the practice feels it is appropriate **FOR FYLDE & WYRE CCG PRACTICES ONLY:** • **COM1 -** Practice representation at all Council of Members meetings • **COM2 -** Practice declaration that feedback provided to practice team on a monthly basis

5.3 - Integrated Neighbourhood Delivery Commissioning Lead/s: Nicola Marland	
Delivery	Placeholder: This section will be revisited following publication of the Network DES in July 2019
KPIs	•

Comment [DB2]: Awaiting Neighbourhood DES

5.4 System Resilience & Emergency Planning Commissioning Lead/s: Nick Medway	
Delivery	Hold a business continuity plan and update the plan annually for the individual practice. Practices are encouraged to work together to identify how a neighbourhood can provide mutual support in order to promote system resilience within the locality Support Emergency Preparedness Resilience and Response (EPRR) in actively engaging with CCG/NHSE when required Provide support to rest centres if and when required i.e. prescriptions for medications to displaced people who have run out of regular supplies or been unable to bring them in due to evacuation process. In such circumstances support required would be short term, routine and likely to be within the geography of the GPs surgery. Support resilience during the winter period by: • Utilising community services • Tier 2 services • Promoting Influenza uptake with patients and front line staff • Promote other services i.e. Extended Access
KPIs	• **SRE1 -** Provide a copy of the business continuity plan to the CCG annually