Members in Attendance:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ingrid Fife (IF)</td>
<td>Chair and Lay Member</td>
<td>NHS Halton CCG</td>
</tr>
<tr>
<td>Jan Snodden (JS)</td>
<td>Chief Nurse</td>
<td>NHS Halton CCG</td>
</tr>
<tr>
<td>Leigh Thompson (LT)</td>
<td>Director of Commissioning</td>
<td>NHS Halton CCG</td>
</tr>
<tr>
<td>Bertha Brown (BB)</td>
<td>Local Pharmaceutical Committee Representative</td>
<td>Local Pharmaceutical Committee</td>
</tr>
<tr>
<td>David Merrill (DM)</td>
<td>Lay Member</td>
<td>NHS Halton CCG</td>
</tr>
<tr>
<td>Paul Brennan (PB)</td>
<td>Primary Care Finance Manager</td>
<td>NHS Halton CCG</td>
</tr>
<tr>
<td>Dr Julie Langton (JL)</td>
<td>Secondary Care Doctor</td>
<td>NHS Halton CCG</td>
</tr>
<tr>
<td>Dr Ivan Camphor (IC)</td>
<td>Local Medical Committee Representative</td>
<td>Local Medical Committee</td>
</tr>
<tr>
<td>Dr Clifford Richards (CR)</td>
<td>Clinical Chair</td>
<td>NHS Halton CCG</td>
</tr>
<tr>
<td>Dr Salil Veedu</td>
<td>Primary Care Lead</td>
<td></td>
</tr>
<tr>
<td>Councillor Marie Wright</td>
<td>Health &amp; Wellbeing – Elected Member</td>
<td>Halton Borough Council</td>
</tr>
</tbody>
</table>

In Attendance by invitation of Chair:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarah Vickers (SV)</td>
<td>Head of Primary &amp; Community Care</td>
<td>NHS Halton CCG</td>
</tr>
<tr>
<td>Julie Holmes (JH)</td>
<td>Commissioning Manager</td>
<td>NHS Halton CCG</td>
</tr>
<tr>
<td>Dr David Lyon (DL)</td>
<td>Governing Body member and clinical lead</td>
<td>NHS Halton CCG</td>
</tr>
<tr>
<td>Louise Murtagh (LM)</td>
<td>Note Taker</td>
<td>NHS Halton CCG</td>
</tr>
<tr>
<td>Rose Gorman (RG)</td>
<td>Senior Commissioning Manager</td>
<td>NHS England</td>
</tr>
<tr>
<td>Lucy Reid (LR)</td>
<td>Head of Medicines Management</td>
<td>NHS Halton CCG</td>
</tr>
<tr>
<td>Julie Holmes (JH)</td>
<td>Primary Care Commissioning Manager</td>
<td>NHS Halton CCG</td>
</tr>
<tr>
<td>Natalie Vinton</td>
<td>Commissioning Manager</td>
<td>NHS Halton CCG</td>
</tr>
<tr>
<td>Helen Northall</td>
<td>Chief Executive, PCC</td>
<td>PCC</td>
</tr>
<tr>
<td>Anthony Leo</td>
<td>Director of Commissioning</td>
<td>NHS England</td>
</tr>
</tbody>
</table>
1. Welcome, Introductions, Declarations and Apologies

Introductions were made and the Chair welcomed all present to the meeting. Apologies were noted as per table above.

Declarations of interest were confirmed as those held centrally on the Register of Interest. The Chair reminded members that they should be mindful of possible conflicts where items may lead onto future decisions.

2. Minutes and Action Log 15 November 2016 (PCCC 45-16)

The minutes of the meeting held on 15 November 2016 were agreed as a correct record subject to the inclusion of apologies for absence from Eileen O’Meara and Councillor Marie Wright; the minutes also referred to Service Development Committee which should be listed as Primary Care Commissioning Committee.

Action Log updated as follows:

- PCC34-16 – Risk Register. LT, SV and JS confirmed that they had met to discuss the risk register and the updated report was to be considered today. Therefore, close the action.
- PCC35-16 – Finance Report of 15 November 2016 had advised that there was a forecast outturn overspend on anticoagulation. JH advised that this was not so and it was due to a pressure on the previous year’s spend being carried forward. This pressure was covered through reserves and so had virtually been wiped out. Q1 and Q2 activity for 2015/16 and 2016/17 confirmed that there had been a slight downward trend in activity. As JH had provided this update Members asked for the action to be closed
- PCC38-16 – General Practice Enhanced Incentive Scheme in Halton – SV confirmed that this was due to be reported to the Committee in February 2017
- PCC39-16 – ETTF – Technology Cohort 1 Schemes. LT advised that this was in the plan due to be considered today. Therefore, close the action
- PCC42-16 – GP Forward View. On agenda today, therefore close the action
• PCC43-16 – General Practice Contract Performance Dashboard. LM confirmed that this had been added to the Committee work plan. Therefore, close the action.

Minutes approved and ratified

3. Chair’s Remarks

The Chair (IF) advised attendees that the primary reason for today’s Primary Care Commissioning Committee was to consider the GP Forward View update and agree the draft local Implementation to support the development of the plan prior to submission to NHS England.

To assist with this Helen Northall, Chief Executive, PCC and Anthony Leo, Director of Commissioning NHS England had kindly agreed to attend today. This would provide members with a national and strategic overview; and the more localised view of the local STP.

IF also advised that Committee members had reviewed the Risk Register during the private session. This was to allow maximum time at the public meeting to consider the GP Forward View item.

4. Community Pharmacy Forward View (PCC46-16)

This item was split into two headings Community Pharmacy 2016/17 and beyond by Bertha Brown (BB), Chief Officer, Halton, St Helens and Knowsley LPC; and Local Pharmacy Forward View, Lucy Reid, Head of Medicines Management, NHS Halton CCG.

Community Pharmacy
BB highlighted the cuts in community pharmacy budgets and listed the potential outcomes of these cuts; and the cost and other benefits of people accessing Community Pharmacies. The Pharmacy Access Scheme was referred to as Halton benefitted from two of these pharmacies. BB also provided information on Quality payments and the Murray Review.

Local Pharmacy Forward View – LR
LR agreed that BB’s presentation showed all of the work that had already been completed and the value that Community Pharmacy adds. There were concerns around reductions in funding and how the CCG would continue with innovation and trials due to the reduction. LR confirmed that we would be placing pharmacists in many places and keeping these all connected was key.

BB and LR confirmed that the CCG would continue to collaborate and that work relating to Pharmacy must link in with the GP Forward View.

The Committee noted the reports and asked for a further report to be presented to member in March 2017.

ACTION: BB and LR to provide a further report on Community Pharmacy to the Committee in March 2017
5. **PCC providing National and Strategic Overview of the GP Forward View (PCC47-16)**

Helen Northall (HN), CEO of Primary Care Commissioning CIC (PCC) spoke to members about the high level, triple aim of the GP Five Year Forward View (GP5YFV) - improving health and wellbeing, better quality for all patients through care redesign and better value for tax-payers in financially sustainable system.

The key ambitions from the GP5YFV were to encourage patient wellbeing and empowerment; and provide patients with appropriate sign-posting and consultation about services. An important component of this was having a strong workforce including GPs, nurses, pharmacists, physiotherapists, welfare rights advisors and specialist managers to name a few. The CCG had to consider that one size did not fit all and that any decision made must be to help develop the future vision for primary care for Halton.

A challenge that the CCG faced was to ensure that the decisions were within regulations and to minimise risk of challenge. Where possible, potential issues should be identified decisions made should support the future vision. The PCC would be able to provide support to the CCG when it developed these plans.

The Committee noted the presentation.

6. **NHS England providing an Overview and Local STP (PID) Plans (PCC48-16)**

Anthony Leo (AL), Director of Commissioning NHS England - North (Cheshire and Merseyside) (MHSE) provided a presentation on the GP Five Year Forward View (GP5YFV) and how this sat with the local STP.

In doing so he gave a brief overview of Cheshire and Merseyside in terms of its geography and demographics; and how clinical commissioning groups, local authorities and providers were set up across the region.

The purpose of the GP5YFW was to stabilise, develop and transform general practice over the next five years with the aim of improving services.

AL then went on to explain the STP and how this fit in with the GP5YFW. He provided information relating to the cross-cutting themes, the progress made to date and the action planned for the next 6 months.

The Committee noted the presentation.

7. **NHS Halton CCG providing draft local plans**

SV provided the Committee with a GP5YFV update and an overview of the draft local implementation to support the development of the plan prior to submission to NHS England.
The report asked members to note the requirements of the GP Forward View and the Clinical Commissioning Groups role in supporting this; and to review the draft implementation plan, noting the work to date and make recommendations for improvement.

SV provided background to the key areas of investment, workforce, workload, infrastructure, and care redesign. Members were then given more detailed information relating to the work undertaken to date, plans in progress and those for future implementation. Appended to the report was the GP5YFW project plan which set the anticipated milestones and completion dates.

TL commented that NHS Halton CCG was in a good place in terms of the progress made on the GP5YFW having already tackled some difficult issues. This provided a good base for the CCG to dovetail care redesign into the system.

The Committee noted the presentation.

8. GP Forward View Workshop

Following the three presentations members were asked to consider if the plan provided by SV was appropriate and could be enhanced in any way.

All attendees agreed that it was comprehensive and subject to a small number of amendments relating to Community Pharmacy, New Model Contracts, GP recruitment, the Maternity Vanguard and Care Homes, endorsed the plan and authorised the executive team to sign off the amendments and submit the plan to NHSE by the deadline of 23 December 2016.

The Committee authorised the Executive Management Team, subject to minor amendments listed above, to submit the plan to NHSE by 23 December 2016.

Date and time of next meeting: Tuesday, 17 January 2017, 1.30pm
<table>
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<tr>
<th>Item Reference</th>
<th>Action</th>
<th>Responsible Officer</th>
<th>Date Due</th>
<th>Status/Update</th>
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<tbody>
<tr>
<td>PCC38-16</td>
<td>General Practice Enhanced Incentive Scheme in Halton</td>
<td>Leigh Thompson&lt;br&gt;Sarah Vickers&lt;br&gt;Paul Brennan</td>
<td>February 2017</td>
<td>SV confirmed that this would be reported to Members in February 2017</td>
</tr>
<tr>
<td></td>
<td>LT and SV to provide a detailed report to the Committee in February 2017 on the Quality &amp; Commissioning Scheme. PB to check with FP (Head of Finance) that the £5 per head was recurrent.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCC46-16</td>
<td>Community Pharmacy Forward View</td>
<td>Bertha Brown&lt;br&gt;L Reid</td>
<td>March 2017</td>
<td></td>
</tr>
</tbody>
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# PRIMARY CARE COMMISSIONING COMMITTEE

<table>
<thead>
<tr>
<th>Date:</th>
<th>21 February 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report title:</strong></td>
<td>Review of Committee Terms of Reference</td>
</tr>
<tr>
<td><strong>Lead Clinician and/or Lead Manager:</strong></td>
<td>Ingrid Fife, Committee Chair&lt;br&gt;Louise Murtagh, Senior Committee Administrator</td>
</tr>
<tr>
<td><strong>Purpose:</strong></td>
<td>To provide a copy of the Primary Care Commissioning Committee Terms of Reference for comment and proposed meeting dates for consideration.</td>
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<tr>
<td><strong>The PCCC is asked to:</strong></td>
<td>To discuss the Primary Care Commissioning Committee Terms of Reference and provide comment. To agree proposed meeting dates</td>
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### This Report supports the following CCG Strategic Objectives

One: To commission services which continually improve the health and wellbeing of Halton residents.

Two: To continually improve and innovate in our engagement with local people and communities to secure their participation in improving their own health outcomes.

Three: To deliver improvements in the quality of the health and care services accessed by the people of Halton within the resources available to our partner organisations and us.

### Commissioning Plan Implications

None

### Financial Implications

Does this require financial support? No

If Yes - Is there currently a budget for this?

### Board Assurance Framework and Corporate Risk Register

Does this report link to either the Board Assurance Framework (BAF) or Corporate Risk Register (CRR) or both? No

If Yes - please state:
- the corresponding reference number.
- state level of assurance this paper provides (Low/Medium/Significant)

### National Policy, Guidance, Standards, Targets or Legislation

None
1. **Terms of Reference**

1.1. The NHS Halton CCG’s Chief Nurse is undertaking a review of all terms of reference for the organisation’s committees. Members are asked to discuss the Committee’s Terms of Reference as at Appendix 1 and provide comments to assist with this.

1.2. The Committee is also asked to review the proposed Work Programme at Appendix 2 and consider if this will assist in the completion of duties listed in the Terms of Reference.

2. **Revised Committee Dates**

2.1. The proposal is for the Committee to return to a bi-monthly pattern, meeting at 1.00pm for the private meeting and 1.30pm for the public meeting on the 4th Wednesday of the month. The dates for the following year would therefore be: 26 April 2017, 28 June 2017, 27 September 2017, 22 November 2017, 24 January 2018 and 28 March 2018.

2.2. This will result in a two month gap between the meeting of 28 June 2017 and 27 September 2017.

2.3. An alternative to this is for the Committee to meet on 23 August 2017, 25 October 2017, 27 December 2017 and 22 February 2018. Although the CCG does not normally hold meetings during August and the December date will clash with the Christmas break.

2.4. Members are asked to discuss and agree meeting dates.
Primary Care Commissioning Committee

Terms of Reference

In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to NHS Halton CCG. The delegation is set out in Schedule 1 of the NHS Act. The CCG has established the NHS Halton CCG Primary Care Commissioning Committee ("Committee"). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

The Committee is established in accordance with NHS Halton Clinical Commissioning Group’s (the CCG) Constitution, Standing Orders and Scheme of Reservation & Delegation. These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Committee. The Committee will act to review and assure the Governing Body in relation to effective commissioning of primary care.

Statutory Framework

NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.

Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as agreed within the Delegation Agreement.

Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

a) Management of conflicts of interest (section 14O);

b) Duty to promote the NHS Constitution (section 14P);

c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);

d) Duty as to improvement in quality of services (section 14R);

e) Duty in relation to quality of primary medical services (section 14S);

f) Duties as to reducing inequalities (section 14T);

g) Duty to promote the involvement of each patient (section 14U);

h) Duty as to patient choice (section 14V);
i) Duty as to promoting integration (section 14Z1);

j) Public involvement and consultation (section 14Z2).

NHS Halton CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those set out below:

- Duty to have regard to impact on services in certain areas (section 13O);
- Duty as respects variation in provision of health services (section 13P).

The Committee is established as a committee of the Governing Body of NHS Halton CCG in accordance with Schedule 1A of the NHS Act.

The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

**Role of the Committee**

The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in Halton, under delegated authority from NHS England.

In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Halton CCG, which will sit alongside the delegation and terms of reference.

The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

This includes the following:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract)

- Newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”)

- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF)

- Decision making on whether to establish new GP practices in an area

- Approving practice mergers

- Making decisions on ‘discretionary’ payment (e.g. returner/retainer schemes).
The CCG will also carry out the following activities:

a) To plan, including needs assessment, primary [medical] care services in Halton
b) To undertake reviews of primary [medical] care services in Halton
c) To co-ordinate a common approach to the commissioning of primary care services generally
d) To manage the budget for commissioning of primary [medical] care services in Halton in line with the scheme of reservation/delegation for the CCG.

**Membership**

The Committee shall consist of:

- Chief Officer (Vice Chair)
- Chief Nurse or Representative
- Chief Finance Officer or Representative
- Director of Transformation
- Two Lay Members of the Governing Body (one of whom will be Chair)
- Registered Nurse or Secondary Care Doctor
- Director of Public Health or Representative
- Director of Commissioning & Service Delivery
- Health and Welling Being representative (chair or Elected Member with portfolio for health)

The Chair of the Committee shall be agreed by the Governing Body and will be elected from its Lay Member representation. The Governing Body shall elect from the lay members on the Committee, the appointment will be reviewed annually.

The Vice Chair of the Committee shall be a lay member or another member of the Governing Body. The Vice Chair will be agreed by the Governing Body and will be reviewed annually.

The following will be included on the Committee as non-voting attendees:

- CCG Head of Primary & Community Care Commissioning
- Medicines Management Clinical Lead or approved Representative
- Governing Body Clinical Leads
- Primary Care Clinical Leads
- Healthwatch Representative
- Local Medical Committee representative
- Local Pharmaceutical Committee representative
- Local Dental Committee
- Local Ophthalmic Committee representative

Other relevant officers and external advisors (e.g. Independent GP) will be invited to attend to ensure and enable the delivery of the functions of the Committee.
Meetings and Voting

The Committee will operate in accordance with the CCG’s Standing Orders. The Secretary to the Committee 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 Committee 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.

Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.

As this meeting is held in public there will at times be a need to complete some of the business of the Committee in private and this part of the meeting and its agenda items will be closed to the public. NHS Halton CCG is open and transparent in its decision making and aims to ensure that all appropriate information is in the public domain. Unfortunately some of the business transacted can be commercial and in confidence and this work will form the private business of the committee.

Quorum

The Chair or Vice Chair of the Committee must be present and four other members, at least one of which must be a member of the CCG Executive Team of the CCG and one must be a clinician (Chief Nurse, Registered Nurse, Secondary Care Doctor or Clinical Chair).

Frequency of meetings

The Committee shall meet monthly, excluding August.

Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

Additionally members will be expected to:

- Attend meetings, having read all papers beforehand
- Act as ‘champions’, disseminating information and good practice as appropriate
- Identify agenda items to the Secretary at least fifteen working days before the meeting
- Submit papers at least eleven working days before the meeting
• Make open and honest declarations of their interests at the commencement of each meeting notifying the Committee Chair of any agreed management arrangements, or to notify the Committee Chair of any actual, potential or perceived conflict in advance of the meeting.

• Uphold the Nolan Principles and all other relevant NHS Code of Conduct requirements.

The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties' 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.

Members of the Committee shall respect confidentiality requirements as set out in the CCG’s Standards of Business Conduct.

The Committee will present its minutes to Cheshire and Merseyside sub Regional Team of NHS England and the Governing Body of NHS Halton CCG each month or after each committee for information, including the minutes of any sub-committees to which responsibilities are delegated.

The CCG will also comply with any reporting requirements set out in its constitution.

It is envisaged that these Terms of Reference will be reviewed from time to time, reflecting experience of the Committee in fulfilling its functions. NHS England may also issue revised model terms of reference from time to time.

**Accountability of the Committee**

Budget and resource accountability arrangements and the decision-making scope of the Committee have been agreed and are laid out with the Scheme of reservation /delegation.

For the avoidance of doubt, in the event of any conflict between the terms of this Scheme of Delegation and Terms of Reference and the Standing Orders of Standing Financial Instructions of any of the members, the latter will prevail.

The Committee will publish, in line with national requirements all committee procurement decisions onto NHS Halton CCG Website. The Committee will ensure that the CCG engages and consults with the public and its members in the delivery of its functions.

**Procurement of Agreed Services**

The detailed arrangements regarding procurement are set out in the Delegation Agreement.
3.1 The CCG will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

3.2 In discharging its responsibilities set out in Performance of the Delegated Functions, of this Agreement and paragraph 1 of this Schedule 2 (Delegated Functions), the CCG must comply at all times with Law including its obligations set out in the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013/500 and any other relevant statutory provisions. The CCG must have regard to any relevant guidance, particularly Monitor’s guidance Substantive guidance on the Procurement, Patient Choice and Competition Regulations

**Decisions**

The Committee will make decisions within the bounds of its remit. The decisions of the Committee shall be binding on NHS England and NHS Halton CCG.

The Committee will produce an executive summary report which will be presented to Cheshire and Merseyside area team of NHS England and the Governing Body of NHS Halton CCG each month/after each committee for information.

The Committee shall publish its commissioning decisions on the CCG website in line with the requirements of transparency and management of conflicts.

**Administrative Arrangements**

The Committee will be supported by an appropriate Secretary that will be responsible for supporting the Chair in the management of the Committee’s business.

The Secretary will ensure:

- Correct minutes are taken and once agreed by the Chair, distributing minutes to the members within five working days of the meeting taking place
- A Key Issues report is produced following the meeting and submitted to the next meeting of the Governing Body
- An Action Log is produced following each meeting and any outstanding actions are carried forward until complete
- The agenda and accompanying papers are distributed to members at least five working days in advance of the meeting date
- They provide appropriate support to the Chair and Committee members
- The papers of the Committee are filed in accordance with NHS Halton CCG policies and procedures
• The meetings of this Committee will be held in public to enable transparency of decision making. The guidance and arrangement for this is in Appendix 1

The Work Plan will be agreed at the start of each financial year and will be approved by the Governing Body. The focus of the work programme will be in line with the strategic objectives of the CCG.

These Terms of Reference were approved at the Governing Body meeting on 7th April 2016

The information on the delegated agreement was shared with the Members at the meeting held on the 5th May 2015. This information can be made available on request.

Version 2: March 2016
Review Date March 2017
MEETINGS HELD IN PUBLIC

Introduction

NHS Halton Clinical Commissioning Group, in common with other NHS organisations has agreed to hold meetings of the Primary Care Commissioning Committee in public so that the public can observe how decisions are made about the use of public money for health and health services. NHS Halton Clinical Commissioning Group is keen to listen to the views of staff and the public.

Health Services Circular 1998/207 guidance states that:

‘to enable the public to observe the decision-making processes of Health Authorities so that they can understand the internal arguments, tensions and restrictions which lead to a decision. Public board meetings should not be orchestrated events with decision taken behind the scenes in closed session’

The Public Bodies Order 1997 Act also states that:

- Any meeting of a body should be open to the public,
- The public should be given at least three days notice of the time and place of the meeting

Who can attend the Meetings

Any member of the public or staff of any organisation is welcome to attend.

Can members of the public ask questions during the meeting?

Time is allocated before each meeting for questions from the public, however the public are invited to submit questions to the Primary Care Commissioning Committee 10 days prior to the date of the meeting to liz.walker@haltonccg.nhs.uk.

Answers to the public questions will be displayed on the NHS Halton CCG Website.

How do I find out about the Meetings?

The dates of the meetings will be advertised on the NHS Halton CCG Website, along with the agenda and supporting papers. Any details of changes to dates/venues will also be published.

Are all the meetings held in public?

No. There are some cases where issues are considered confidential. The Public Bodies Admission to Meetings 1960 Act includes provision for the discussion of confidential business in private sessions.
Under the terms of this Act, a Board may:

"... by resolution, exclude the public from a meeting (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution ..."

How do I find out about the meetings?

Details are advertised one week before the meeting and the Agenda and supporting papers will be available on the website, along with details of meeting dates and venues. This information is also available from the Committee Administrator (telephone 01928 593013).

The Primary Care Commissioning Committee meets in public and meetings are usually held between 2.00 pm – 4.00 pm at Runcorn Town Hall, WA7 5TD.
## PRIMARY CARE COMMISSIONING COMMITTEE WORK PLAN 2017/2018

<table>
<thead>
<tr>
<th>Item</th>
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<th>Frequency</th>
<th>April</th>
<th>June</th>
<th>September</th>
<th>November</th>
<th>January</th>
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<td><strong>Governance</strong></td>
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<td>Terms of Reference Review</td>
<td>Ingrid Fife / Leigh Thompson</td>
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| Work Plan owner(s)                                             | Ingrid Fife, Committee Chair  
|                                                              | Leigh Thompson, Director of Commissioning  
|                                                              | Sarah Vickers, Head of Primary & Community Commissioning  
|                                                              | Louise Murtagh, Committee Administrator |
Primary Care Commissioning Committee

Date: 21 February 2017

Report title: Primary Care Commissioning Committee Risk Report

Lead Clinician and/or Lead Manager: Ingrid Fife / Report Authored by Louise Murtagh

Purpose: To inform the Committee of the Status of all relevant risks contained in the Corporate Risk Register and the Board Assurance Framework.

The Committee is asked to Consider the following questions:

- Which papers on today’s agenda provide assurance to these risks and at what level?
- Do the controls deliver control?
- Does the assurance process deliver assurance?
- Is the residual score appropriate?
- What gaps do we have in controls & insurance and how do we close them?

This Report supports all of the following CCG Strategic Objectives

One: To commission services which continually improve the health and wellbeing of Halton residents.

Two: To continually improve and innovate in our engagement with local people and communities to secure their participation in improving their own health outcomes.

Three: To deliver improvements in the quality of the health and care services accessed by the people of Halton within the resources available to us and our partner organisations.

Four: To deliver all of our statutory duties and commissioning responsibilities effectively, whilst ensuring there are robust constitutional, governance and financial control arrangements in place.

Five: To develop the skills, knowledge and competence of the people who are working with us to create a high performing organisation that will allow us to build effective partnerships with other organisations and develop leadership from within.

Commissioning Plan Implications

None

Financial Implications

Does this require financial support? Yes/No
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<tr>
<th><strong>If Yes - Is there currently a budget for this? No/Yes</strong>&lt;br&gt;If No - please indicate if this has been discussed with and has the sign off, of the CCG finance department</th>
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<tr>
<td><strong>Board Assurance Framework and Corporate Risk Register</strong>&lt;br&gt;This report is the latest full version of the Board Assurance Framework.</td>
</tr>
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<td><strong>National Policy, Guidance, Standards, Targets or Legislation</strong>&lt;br&gt;N/A</td>
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<td><strong>Equality and Diversity and Human Rights</strong>&lt;br&gt;What are the identified equality implications across protected characteristics?&lt;br&gt;Are these implications mitigated in your plan? Yes/No – (if Yes please escalate this issue)</td>
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<tr>
<td><strong>Information Governance</strong>&lt;br&gt;Do you need to complete a Privacy Impact Assessment? Yes / No&lt;br&gt;Do you need an Information Sharing Protocol? Yes / No</td>
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## Risk Framework Heat Map

**Primary Care Commissioning Committee**

**Risk Framework Heat Map, 21 February 2017**

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### Summary:

**Closed Risks:**
- None

**New Risks:**
- None
# NHS Halton CCG Risk Summary

This form is to be used to provide a full & detailed update to the Governing Body & or associated Committees

## Section 1 – Risk Details

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<td><strong>Handler</strong></td>
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### Strategic Objectives
1. To commission services which continually improve the health and wellbeing of Halton residents.
2. To deliver improvements in the quality of the health and care services accessed by the people of Halton within the resources available to us and our partner organisations.
3. To deliver all of our statutory duties and commissioning responsibilities effectively, whilst ensuring there are robust constitutional, governance and financial control arrangements in place.
4. To develop the skills, knowledge and competence of the people who are working with us to create a high performing organisation that will allow us to build effective partnerships with other organisations and develop leadership from within.

### Risk Description
Failure to develop and implement a robust workforce plan for out of hospital locally could lead to the failure of the CCG to commission high quality out of hospital services and transform services. This could impact on patient care and the ability of the CCG to deliver its statutory functions.

## Section 2 – Controls

### Controls in Place
This risk as allocated to the PCC is clearly not focused on primary care workforce so PCC will ensure delivery across the patch.

- Annual workforce capacity survey undertaken by HEE.
- Good local participation in new schemes to address workforce development e.g. Pharmacists in practice, GP Access Fund, GP Federation
- National GP Forward View launched which recognises national workforce issues and includes additional funding streams to support development programme.
- Local Cheshire & Merseyside discussions commenced on how CCGs can work together to develop joint development programmes and maximise economies of scale.
- One local Halton practice successful in a bid to GP Forward View Targeted investment in Returning Doctor’s Scheme
- National Practice Nursing Strategy including training and succession planning in development.
- General Practice workforce control Payment to practices for Maternity/paternity/adoption locum cover, sickness locum cover, retainer scheme and returner scheme passed to CCG from 1 November 2016 providing greater intelligence on local workforce issues

### Gaps in Controls
The annual survey has poor reporting for Halton action is to work with practice to improve their submissions.

- Robust Primary Care workforce plan required which includes strategies for mitigating against an ageing workforce, early retirement, poor supply of new GPs, Nurses and Practice Managers, shift in work life balance expectations, impact of clinical commissioning on available time.
- Action to develop a workforce strategy through a Task and finish Group starting in January 17.
- Workforce plan should explore use of GPsSIs, skill mix in practice and inter practice working.
- Workforce review and planning Group to be established, linked to LDS

## Section 3 – Assurance

### Assurance
Governance to oversee development of work force plan is in place via Primary Care Group and PCCC which will monitor this with reporting to Governing Body.

- HEE produce for the CCG a report re survey for general practice.
- Workforce recognised as a national issue in the GP Forward View ensuring national support and additional funding becoming available.
- Annual HEE workforce survey to be reported to Primary Care Group and PCCC.

### Gaps in Assurance
Work force work stream to be developed and reported to PCCC.
### Section 4 – Risk Scoring

#### Initial Position

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<th>Likelihood</th>
<th>1 Negligible</th>
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#### Current Position

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### SECTION 5 - Position

#### 2015/2016 Final Position

N/A new risk. Replaces risk 212

#### Quarter 1 Position

GPFV additional funding identified to support workforce work streams identified in GPFV

#### Quarter 2 Position

Discussions commenced across LDS regarding developing a Primary Care Group to address workforce issues. Funding from GPFV starting to become available, for example reception and clerical training; and discussions across LDS include how to make best use of this funding and share best practice. Work to commence on developing a CCG work stream focusing on workforce issues in order to understand and begin to address workforce issues.

Chief Nurse supporting Cheshire and Merseyside wide workforce planning process for none medical workforce across primary, community and social care

#### Quarter 3 Position

Primary Care LDS group developing which includes workforce. National Workforce 2020 programme commencing. Cumbria, Cheshire and Merseyside identified as the most under doctored areas in North England. NHSE to calculate baseline number of doctors at 1 April 2015, at CCG level and area target set. Overseas recruitment programme commenced in Lincolnshire and Cumbria. NHSE Cheshire and Merseyside wish to participate in Phase 2 and the Head of Primary care is liaising with Lincolnshire.

GP retainer scheme: Payments to practices increased, only 120 areas across country. NHSE and CCGs to promote across Cheshire and Merseyside. 2nd wave clinical pharmacists in practice to be announced by 31 October 2016. Administration and receptionist training programme for 2017 under discussion with practices. Head of Primary Care leading on Cheshire and Merseyside wide training needs analysis of receptionist and administration staff to inform 2017/2018 provision.

Chief Nurse supporting Cheshire and Merseyside wide workforce planning process for none medical workforce across primary, community and social care.

#### Quarter 4 Position

Participation in NHS Digital Workforce census now a mandatory contractual requirement (GMS negotiations 2017/18) therefore supporting more robust workforce planning. Planning to support development of workforce strategy commenced including review of other areas and literature search undertaken. Planning meeting arranged with Federation leads to support collaborative development. Initial scope reported to PCCC 21/02/17 and consideration being given to partner organisations.

Reception and admin training for signposting and clinical correspondences booked for February & March 2017 and Training Needs analysis near completion to assist in planning for 2017/18.

### SECTION 6 – Overall Assurance

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This form is to be used to provide a full & detailed update to the Governing Body & or associated Committees

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**Committees**
- Primary Care Commissioning Committee

**Strategic Objectives**
1. To commission services which continually improve the health and wellbeing of Halton residents
4. To deliver all of our statutory duties and commissioning responsibilities effectively, whilst ensuring there are robust constitutional, governance and financial control arrangements in place.

**Risk Description**
Increasing pressure on General Medical Services due to increasing patient demand may impact on the ability to implement quality services.

### Section 2 – Controls

**Controls in Place**
- GP Forward view programme will support development of initiatives and bring additional national and regional funding e.g. implementation of 10 High Impact changes in General Practice to free up time, Sign posting training. GPFV Implementation Plan being developed.
- GP strategy in place.
- The CCG utilises a number of tools and soft intelligence to highlight pressures and capacity to deliver.
- Primary Care Working Group ensures the delivery against these plans.
- Recruitment of Pharmacists in Practice, Web GP pilot, telephone triage in some practices to support capacity
- Urgent Care Centres available in both towns and GP Extra being developed in both towns.
- GP Extra Funds secured for 2016/17 to expand pilot into both towns.
- Examine your options promotion in place.

**Gaps in Controls**
- The CCG does not currently have a systematic strategy for self care locally though a number of local areas of development these are required and need to be pulled together for the GP forward view to support management of demand

### Section 3 – Assurance

**Assurance**
- Projects which support reducing demand on General Practice are overseen by working groups and reported to PCCC.
- New CCG PMO role in place and engaged with Head of Primary Care to ensure project management support, robust commissioning oversight and that CCG commissioning plans support the Primary Care agenda and do not impact negatively on the service.
- GP forward plan submitted to NHSE for assurance and to PCCC for approval.
- PCCC will then monitor delivery of the plan and act as process for escalation if any problems with delivery.
- PCCC will monitor performance of local practices through robust reporting.

**Gaps in Assurance**
- Limited oversight of CCG projects supporting strategic direction, interdependencies and impact on General Practice with regards to reducing demand in General Practice.
- GP FV Implementation Plan to be submitted to NHSE by 23rd December.
### Section 4 – Risk Scoring

#### Initial Position

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### SECTION 5 - Position

#### 2015/2016 Final Position
N/A new risk. Replaces risk 212

#### Quarter 1 Position
ETTF bid submitted to expand Web GP use across all practices in order to support demand management. GP Extra Funds secured for 2016/17 to expand pilot into both towns.

#### Quarter 2 Position
Service model and specification for GP Extra being developed, against new national criteria. Further detail of GP Forward View programmes available which includes signposting training for receptionists. New PMO role in place and linked to Head of Primary Care to develop improved oversight of commissioning intentions and impact on General Practice.

#### Quarter 3 Position
Draft GPFV Implementation Plan developed and presented to PCCC November 2016. Discussions commenced with practices regarding implementation of programmes. CCG actively engaged in NHSE Primary Care LDS Group.
Self-Care (pre LTC diagnosis) work programme commenced with Public Health to scope work in other CCGs with a view to develop a Self-care Programme to reduce demand in General Practice.
GP forward view plan to PCCC for approval and submission to NHSE

#### Quarter 4 Position
ETTF technology funding secured to support expansion of Web GP across all practices. Project Plan under development. Wave 2 Clinical Pharmacists in practice announced and Head of Medicine Management working with GP Federation Leads to develop Wave 2 bid, building on Wave 1. GP Extra Runcorn awaiting outcome of CQC registration to commence service delivery.

Receptionist signposting training dates and attendees booked for February and March 2017 and Training Needs Assessment as an online survey nearing completion to assist in planning for 2017/18. Further clarity required regarding self-care work stream and how this sits with CCG commissioning intentions. However note national programme on self care and appropriate use of GP to commence as noted in contract negotiations 2017/18.

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### SECTION 6 – Overall Assurance

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<td>Quarter 1</td>
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#### Full | High | Significant | Adequate | Limited | x | Nil
Benefits of delegated commissioning: a case study

NHS Halton CCG

January 2017
This case study will be of interest if you want to know how delegated commissioning can:

- Ensure the smooth transition of delegated functions in a managed way.
- Enable more equitable funding of practices.
- Support the effective management of contract issues to get the best outcomes for patients.
- Drive the development of a primary care strategy, owned by all member practices.

What has been achieved

Development of a local process for effective management of contractual issues which align to national policies and procedures, such as list closures, to ensure best outcome for patients.

Development of a strategy for primary care owned by all practices.

Development of a funding framework to ensure all practices are funded equally to deliver the same services.

Assessment of workforce and estates to plan to meet the needs of the future.

Building the foundations to inform discussions on the development of new models of care to develop services that meet local needs.

‘Delegated commissioning means decisions are made closer to home. All the practices agreed. There was a consensus to take it on.’
Cliff Richards, Clinical Chair.
Executive summary

Delegated commissioning has enabled Halton CCG to develop detailed knowledge of their member practices. This has enabled tailored support to be given to sustain general practice and facilitate collaborative working.

Halton CCG has:

- Managed PMS reviews to develop more tailored services that meet local needs.
- Developed local processes for managing contract issues such as list closures, which align to national policies and procedures resulting in more supportive processes for practices and patients.
- Developed a funding framework to ensure an equitable level of funding for general practice based on weighted capitation.
- Progressed discussions on the development of multispecialty community services to address inequalities and respond to local needs.

Halton CCG has found that delegated commissioning has:

- Enabled more effective communication with and between practices, fostering productive relationships and greater connectivity between practices.
- Increased the CCG’s knowledge and understanding of general practice to inform the planning process.
- Given an opportunity to negotiate a more equitable funding level for general practice.
- Enabled more rapid decision-making on issues relating to general medical services.

The CCG has identified a number of critical success factors to delegated commissioning. This includes having:

- The support of all member practices to take on delegated commissioning.
- The right capacity and expertise in primary care contracting.
- A transition group with a clear plan that allows a phased transfer of responsibilities.

‘We have worked with the practices to agree a process to level the core funding of all practices over a four year period. Having delegated commissioning allowed us to do that as it was us making the decisions.’

Cliff Richards, Clinical Chair, Halton CCG.
Transfer of functions and contract management

The CCG discussed co-commissioning with all member practices prior to taking on delegated commissioning. There was a consensus to take up delegated commissioning.

The CCG set up a transition group to support the transfer of responsibilities under delegated commissioning. This group included representatives from the CCG (including the Head of Primary Care, commissioning and contracting managers and the Director of commissioning) and NHS England.

A transition plan was developed with timescales for each step. The group agreed the roles and responsibilities for both organisations.

A phased approach was agreed to ensure a smooth transfer of responsibilities and support for practices and patients. The CCG first picked up list closures, followed by PMS reviews and contract management. The CCG worked through an estates issue with NHS England initially. Once the CCG gained more knowledge and experience of estates issues they led on the processes thereafter.

Having access to and management of services on CQRS came later.

The phased approach allowed the CCG to run with the areas they were comfortable with and allowed the CCG to learn and develop in the areas they were less knowledgeable about.

The CCG developed its own process for managing contract issues such as list closures which align to the national policies. This involves the practice who is intending to close, discussing the issues with all the other practices. The other practices are then able to offer support and ensure a smooth process with the least disruption to patients.

“The local team were really supportive. We weren't just expected to pick everything up at once.”
Sarah Vickers, Head of Primary Care, Holton CCG.

Top tips:

Set up a transition group between the CCG and NHS England and have a phased transfer to ensure smooth transition of functions.

Agree roles and responsibilities between NHS England and the CCG

Be clear on the situation for each general practice contract
Like most CCGs, there was a large discrepancy in the funding of general practice. The practices agreed to level the funding over a four year period for core services delivered at every practice. This will result in some practices receiving less funding. However, discussions are ongoing to develop a range of enhanced services which will provide the opportunity for all practices to increase their funding level.

The CCG has 15 (out of 17) PMS practices. Delegated commissioning has enabled the CCG to review these practices with a view to developing more consistent services tailored to local needs.

Practices are working together with the CCG to develop:
- A local incentive scheme;
- Sharing data across practices (including A&E attendances, out of hours, urgent and emergency centre attendances);
- Align a practice to each care home to improve patient care by providing proactive care and reduce emergency admissions.

Proposals for the development of any primary care service may be developed through a number of routes such as:
- The Primary Care Group.
- Service development committee or
- Through meetings with practices.

Any proposals are then presented to the Primary Care Commissioning Committee for consideration.

Having delegated commissioning has helped to bring practices together to think about ‘population’ health rather than just the health of individuals.

‘Relationships have improved with all practices since taking on delegated commissioning’
Julie Holms, Commissioning Manager, Primary Care.
Workforce and Estates

- In 2015, the Halton Strategic Estates Plan was produced which reviewed the primary care estate and identified estate rationalisation opportunities which will deliver both clinical and financial benefits. By understanding its estate function, the CCG can maximise the use of high quality buildings and dispose of unwanted costly buildings.

- On a wider, Borough wide footprint, the CCG is working with all its estates colleagues to collectively achieve efficient use of buildings across the public, private and voluntary sectors – but especially health and social care. By working in partnership and looking at the estate as assets of the community, they will ensure that there is an integrated approach to sharing premises or acquiring assets, when it is in the best interests of the partnership to do so.

- The partnership is also aligning the assets with the digital healthcare plans across the borough to ensure the estate is ‘technology-proof’ to enable future plans.

‘Having delegated commissioning helped us to develop and implement our estates plan.’
Karen Hampson, Commissioning and Contracts Manager

‘Patients are much more engaged in primary care services. Practices have their own patient groups but through our engagement programme we discuss general practice services.’
Julie Holmes, Commissioning Manager (Primary Care)
Partnership working and new models of care

The “One Halton” programme emerged following the production of the CCGs Strategy for General Practice Services in which a new care model was set out focusing on integrated health and social care services working in the community.

It has been developed and delivered in partnership with local people, communities and organisations to formulate and implement the response, as a borough, to the Five Year Forward View.

The CCG and member practices have been working with the Borough Council and community services to review the workforce model along a frailty pathway. These plans will support the Sustainable and Transformation Plans (STP) and local transformation plans.

The CCG and member practices are proposing the development of a Multispecialty Community Provider (MCP) model. This will develop community services around people to meet their needs through integrated health and social care services. Practices will work together in a number of community neighbourhoods with community mental health and wellbeing, social care, urgent and pharmacy services.

The local developments are feeding into the STP. The emerging priorities for the STP are:

• Reconfiguration of individual secondary care service lines to achieve sustainability in terms of quality, workforce and finance.
• Development of sustainable, responsive, out-of-hospital services: primary, community and social care.
• Public health work to deliver greater wellbeing, with primary and secondary prevention of long term conditions.

www.england.nhs.uk
Resources to support delegated commissioning

- There are a number of individuals in the CCG who provide all or part of their time to support delegated commissioning. This includes:
  - A clinical lead to oversee the primary care strategy
  - Head of primary care
  - Primary care commissioning manager
  - Commissioning and contracts manager
  - Finance support (across three CCGs).
  - Administrative support

- The CCGs recognise the key role primary care has on the development and implementation of their strategy to improve the health and wellbeing of their population. The benefit of having a primary care team is having the dedicated capacity to focus on transforming primary care.

- The CCG continues to access support from NHS England. This enables sharing information and learning across CCGs.

Top tips:

- Develop a culture of ‘all in it together’ with member practices and CCG governing body members

‘You need to make sure your team is right – having access to or someone with the right contracting knowledge.’

Julie Holmes, Commissioning Manager (Primary Care)
What difference has delegated commissioning made?

- It gives a lever for **engaging with practices**.

- It provides the local knowledge and understanding of general practice to **inform the planning** process – you know where you are starting from.

- It enables **more effective communication** with and between practices, fostering productive relationships and greater connectivity between practices.

- It enables your **practices to have a voice** and shape primary care locally.

- It has helped to **stabilise general practice** and retain GPs’ knowledge, skills and experience.

Top tips:

Have regular communication with practices and respond to issues they raise quickly.

‘We are able to respond quickly. Its easy for us to go out and see the practices if they want to discuss anything.’

Sarah Vickers, Head of Primary Care
Halton CCG
Top tips for implementing delegated commissioning

- Develop a **culture of mutual trust**, through regular communication, listening, responding and being supportive to the member practices.

- Ensure you have the right **capacity and expertise** for the operational management of the contracts, as well as to feed into service development discussions.

- Set up a **transition group** with NHS England and agree a clear transition plan for the phased transfer of functions with **clarity on roles and responsibilities**.

- Having **partner organisations** on your primary care commissioning committee can help to give a balance of views, support the management of conflicts of interest and make links to wider plans on **sustainability and transformation**.

---

Top tips:

Be clear with practices about who is doing what in the transition period, so they know who to contact.

‘You need good relationships with NHS England so the transition is as smooth as possible.’

Paul Brennan  Primary Care Finance Manager  Halton and Knowsley and St Helens CCGs

www.england.nhs.uk
Delegated commissioning of primary care: case studies

- NHS England is collating a library of case studies to show how CCGs have seized the opportunities of delegated commissioning to develop more innovative primary care services.

- For more information on Halton CCG’s approach to delegated commissioning, please email Sarah Vickers, sarah.vickers@haltonccg.nhs.uk Telephone 01928 593023

- To read more case studies in our series, please visit XXXXXXX

- For general enquiries about co-commissioning, you can contact the NHS England co-commissioning policy team at england.co-commissioning@nhs.net.
Primary Care Commissioning Committee

Date: 21st February 2017

Report title: General Medical Services Quality & Performance Report

Lead Clinician and/or Lead Manager: Sarah Vickers, Head of Primary Care Supported by: Louise Owen, Commissioning Support Team

Purpose: To provide the Committee with an overview quality and performance report for general medical services

The Committee is asked to:
- Note the contents of the report and comment on the format presented.

This Report supports the following CCG Strategic Objectives

One: To commission services which continually improve the health and wellbeing of Halton residents

Four: To deliver all of our statutory duties and commissioning responsibilities effectively, whilst ensuring there are robust constitutional, governance and financial control arrangements in place

Commissioning Plan Implications

The commissioning of high quality general medical services underpins the CCGs Commissioning Intentions and is at the heart of the One Halton programme.
### Financial Implications
There are no financial implications for the majority of schemes attached as each of the commissioning schemes discussed have funding already aligned.

### Board Assurance Framework and Corporate Risk Register
The report links to the Board Assurance Framework:
- ID 378

### National Policy, Guidance, Standards, Targets or Legislation


### Equality and Diversity and Human Rights
There are no equality implications across the protected characteristics identified in the Equality Act 2010.

### Information Governance
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you need to complete a Privacy Impact Assessment?</td>
<td>No</td>
</tr>
<tr>
<td>Do you need an Information Sharing Protocol?</td>
<td>No</td>
</tr>
</tbody>
</table>
1.0 Background

1.1 On the 1st April 2015 NHS Halton Clinical Commissioning Group (CCG) commenced delegated commissioning arrangements for general medical services.

1.2 This brings a requirement to oversee the quality and performance management of general medical services on behalf of NHS England. In order to meet this requirement a regular report will be collated.

1.3 There are a number of data sources already available to CCGs providing access to quality and performance data. In order to streamline reporting a range of key indicators have been selected and are presented in this report. Indicators have been selected which provide an overview of General Practice services and are grouped under the quality headings of Patient Experience, Patient Safety and Clinical Effectiveness as well as activity.

1.4 A wider dashboard is utilised as a key information repository for the Primary Care Team to support contracting and performance monitoring processes.

2.0 Aristotle and the development of a CSU General Practice Dashboard

2.1 The Midlands and Lancashire Commissioning Support Unit have commenced the development of a General Practice dashboard which would be available to Practices and CCGs via Aristotle (an on line web tool to view data.)

2.2 The dashboard, which is very similar to the local Halton dashboard, is currently available on Aristotle as a test page in order to gather feedback from CCG leads and will be made available to practices shortly.
3.0 Quality & Performance Observations

3.1 The Committee is asked to note that due to the range of reporting dates for the dashboard indicators only the secondary care activity indicators have been updated since the dashboard was last presented at the meeting of the 15th November.

3.2 At the previous Committee the following observations are noted:

- Above average patient satisfaction in both making an appointment and would recommend their GP by patients from Hough Green, Oaks Place, Brookvale and Heath Road practices.

- Only Upton Rocks has met the Bowel Screening target however the data does need to be updated from Quarter 3 December 2014/15

- Variation in Flu uptake and Pre School Booster with only five practices meeting the national target of 75% for Pre School Booster (Bevan Group, The Beeches, Upton Rocks, Brookvale and Murdishaw)

- Wide variation in COPD Prevalence, record of FEV1 in the last 12 months and exception reporting of this indicator which ranges from 0% to 40.55% in Peel house Medical Plaza and 49.47% at Tower House.

- Wide variation in exception reporting for Diabetes, last IFCC is 59 mmol/mol in last 12 months, ranging from 2.3% to 33% at Peel House Medical Plaza.

- Variation in prevalence of Atrial Fibrillation, percentage of patients treated with a bet blocker if a CHADS2-VASc score of 2 or more and variation in exception reporting for this indicator ranging from 0% to 25.2% at Brookvale Practice.

3.2 It was also reported that the above variation and exception reporting would be raised with practices during the Contracting and Quality visit programme. This programme remains under development and once the PMS and Incentive Scheme discussions have been finalised, the Contract and Quality Visit programme will commence. In the meantime, whilst the Clinical Lead review is being finalised, those indicators which relate to a current Clinical Lead profile area will be raised with them for discussion with practices.
4.0 CCG Clinical Priority Assurance Indicators

The following Quality & Outcome Framework (QOF) indicator areas and Direct Enhanced Service are included within the CCG Clinical Priority Assurance Framework which the CCG is held to account against. These two specific indicators are not currently included within the General Practice dashboard however the work detailed below has commenced in order to improve the quality of patient care.

4.1 Dementia Diagnosis & Care Plan Review

NHS Halton CCG was graded as Needs Improvement. This assessment is based on the result of 2015/16 QOF data: Dementia diagnosis rate (DEM001) of 72% (England average 69.6%) and care plan, face to face reviews rate (DEM004) of 75.5% (England average 77.4%).

A paper was presented to the Governing Body suggesting that the Admiral Nurses could be commissioned to improve performance. However as these are QOF indicators the first step is to review individual practice achievement to understand if an improvement can be made.

The Commissioning Lead for Dementia has discussed this work with the Head of Primary Care and has received practice level QOF achievement and exception reporting data in order to identify practices to target for review. The Commissioning manager will visit those practices who have high achievement and low exception reporting to identify best practice. They will also visit those practices with low achievement and/or high exception reporting in order to share best practice and identify barriers to improvement.

4.2 Learning Disabilities

NHS Halton CCG was graded as Needs Improvement. This assessment is based on the result of two metrics contained within the Direct Enhanced Service Specification: GP Health Checks. Due to data quality concerns a CCG percentage was not calculated to compare against the England average of 47%.

The Performance Manager has discussed this with the Head of Primary Care in order to identify suitable action. The data quality issues are of concern and as the CCG approaches its first end of year contractual sign off it important to ensure the data quality issues are resolved in order for accurate CCG achievement to be available. The Primary Care Team will therefore work with those practices who have data quality issues to ensure accurate data is available.

The Primary Care Team will also continue to work with the Clinical lead for Learning Disabilities to ensure best practice is identified and shared across all practices. For Example the Clinical Lead has been looking to share a clinical system template to improve the quality of health checks undertaken.
**Halton Clinical Commissioning Group**

**Widnes Practices (Update February 2017)**

(NB: West Bank still illustrated due to data reporting periods prior to West Bank and Beaconsfield merger.)

### Practice Population

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Date</th>
<th>Widnes Average</th>
<th>National CCG</th>
<th>Date</th>
<th>Widnes Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>0% Patients attracting a deprivation payment</td>
<td>Oct-16</td>
<td>140,817</td>
<td>11,083</td>
<td>15,165</td>
<td>9,106</td>
</tr>
<tr>
<td>6.1% Low income</td>
<td>Oct-16</td>
<td>10,909</td>
<td>1,030</td>
<td>6,192</td>
<td>2,401</td>
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<tr>
<td>4,260</td>
<td>Oct-16</td>
<td>15,628</td>
<td>2,801</td>
<td>0</td>
<td>0</td>
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</table>

### Performance Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Date</th>
<th>Widnes Average</th>
<th>National CCG</th>
<th>Date</th>
<th>Widnes Average</th>
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</thead>
<tbody>
<tr>
<td>Out-patient Attendances</td>
<td>Oct-16</td>
<td>173</td>
<td>192</td>
<td>135</td>
<td>164</td>
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<tr>
<td>Out-patient First Attendance</td>
<td>Oct-16</td>
<td>191</td>
<td>192</td>
<td>199</td>
<td>175</td>
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<tr>
<td>Out-patient Subsequent Attendance</td>
<td>Oct-16</td>
<td>2706</td>
<td>498</td>
<td>380</td>
<td>477</td>
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</tbody>
</table>

### Practice Comparison

- **A&E Attendances (Rate per 1000)**: 4,260
- **Out-Patient Attendances**: 173
- **Out-Patient First Attendance**: 191
- **Out-Patient Subsequent Attendance**: 2706
<table>
<thead>
<tr>
<th>Indicator</th>
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</tr>
</thead>
<tbody>
<tr>
<td>% Patients attracting a deprivation payment</td>
<td>On 16</td>
<td>Waiting Update</td>
<td>31.4%</td>
<td>0.0%</td>
<td>37.9%</td>
<td>41.1%</td>
<td>32.3%</td>
<td>32.9%</td>
<td>33.1%</td>
<td>29.6%</td>
<td>37.3%</td>
<td>43.1%</td>
<td>2.23%</td>
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<tr>
<td>% Patients aged 70+</td>
<td>On 16</td>
<td>Attack</td>
<td>5.6%</td>
<td>0.0%</td>
<td>3.5%</td>
<td>4.2%</td>
<td>7.0%</td>
<td>8.2%</td>
<td>4.1%</td>
<td>4.4%</td>
<td>7.7%</td>
<td>6.3%</td>
<td>4.3%</td>
</tr>
<tr>
<td>% of practice of the total eligible for the practice</td>
<td>On 16</td>
<td>Attack</td>
<td>3.94%</td>
<td>2.284</td>
<td>2.184</td>
<td>2.184</td>
<td>2.184</td>
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</tr>
<tr>
<td>Number of Care Homes (Current Configuration)</td>
<td>On 16</td>
<td>Attack</td>
<td>25</td>
<td>6</td>
<td>7</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>10</td>
<td>5</td>
<td>1</td>
<td></td>
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</tr>
</tbody>
</table>

Q29. Would you recommend your GP to someone who has just moved to your local area?  
% Definitely Recommended/Probably Recommended | On 16 | Attack | 75% | 73% | 99% | 65% | 70% | 90% | 57% | 62% | 49% | 63% |

Q30. Overall, how would you describe your experience of making an appointment?  
% Very Good/Good | On 16 | Attack | 68% | 69% | 77% | 65% | 69% | 92% | 57% | 62% | 49% | 82% |

Bowel Screening  
% of Patients screened | On 16 | Attack | 51% | 49% | 48% | 54% | 49% | 43% | 46% | 55% | 51% | 45% |

Flu Vaccination  
% 65+ years vaccinated | On 16 | Attack | 72% | 75% | 76% | 76% | 76% | 76% | 73% | 75% | 69% | 72% |

Child Immunisations  
% under 5’s at risk group | On 16 | Attack | 48% | 52% | 56% | 49% | 52% | 60% | 51% | 47% | 45% | 54% |

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</tr>
</thead>
</table>
| Coronary Heart Disease  
CHD002: BP last 12 months ≤150/90 | On 16 | No Target | 3.85% | 3.39% | 3.67% | 4.64% | 4.86% | 4.32% | 4.45% | 3.93% | 2.11% |

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</thead>
</table>
| Chronic Obstructive Pulmonary Disease  
COPD002: Practice Register: prevalence | On 16 | No Target | 2.68% | 2.79% | 0.64% | 3.24% | 6.14% | 0.00% | 1.35% | 4.89% | 4.00% |

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</table>
| Diabeties  
DM007: Practice Register: % prevalence | On 16 | No Target | 756.36% | 8.14% | 8.72% | 9.30% | 8.30% | 8.31% | 8.91% | 8.47% | 7.70% | 5.43% |

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</thead>
</table>
| Atrial Fibrillation  
AF007 - CHA2DS2-VASc score of 2 or more, % treated with anti-coagulation drug | On 16 | No Target | 15.21% | 10.03% | 32.03% | 3.33% | 10.71% | 2.30% | 3.31% | 14.39% | 8.76% | 5.43% |

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</table>
| All-Unplanned Admissions (excluding Maternity admissions)  
Number of Enhanced Services | On 16 | No Target | 12.16% | 14.04% | 25.20% | 13.25% | 15.71% | 0.00% | 11.76% | 12.89% | 15.84% | 17.65% |

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<tbody>
<tr>
<td>A&amp;E Attendances</td>
<td>On 16</td>
<td>No Target</td>
<td>175</td>
<td>162</td>
<td>186</td>
<td>164</td>
<td>137</td>
<td>174</td>
<td>193</td>
<td>132</td>
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<td>Outpatient Attendances</td>
<td>On 16</td>
<td>No Target</td>
<td>2927</td>
<td>467</td>
<td>552</td>
<td>455</td>
<td>452</td>
<td>436</td>
<td>569</td>
<td>450</td>
<td>473</td>
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Quality & Performance Report 21/02/17
Dear Colleague

OUTCOME OF 2017/18 GMS CONTRACT NEGOTIATIONS

This letter confirms the outcome of the contract negotiations between NHS Employers (on behalf of NHS England) and the BMA’s General Practitioners Committee (GPC) on amendments that will apply to GMS contractual arrangements in England from 1 April 2017.

An agreement has been reached with GPC on changes to the GMS contract for 2017/18 which seeks to address concerns of the profession in relation to workload and increasing expenses and other agreed changes. The agreement also reflects commitments made as part of the General Practice Forward View (GPFV) and continues to make significant investment in primary care. The agreement has been approved across Government.

We suggest regional teams discuss with clinical commissioning groups (CCGs) how these changes can support local strategic plans for strengthening the quality of general practice services and making more effective use of NHS resources and how the changes might need to be reflected in co-commissioning plans.

As last year, we will now work with NHS Employers and GPC to develop more detailed guidance where appropriate, on all of the agreed changes which are provided in the attached annex.

The NHS Employers contract website www.nhsemployers.org/gms provides details of the agreement www.nhsemployers.org/gms201718 and we will be updating this and NHS England’s dedicated GP contracts page https://www.england.nhs.uk/gp/gpfv/investment/gp-contract/ with details of the implementation guidance, links to supporting legislation and standard contract documentation in time for these new arrangements to take effect from 1 April 2017. Given the timing of this announcement we will be implementing the changes to the Regulations from July 2017 at the earliest.
Please ensure that this letter is distributed to all relevant people within your teams.

Yours faithfully

Rosamond Roughton  
Director of NHS Commissioning
Key Changes to GMS Contract for 2017/18

Contract Uplift and Expenses

We have agreed an investment of £238.7 million in the contract for 2017/18. This investment is to uplift the contract and to take into account increasing expenses, covering:

- A pay uplift on pay of 1% (based on DDRB formula) and an uplift on expenses of 1.4% (using latest OBR inflation forecast for CPI)
- Payments for indemnity costs that will be made based on registered patients at 51.6p per patient
- An increase in the value of a QOF (Quality and Outcomes Framework) point
- The payment fee for the Learning Disabilities Health Check Scheme will increase from £116 to £140 per health check

Carr-Hill formula

Negotiations on changes to the Carr-Hill formula will begin shortly. Full implementation of any agreed changes will be effective from 1 April 2018 at the earliest.

QOF

We have agreed that for 2017/18 there will be no change to the number of QOF points available, the clinical or public health domains and no changes to QOF thresholds. However, the CPI will be adjusted to reflect the changes in list size and growth in the overall registered population for one year from 1 January 2016 to 1 January 2017.

We have also agreed that a working group will be set up immediately following these negotiations to discuss the future of QOF after April 2017.

Directed Enhanced services (DESs)

The payment for the Learning Disabilities Health Check Scheme will increase from £116 to £140 per health check. A new learning disabilities health check template has been developed by NHS England for practices to use if they so choose. All other requirements of the enhanced service will remain unchanged.

The Extended Hours Access DES will continue unchanged until 30 September 2017 (see below – core opening hours and extended hours access DES).

The Avoiding Unplanned Admissions DES will cease at 31 March 2017. Funding of £156.7 million will be transferred into global sum, weighted and without the out-of-hours deduction applied, and used to support the new contractual requirement on Identification and Management of Patients with Frailty (see below).
**Identification and management of patients with frailty**

We have agreed a new contractual requirement to be introduced from 1 July 2017.

Practices will use an appropriate tool, e.g. Electronic Frailty Index (eFI) to identify patients aged 65 and over who are living with moderate and severe frailty. For those patients identified as living with severe frailty, the practice will deliver a clinical review providing an annual medication review and where clinically appropriate discuss whether the patient has fallen in the last 12 months and provide any other clinically relevant interventions. In addition, where a patient does not already have an enriched Summary Care Record (SCR) the practice will promote this by seeking informed patient consent to activate the enriched SCR.

Practices will code clinical interventions for this group appropriately. Data will be collected on the number of patients recorded with a diagnosis of moderate frailty, the number of patients with severe frailty, the number of patients with severe frailty with an annual medication review, the number of patients with severe frailty who are recorded as having had a fall in the preceding 12 months and the number of severely frail patients who provided explicit consent to activate their enriched SCR. NHS England will use this information to understand the nature of the interventions made and the prevalence of frailty by degree among practice populations and nationally. This data will not be used for performance management purposes or benchmarking purposes.

**National diabetes audit (NDA)**

Practices will be contractually required to allow collection of data relating to the NDA from July 2017 at the earliest.

**NHS Digital Workforce Census**

Practices will be contractually required to allow collection of data relating to the NHS Digital Workforce Census from July 2017 at the earliest. Recurrent funding of £1.5 million has been agreed to support this requirement and will be added to global sum allocations without the out of hours deduction applied.

**Data collection**

We will introduce a contractual requirement, from July 2017 at the earliest, for practices to allow data collections for a selection of agreed retired QOF indicators (INLIQ) and retired DESs.

**Registration of prisoners**

We will introduce a contractual change from July 2017 at the earliest, to allow prisoners to register with a practice before they leave prison. This agreement will include the timely transfer of clinical information, with an emphasis on medication history and substance misuse management plans, to the practice from the prison to enable better care when a new patient first presents at the practice.
Access to healthcare

We have agreed contractual changes that help to identify patients with a non-UK issued EHIC or S1 form or who may be subject to the NHS (Charges to Overseas Visitors) Regulations 2015.

Practices will be required to provide all new patients with a revised GMS1 form, which includes supplementary questions to determine a patient’s eligibility to healthcare. For those patients who self-declare that they hold either a non-UK issued EHIC or a S1 form, the practice will be required to manually record that the patient holds either a non-UK issued EHIC or a S1 form in the patient’s medical record and then send the form and supplementary questions to NHS Digital (for non-UK issued EHIC cards) or the Overseas Healthcare Team (for S1 forms) via email or post. The Department of Health has agreed to provide practices with hard copy patient leaflets which will explain the rules and entitlements overseas patients accessing the NHS in England.

We have also agreed that NHS England and GPC will work with GP system suppliers to put in place an automated process, as soon as possible, to replace the manual process. This will include discussions on development of systems to support collection of GP appointment data for these patients.

Once the technical solution to automatically collect this data is in place, we have agreed that further discussions on implementing the system to support collection of the data will take place.

New recurrent investment of £5 million will be added to global sum allocation, without the out of hours deduction applied, to support this requirement.

GP retention scheme

We have agreed a new scheme to replace the existing one, with the key changes being as follows:

• Tighter criteria for those who are joining the new scheme. The scheme is aimed at those GPs who are seriously considering leaving or have left general practice due to personal reasons, approaching retirement, or require greater flexibility.

• In 2016, under an interim scheme, the practice payment rose from £59.18 to £76.92 per session, an increase of approximately 30 per cent. NHS England will fund the 2017 scheme wholly from within the primary care allocation budget and the practice payment and bursary professional expenses salary supplement will remain the same as the 2016 scheme. The payment is to be used by the practice as an incentive to provide flexibility for the retained GP and should be used towards the retained GP’s salary, to cover human resources administration costs and to provide funding to cover any educational support required from the practice, including course fees where relevant.
A professional expenses salary supplement will be payable to the GP via the practice (on a sliding scale, net of any applicable deductions payable by the doctor in respect of income tax, national insurance and superannuation contributions) and is to go towards the costs of the GP’s indemnity cover, professional expenses and Continuing Professional Development (CPD) needs.

A strong element of the new scheme is around education and CPD. The retained GP will be entitled to the pro rata full time equivalent of CPD as set out within the salaried model contract. The CPD aspects will be based on the needs of the individual, as established at their appraisal and in discussion with the educational supervisor.

GPs can be on the scheme for a period of up to five years. In exceptional circumstances an extension can be made for up to a further 24 months.

Any retainers on the 2016 Retained Doctors Scheme will continue under these arrangements until 30 June 2019 after which time they will default to the new scheme.

Retainees who have been accepted on to the Retained Doctor Scheme 2016 (where the application form has been approved by the NHS England DCO) but who are not in post before 31 March 2017, will be accepted onto the GP Retention scheme without the need to re-apply.

Payments for sickness leave cover

We have agreed changes to the arrangements for making sickness leave payments, as follows:

To allow for cover to be provided by external locums or existing GPs already working in the practice but who do not work full time.

An amendment to the qualifying criteria for reimbursement to begin when the absence is two or more weeks (as opposed to current arrangements which is linked to patient numbers and the period of absence).

An increase in the maximum amount payable to £1,734.18 per week. Payments will no longer be discretionary and will be payable where the absence is two or more weeks.

Sickness leave payments will not be made on a pro-rata basis and will be the lower of actual or invoiced costs up to the maximum amounts as set out in the Statement of Financial Entitlements (SFE).

These changes will be applicable as from 1 April 2017 and all other requirements will remain unchanged.
Parental leave payments

We have agreed that parental leave payments will not be made on a pro-rata basis and will be the lower of actual or invoiced costs up to the maximum amounts as set out in the SFE. All other requirements will remain unchanged.

Business Improvement District (BID) levies

Agreement has been reached for eligible practices to be reimbursed for costs relating to BID levies. The reimbursement is to be made via the Premises Costs Directions on submission of a paid invoice. Payment of the BID levies will not be a discretionary payment.

Care Quality Commission (CQC) Fees

CQC Fees will be reimbursed directly. Practices will present their CQC invoices to the CCG (where delegated powers exist) or the NHS England regional team and they will be reimbursed as part of the practice’s next regular payment.

Vaccinations and immunisations (V&I)

We have agreed to the following V&I programme changes from April 2017:

• Childhood seasonal influenza – the removal of four year olds from enhanced service patient cohort (transferring to schools programme) and the removal of the requirement to use Child Health Information Systems (CHIS).

• MenACWY programmes – a reduction in the upper age limit from ‘up to 26th birthday’ to ‘up to 25th birthday’ (in line with the Green Book).

• Seasonal influenza – the inclusion of morbidly obese patients as an at-risk cohort in the DES and a reminder for practices that it is a contractual requirement to record all influenza vaccinations on ImmForm. Funding to cover this new cohort will be from Section 7A.

• Pertussis or pregnant women – a reduction in the eligibility of patients for vaccination from 20 weeks to 16 weeks.

• Singles (routine) – a change in patient eligibility to the date the patient turns 70 rather than on 1 September.

• Shingles (catch-up) – a change in patient eligibility to the date the patient turns 78 rather than on 1 September.

The following programmes will roll-over unchanged:

• hepatitis B (newborn babies)
• HPV for adolescent girls
• measles mumps and rubella (aged 16 and over)
• meningococcal B
• pneumococcal polysaccharide
• rotavirus.

**Core opening hours and extended hours access DES**

In relation to the extended hours access DES new conditions will be introduced from October 2017 which will mean that practices who regularly close for a half day, on a weekly basis, will not ordinarily qualify for the DES. GPC have agreed that Local Medical Committees should be integral partners in working with local commissioners in ensuring practices are fulfilling their contractual requirements.

**GMS digital**

We have agreed to build on the work of recent years to develop high quality secure electronic systems and pro-actively encourage patients and practices to use them. The changes that we have agreed for 2017/18 will be taken forward through non-contractual working arrangements which we will jointly promote in guidance.

Recognising the importance of cyber security, practices will want to ensure that they have strong underpinning information governance which supports their and patients’ use of all electronic systems.

We have further agreed non-contractual changes to joint guidance that will promote:

- practice compliance with the ten new data security standards in the National Data Guardian Security Review,
- practice completion of the NHS Digital Information Governance toolkit including attainment of level 2 accreditation, and familiarisation with the July 2016 Information Governance Alliance guidance
- an increased uptake of electronic repeat prescriptions to 25 per cent with reference to co-ordination with community pharmacy,
- an increased uptake of electronic referrals to 90 per cent where this is enabled by secondary care,
- continued uptake of electronic repeat dispensing with reference to CCG use of medicines management and co-ordination with community pharmacy
- uptake of patient use of one or more online service to 20 per cent including, where possible, apps to access those services and increased access to clinical correspondence online,
- better sharing of data and patient records at local level, between practices and between primary and secondary care.

**Indemnity Inflation**

Further work

NHS England and GPC have committed to take forward discussions in the coming months on a national programme of self-care and appropriate use of GP general practice services and information sharing between practices.
Primary Care Commissioning Committee

Date: 21st February 2017

Report title: General Practice Commissioning, Quality and Transformation Scheme

Lead Clinician and/or Lead Manager:
Sarah Vickers, Head of Primary Care
Dr Gary O’Hare, GP Primary Care Clinical Lead

Purpose: To outline the proposals for the PMS redistribution and development of local enhanced service specifications for ECG, Spirometry and 24 Hour BP Monitoring / Ambulatory Blood Pressure Monitoring, and the Commissioning, Quality & Transformation Scheme.

The Committee is asked to:
• Approve the principle of the scheme and suggested associated budget lines in preparation for the final scheme being approved in April.

This Report supports the following CCG Strategic Objectives

One: To commission services which continually improve the health and wellbeing of Halton residents

Four: To deliver all of our statutory duties and commissioning responsibilities effectively, whilst ensuring there are robust constitutional, governance and financial control arrangements in place

Commissioning Plan Implications

The review of general medical service provided by general practices with a personal medical services contract supports will support the delivery of the Strategy for General Practice Services in Halton, and ensure that high quality primary care, is at the heart of the One Halton programme.
### Financial Implications

There are financial implications to the CCG budget in that the paper proposes to utilise the £5 per head budget. There are also implications for member practices and their income levels. There may also be implications to the delegated budget for general practice medical services.

### Board Assurance Framework and Corporate Risk Register

The report links to two risks in the Board Assurance Framework:

- ID 374 & 378

### National Policy, Guidance, Standards, Targets or Legislation


### Equality and Diversity and Human Rights

There are no equality implications across the protected characteristics identified in the Equality Act 2010.

### Information Governance

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you need to complete a Privacy Impact Assessment?</td>
<td>No</td>
</tr>
<tr>
<td>Do you need an Information Sharing Protocol?</td>
<td>No</td>
</tr>
</tbody>
</table>
DEVELOPING A GENERAL PRACTICE COMMISSIONING, QUALITY & TRANSFORMATION SCHEME

1. Background

1.1 In response to the identified variation, in January 2014 NHS England Area Teams were asked to review local Personal Medical Services (PMS) agreements. The review was tasked with developing a proposal by the end of March 2016, to ensure any additional funding, over and above the General Medical Services level, meets a set of consistent principles and criteria, and where it does not the funding should be withdrawn:

- Reflect local strategic plans for primary care agreed jointly with CCGs;
- Secure services or outcomes that go beyond what is expected of core general practice or improve primary care premises;
- Help reduce health inequalities;
- Give equality of opportunity to all GP practices;
- Support fairer distribution of funding at a locality level.

1.2 In September 2014 NHS England published its Framework for Personal Medical Services (PMS) Contracts Review. Within the guidance it states:

- Any resources freed up from PMS Reviews should always be reinvested in general practice services (including, as appropriate, general practice premises developments.)
- Except with the agreement of all CCGs involved, PMS resources should not be redeployed outside the current CCG locality.
- In the interest of greater consistency for future decisions, area teams should, unless there are compelling reasons otherwise, redeploy any freed-up resources over a minimum four-year period (year one being 2014/15.)

1.3 From 1st April 2015 NHS Halton CCG became a delegated commissioner for General Medical Services and therefore became the lead commissioner to undertake the review of PMS agreements.

1.4 A number of discussions were held with all Practices regarding the services which should be regarded as core contract and those which are provided over and above. All practices that hold a PMS contract have engaged in these discussions and have agreed in principle that the services provided over and above core are the diagnostic services Spirometry, ECGs and 24 Hour BP Monitoring / Ambulatory Blood Pressure Monitoring.

1.5 Early in the discussions it had been thought that the PMS Premium might also need to fund activity from the Minor Surgery Directed Enhanced Service, as Halton Practices undertook some activity under their historic PMS contracts. Further investigation has
found that this is not required and the Minor Surgery Directed Enhanced Service has a sufficient budget line to cover activity.

1.6 This paper outlines the plan to ensure that diagnostic services are commissioned effectively and the plan to re-invest the PMS premium into General Practice as a Commissioning, Quality and Transformation Scheme. The contents of the schemes presented have been discussed and agreed with practices.

2. Developing a Commissioning, Quality and Transformation Scheme

2.1 The indicators selected for inclusion in the scheme should support the principles and criteria of the national PMS Review, along with the strategic commissioning direction of the CCG (i.e. Sustainability & Transformation Plans, Local Delivery System Plans and local CCG plans.) This should include:

- To reduce variation and ensure a high quality service is in place across all Halton Practices.
- To ensure practices play their part in supporting commissioning and sustainability plans.
- To support the development of new models of care and the transformation of general practice services.
3. Budget

3.1 The budget for the Commissioning, Quality & Transformation scheme brings together two funding streams; the PMS Premium and the former Reducing Unplanned Admissions in the Over 75’s.

3.2 At the 1st January 2017 the PMS budget is £892,122 which equates to £6.33 per weighted patient (141,052) when distributed across all sixteen practices.

3.3 The former Reducing Unplanned Admissions in the Over 75’s budget is £652,645 which equates to £5 per registered patient (130,529.) This includes the mandatory requirement now placed on CCGs and outlined in the GP Forward View, to invest transformation monies into General Practice. Local agreement is that £1.50 in 2017/18 and 2018/19 will be invested and that this is contained within the £5 mentioned above for 2017/18. No further funding agreements are in place for 2018/19.

3.4 Together these two budgets total an investment into Halton General Practices of £1,544,767 for 2017/18.

3.5 It is proposed to divide the total budget as follows to fund the stated schemes, using the registered population at 1st January 2017 of 130,529:

- **Spirometry Local Enhanced Service:** £195,793 (£1.50 per registered population)
- **ECG Local Enhanced Service:** £195,793 (£1.50 per registered population)
- **24 Hour BP Monitoring / Ambulatory Blood Pressure Monitoring:** £195,793 (£1.50 per registered population - this is being assigned as an estimate whilst further commissioning work is undertaken.
- **Commissioning, Quality & Transformation Scheme:** £891,513 (£6.83 per registered patient)

3.6 It should be noted that actual payments to practices will vary according to the practices position on the redistribution timeline.
4. Spirometry Local Enhanced Service

4.1 The previous PMS contract did not include a robust service specification for the provision of a practice based Spirometry service. Therefore once this had been identified as a service provided above core general practice and one, which should be, retained in General Practice, work commenced on developing and agreeing a local specification.

4.2 The budget for this service was identified by reviewing specifications from other CCGs and by considering the staffing, time, training requirements, consumables and equipment costs.

4.3 The local specification is open to all practices and a budget per practice has been set at £1.50 per registered patient. Discussions with practices debated setting a fee per activity or a block total budget. It was felt that in order to provide greater clarity regarding practice income and to support CCG financial planning a block budget should be set. An added benefit of this approach is that should practices wish to work together to deliver this service then there is clarity regarding the budget available to be pooled.

4.4 The implementation of a new service specification will mean that this service will be closely monitored and accurate activity data will be available for the first time. Should a practices activity outweigh the budget, or be below expected levels then the budget would need to be re-negotiated.

4.5 The new Spirometry Specification is provided in Appendix 1.

5. ECG Local Enhanced Service

5.1 The previous PMS contract did not include a robust service specification for the provision of a practice based ECG service. Therefore once this had been identified as a service provided above core general practice and one, which should be, retained in General Practice, work commenced on developing and agreeing a local specification.

5.2 The budget for this service was identified by reviewing specifications from other CCGs and by considering the staffing, time, consumables and equipment costs.

5.3 The local specification is open to all practices and a budget per practice has been set at £1.50 per registered patient. Discussions with practices debated setting a fee per activity or a block total budget. It was felt that in order to provide greater clarity regarding practice income and to support CCG financial planning a block budget should be set. An added benefit of this approach is that should practices wish to work
together to deliver this service then there is clarity regarding the budget available to be pooled.

5.4 The implementation of a new service specification will mean that this service will be closely monitored and accurate activity data will be available. Should a practices activity outweigh the budget, or be below expected levels then the budget would need to be re-negotiated.

5.5 The new ECG Specification is provided in Appendix 2.

6. **24 Hour BP Monitoring / Ambulatory Blood Pressure Monitoring**

6.1 The previous PMS contract did not include a robust service specification for the provision of a 24 hour BP monitoring / Ambulatory Blood Pressure monitoring. As this has been identified as a service provided above core general practice and one, which should be, retained in General Practice, work will commence on developing and agreeing a local specification.

6.2 The budget for this service will be identified by reviewing specifications from other CCGs and by considering the staffing, time, equipment and licence costs.

6.3 It is proposed that the local specification will be open to all practices and a budget per practice has been set initially at £1.50 per registered patient whilst further commissioning work is undertaken. It is anticipated that in order to provide greater clarity regarding practice income and to support CCG financial planning a block budget will be set. An added benefit of this approach is that should practices wish to work together to deliver this service then there is clarity regarding the budget available to be pooled.

6.4 The implementation of a new service specification will mean that this service will be closely monitored and accurate activity data will be available. Should a practices activity outweigh the budget, or reduce below expected levels then the budget would need to be re-negotiated.

6.5 It is anticipated that the specification for this service will be agreed by the end of June 2017.
7. **Commissioning, Quality & Transformation Scheme**

7.1 The table below summarises the indicators developed for the Commissioning, Quality & Transformation scheme and their funding allocation. These indicators and work areas have been identified to support a collaborative approach to commissioning and transformation, whilst also providing a focus for specific areas of quality improvement.

<table>
<thead>
<tr>
<th>Potential Indicator / work stream</th>
<th>Funding allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Supporting practices to develop a collaborative approach to care provision, reducing unwarranted variation in referrals and utilising care pathways via bi-monthly meetings.</td>
<td>£3.50 per registered patient</td>
</tr>
<tr>
<td>Supporting practices to work collaboratively to implement transformation programmes such as those projects outlined in the GP Forward View Implementation Plan via bi-monthly meetings.</td>
<td>£1.50 per registered patient</td>
</tr>
<tr>
<td>2 Undertake a Clinical Audit based on NICE Guidelines: For 2017/18 complete an audit cycle of the NICE Hypertension Audit – as developed by the Public Health Team and piloted during 2015/16. This is also a Local Delivery System priority clinical area.</td>
<td>90p per registered patient</td>
</tr>
<tr>
<td>3 All practice reception and admin staff to undertake Dementia Friends training and Dementia service awareness training</td>
<td>15p per registered patient</td>
</tr>
<tr>
<td>4 Embed use of EPACS template across practice</td>
<td>10p per registered patient</td>
</tr>
<tr>
<td>5 Risk Management – Undertake an SEA for new cancer diagnoses, diagnosed outside of the fast-track process and excluding Basal Cell carcinomas. Number undertaken per practice to be agreed.</td>
<td>35p per registered patient</td>
</tr>
<tr>
<td>6 Safe Prescribing Processes - A Review of practice processes such as repeat prescribing, emergency drugs, cold chain</td>
<td>15p per registered patient</td>
</tr>
<tr>
<td>7 Review and develop Practice Safeguarding administration processes for vulnerable people.</td>
<td>15p per registered patient</td>
</tr>
</tbody>
</table>

7.2 As noted earlier, the following 3 years are transition years until 31st March 2020 when all practices will be funded equitably. In recognition of this practices that currently receive less than the PMS value of £6.83 per registered patient in 2017/18 will not be expected to undertake all the projects listed in the table. Each practice will negotiate with the Primary Care Team and their peers to agree which pieces of work will be completed. It is suggested that scheme 1 is a mandatory requirement and where possible scheme 2 should also be completed.

7.3 Further detail on each of the schemes above is currently being developed into a specification and will be discussed with practices at the final PMS meeting of 22nd March 2017 prior to final approval at the April Committee meeting.
## SCHEDULE 2 – THE SERVICES

### A. Service Specifications

Mandatory headings 1 – 4: mandatory but detail for local determination and agreement
Optional headings 5-7: optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

<table>
<thead>
<tr>
<th>Service Specification No.</th>
<th>Service</th>
<th>Commissioner Lead</th>
<th>Practice Lead</th>
<th>Period</th>
<th>Date of Review</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Spirometry in Primary Care</td>
<td>NHS Halton CCG</td>
<td></td>
<td>1 April 2017 – 31&lt;sup&gt;st&lt;/sup&gt; March 2018</td>
<td>Annual</td>
</tr>
</tbody>
</table>

### 1. Population Needs

1.1 National/local context and evidence base

1.1.1 National context

Several publications at the national level have recommended earlier and accurate diagnosis of COPD via quality-assured spirometry.

The *Outcomes Strategy for COPD and Asthma* and the subsequent *NHS Companion Document to the Strategy* suggested the NHS could:

- perform quality-assured diagnostic spirometry on those identified and confirm diagnosis, together with other investigations to assess severity and coexistence of other conditions

The *NICE Clinical Guideline for COPD* highlights diagnosis as a priority for implementation, recommending:

- ensuring that people have an appropriate diagnosis of COPD confirmed by an competent professional performing spirometry

The *NICE Quality Standard for COPD* also highlights the importance of diagnosis through quality-assured spirometry:

- Quality Statement 1: People with COPD have one or more indicative symptoms recorded, and have the diagnosis confirmed by post-bronchodilator spirometry carried out on calibrated equipment by healthcare professionals competent in its performance and interpretation.
1.1.2 Local context

The 2014 Halton Respiratory Health Profile details the significant respiratory health issues within Halton. The key issues identified within the health profile include:

- It is estimated about 3,916 people aged 16+ living in Halton had Chronic Obstructive Pulmonary disease (COPD) in 2010. By 2020 this figure may be as much as 4,420.
- There have been improvements in case finding since 2009/10 closing the gap between the modelled expected number of people with COPD and those known about on GP disease registers. However, the number of people on the asthma register remains lower than the expected number.
- Death rates for COPD have been falling but are above the North West and England rates. Death rates from respiratory causes in those aged under 75 years and pneumonia are also higher than England but similar to the North West.
- Halton has high rates of smoking. In 2014, 22.6% of the adult population smoked compared to an England average of 19.5%.
- The rate of smoking related deaths was 416 (per 100,000 population), worse than the average for England. This represents 248 deaths per year and is considerable worse than the England average smoking related death rate of 292 (per 100,000 population).

In addition, the incidence and mortality from cancer is higher in Halton than in many other parts of the country. Lung cancer represents the greatest proportion of all cancers within Halton (almost 17% of all cancers) and incidence fluctuates unequally across the Borough. While the incidence amongst men has seen a decline since the early 1990s, the incident rate amongst women continues to increase (increasing by 15.43 cancers per 100,000 population, from 1993-95 to 2009-11). Lung cancer represents a significant burden of respiratory illness for the population of Halton.

Halton’s Respiratory Strategy 2015 – 2020 identifies five strategic aims;

**Prevent respiratory ill health**
Increase awareness of how to maintain good respiratory health so that people are aware how to live healthy lifestyles and make informed healthy choices to minimise the risks to poor respiratory health. Ensure that services and agencies activities support activities to prevent poor respiratory ill health.

**Earlier detection of respiratory diseases**
Make sure people are aware of the signs and symptoms of respiratory diseases to encourage positive health seeking behaviours and ensure robust services and pathways are in place to enable access to early investigation and treatment.

**Primary Care and Community based support**
Provide a fully integrated approach to primary care and community based services, to ensure all community treatment and support services are aligned to best meet the needs of patients and carers, and facilitate seamless community services.

**High Quality Hospital Services**
Ensure that pathways and services are in place so that people who need them receive prompt effective treatment for their respiratory condition and have the best chance to optimise their quality of life and survival.
Promoting Self Care and Independence

Ensure that people are placed at the centre of their own respiratory care, able to identify their individual needs and provided with appropriate information, support and interventions to help them manage their own respiratory health issues.

Successful delivery of the Respiratory Strategy means that by 2020 Halton will see:

I. A decline in prevalence of a number of key preventable respiratory illnesses.
II. Improved smoking quit rates and increased numbers of people referred to smoking cessation services.
III. Increased uptake of flu vaccination amongst those with existing respiratory conditions and amongst those with other on term health conditions, including those with learning disability, to mitigate the effects of flu on general respiratory health.
IV. Improved awareness within the general population of factors that prevent and protect against respiratory ill health, enable earlier identification of problems and health seeking behaviours.
V. Improved recognition, diagnosis and management of a variety of respiratory illnesses (including COPD, asthma, lung cancer) within primary care.
VI. A range of interventions and support to enable individuals and their carers to better ‘self–manage’ their respiratory condition.
VII. More individuals and their carers involved in the planning and quality assurance of respiratory health services.
VIII. Improved pathways between primary, acute, residential, nursing and social care for individuals and their carers.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

<table>
<thead>
<tr>
<th>Domain</th>
<th>Preventing people from dying prematurely</th>
<th>Enhancing quality of life for people with long-term conditions</th>
<th>Helping people to recover from episodes of ill-health or following injury</th>
<th>Ensuring people have a positive experience of care</th>
<th>Treating and caring for people in safe environment and protecting them from avoidable harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1</td>
<td>√</td>
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<td></td>
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<td>Domain 2</td>
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<td>Domain 5</td>
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</tbody>
</table>

2.2 Local defined outcomes

NHS Halton CCG, together with Halton Borough Council have a clear focus on achieving the following objectives with regards to patients with respiratory disease:

- Reductions in accident & emergency attendances
- Reductions in avoidable emergency admissions to hospital
- Reductions in delayed transfers of care for patients who have been admitted to hospital
- Reductions in length of stay for patients who have been admitted to hospital
- Reductions in permanent admissions to nursing and residential care (including at End Of Life)
- Reductions in readmissions to hospital
- Increases in the number of people who use services and their carers, who
reported that they had as much social contact as they would like
• Increases in the number of carers who report that they have been included or consulted in discussions about the person they care for

### 3. Scope

#### 3.1 Aims and objectives of service

This Service is commissioned to deliver quality-assured spirometry within general practices in Halton. The aim is that patients are effectively screened for, and monitored with, COPD.

The high-level objectives of the Service are:

- to ensure the accuracy of diagnosis and severity assessment in people with COPD through the provision of a quality assured spirometry service.
- to increase the proportion of people with COPD who are diagnosed comparing recorded prevalence with predicted prevalence
- to increase the number of people accurately diagnosed at an early stage of disease
- to help to decrease the number of people dying prematurely from COPD
- to ensure that users of the Service have a positive experience of care and to offer a service which is accessible and convenient for patients
- to enhance the quality of life for people with COPD
- to ensure effective communication between relevant health professionals

#### 3.2 Service description/care pathway

In the delivery of this service, the Practice will adhere to Primary Care Commissioning’s Guide to Performing Quality Assured Diagnostic Spirometry (2013).

Patients will be identified as follows:

- Patients who present to a clinician with clinical features that suggest the possibility of COPD:
  
  Such features might include exertion breathlessness, chronic cough, regular sputum production, frequent winter “bronchitis” and wheeze.

  The clinician should refer all such patients directly to someone within the practice who is competent to deliver Spirometry and be advised on how to prepare for the appointment.

- Case finding for symptomatic patients with airflow obstruction (i.e. audit of primary care register).

The Practice shall ask the patient to avoid, if possible:

- smoking for at least 24 hours before the test
- eating a large meal before the test
- exercise or exertional activity before the test
- wearing tight clothing
- bronchodilators prior to the test
The Practice shall ask the patient to bring all prescribed inhalers to the appointment (in the event that the patient has been prescribed inhalers but has not undergone quality-assured diagnostic spirometry).

The content of the spirometry procedure should include:

- An appropriate review of patients’ health, including checks for potential contra-indications, that the patient is safe to undergo the test and meets the criteria.
- Interpretation of the results.
- Results of patients diagnosed with COPD are classified and recorded (including scanning of hard copies where generated) as mild, moderate, severe or very severe.
- Arrange access to Halton’s Community COPD Service as required according to diagnosis and severity of condition including Respiratory Consultant MDT’s/ Primary Care MDT’s/ Pulmonary Rehabilitation/Rapid Response nursing and physiotherapy.
- Prescribed and administered medication, where & as appropriate.
- Provide advice and support to patients with regard to inhaler technique and therapy optimisation.
- For patients who smoke, onward referrals to the smoking cessation service should also be offered at the point of diagnosis.
- Identify issues impacting on respiratory health & wellbeing and work, and refer on to social, third sector and lifestyle services as appropriate.
- Operate a call & recall system to ensure annual review for all patients on the COPD register in line with relevant Quality Outcomes Framework or other quality standards in place for primary care Practices throughout the period of the contract.
- **Record results of spirometry in patient’s notes using ………check with Chris Woodforde.**

### 3.2.1 Reversibility Testing

In most patients, routine spirometric reversibility testing is not necessary as a part of the diagnostic process or to plan initial therapy with bronchodilators or corticosteroids. However in some cases reversibility testing may need to be undertaken if asthma is suspected. In all cases spirometry results should be recorded & interpreted 20-30’ post bronchodilator [400mg salbutamol via volumatic spacer] and this should be documented.

### 3.3 Training / Staffing

To be of clinical value, diagnostic spirometry has to be performed to a high standard. If it is not, there is a significant risk that the diagnosis will be incorrect and patients may receive inappropriate and potentially harmful treatment as a result, or be denied appropriate treatments that could potentially improve their condition. To be valid, diagnostic spirometry must be quality-assured and only be performed by people who have been appropriately assessed as competent, and have completed an approved competency-based training course in spirometry.

They will also be expected to keep their skills up to date.

Diagnostic spirometry tests and interpretation of the results can be separate
functions performed by different individuals. There are different competences associated with each function.

Staff undertaking spirometry only and do not have a role in interpretation or treatment should either hold one of the following:

- Association for Respiratory Technology and Physiology [ARTP] - Foundation Certificate in Spirometry
- Education for Health - A range of courses written by experts.
- Or Equivalent.

Staff responsible for performing spirometry and interpreting results should hold:

- Association for Respiratory Technology and Physiology [ARTP] – Full Certificate in Spirometry
- Education for Health - A range of courses written by experts.
- Or Equivalent.

Staff responsible for interpreting results only should hold:

- Association for Respiratory Technology and Physiology [ARTP] – Interpretation Certificate in Spirometry
- Education for Health - A range of courses written by experts.
- Or Equivalent.

Staff who are already highly experienced at performing spirometry but are not ARTP Accredited should be confirmed as competent by having their skills assessed against ARTP standards via the:

- Association of Respiratory Technology and Physiology [ARTP] – Experienced Practitioner Scheme

### 3.3.1 The National Register

To provide assurance that those undertaking spirometry assessments and interpretation have achieved the required standard of practice, the ARTP will maintain an up-to-date national register of certified healthcare professionals/operators.

The Register lists individuals’ names according to whichever of three categories of certification that person has achieved: Foundation (=Performing Only), Full (=Performing and interpretation) or Interpretation Only.

Once certified as competent, all those performing and/or interpreting diagnostic spirometry will be required to record their qualification on the National Register. Implementation will be phased over four years from 1 April 2017.

It is expected that all staff currently performing and interpreting spirometry will have until 31 March 2021 to ensure they have been assessed and entered on to the national directory of certified healthcare professionals and should be working towards achieving this.

### 3.4 Equipment
Purchasing of spirometers and consumables will be the responsibility of the Practice and is included with the service price. This includes replacing spirometers that have reached the end of their lifespan. There are several makes of equipment and all spirometers need as a minimum to meet the standards of measuring and recording as specified in international guidelines. The Practice will ensure that spirometers used meet the following standards and requirements:

- Meet ISO standard 26782
- One-way mouthpieces and nose clips
- Bacterial and viral filters (as indicated in selected patients)
- Height measure and weighing scales — calibrated according to manufacturer’s instructions.
- Nebuliser or single patient use volumatics (for post bronchodilator spirometry and reversibility testing).
- Single-patient use mask/mouthpiece for nebulizer
- Short acting bronchodilators as per guidelines, must be able to calculate fev1 % as well as actual numbers (see below)

It is the Practice’s responsibility to calibrate, clean and arrange for servicing of the device in line with the manufacturer’s guidance and in line with PCC’s Guide to Quality Assured Spirometry. Calibration should be verified prior to every clinic/session or after every 10th patient (whichever comes first). A calibration log should be maintained.

It is the Practice’s responsibility to monitor the quality of tests performed using each spirometer and to purchase a new device as and when required. Again this cost will be borne by the Practice as it is built into the service price.

Any necessary cleaning and maintenance processes should be carried out on a regular basis according to manufacturer’s instructions with reference to local guidelines and protocols. A record of cleaning and calibration must be kept accordingly by the Practice accordingly as evidence which will be verified annually.

### 3.5 Population covered

The service is available for people over 16 years of age with suspected or known respiratory disease who are registered with a Halton CCG member practice or are a Halton resident.

### 3.6 Any acceptance and exclusion criteria and thresholds

Patients should not undergo spirometry when the test may be harmful due to other medical conditions.

### 3.7 Interdependence with other services/Practices

- Halton’s Community COPD Service
- Map of Medicine (Appendix 1)
- Pulmonary Rehabilitation
- Domiciliary care Practices in Halton
- Out of Hours Practice UC24
- Breathe Easy
- Community Pharmacists
- Local Fire & Rescue Service
3.8 Payment

The Practice will receive a block payment of £1.50 per registered patient based on the list size at 1 April 2017.

In recognition that 2017/18 is a transition year, and that activity has not previously been closely monitored, the Practice will be expected to carry out at least the same activity as during 2016/17 (baseline activity to be clarified at 31 March 2017). Activity will then be monitored on a quarterly basis. Any significant under or over activity may result in a discussion with the Commissioner to understand the reason and discuss how this can be addressed.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

- Chronic obstructive pulmonary disease: Management of chronic obstructive pulmonary disease in adults in primary and secondary care (partial update) (CG1010) – June 2010
- Quality standard for patient experience in adult NHS services NICE quality standard [QS15] Published date: February 2012
- Quality standards for asthma (QS25) - February 2013
- Idiopathic pulmonary fibrosis: The diagnosis and management of suspected idiopathic pulmonary fibrosis (CG163) June 2013
- Chronic obstructive pulmonary disease quality standards (QS10) - July 2011
- Idiopathic pulmonary fibrosis NICE quality standard [QS79] Published date: January 2015

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

- Spirometry in Practice, The British Thoracic Society COPD Consortium – April 2005
- Guidelines for non-CF Bronchiectasis, British Thoracic Society – July 2010
- A Guide to Performing Quality Assured Diagnostic Spirometry, PCC et al - 2013
- BTS/SIGN 141 • British guideline on the management of asthma – October 2014
- Improving the quality of diagnostic spirometry in adults: the National Register of certified professionals and operators, ARTP et al – September 2016

4.3 Applicable local standards

The Practice will be required to evidence compliance with all standards listed above along with any further appropriate NICE guidance or Technology Appraisal
Guidance which may be published during the life of the contract.

5. **Applicable quality requirements**

5.1 **Applicable Quality Requirements**

<table>
<thead>
<tr>
<th>Data</th>
<th>Frequency</th>
</tr>
</thead>
</table>
| Names of staff providing the service (undertaking spirometry and interpretation) and confirmation that their training meets the requirements set out in section 3.3. | Pre contract  
                                        | Annually                     |
| Log of equipment used to deliver the service and declaration that this meets the requirements set out in section 3.4 | Pre contract  
                                        | Annually                     |
| Reporting of any significant untoward events, including action taken by the Practice. | By Exception                  |
| Number of patients assessed                                        | Quarterly                     |
| Number of spirometries undertaken                                  | Quarterly                     |
| Number of spirometries performed with an FEV1<80%                   | Quarterly                     |
| Number of reversibility tests undertaken                           | Quarterly                     |
| Number of patients referred onto other services and service specified | Quarterly                     |
| DNA rate                                                            | Quarterly                     |
| Numbers of new COPD diagnoses, with spirometry, since 1st April 2017 | Quarterly                     |

6. **Location of Practice Premises**

The Practice’s Premises are located at:

7. **Individual Service User Placement**

Not applicable.
LOCAL ENHANCED SERVICE
PROVIDING ECG RECORDINGS AND INTERPRETATION IN GENERAL PRACTICE
SPECIFICATION

Part 1: Activity and Resources

Service Outline

SCHEDULE 2 – THE SERVICES

A. Service Specifications

<table>
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<tr>
<th>Service Specification No.</th>
<th>Service</th>
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<th>Provider Lead</th>
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<tbody>
<tr>
<td></td>
<td>Electrocardiograms (ECGs) in Primary Care</td>
<td>NHS Halton CCG Primary Care</td>
<td>General Practice</td>
<td>1st April 2017 – 31st March 2018</td>
<td>Annual Review</td>
</tr>
</tbody>
</table>

1. Population Needs

1.1 National/local context and evidence base

HCCG will ensure delivery of the nationally determined improvement areas as detailed within the Department of Health Our NHS Care Objectives 3 draft mandate; within the following five domains:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Preventing people from dying prematurely</td>
</tr>
<tr>
<td>2</td>
<td>Enhancing quality of life for people with long-term conditions</td>
</tr>
<tr>
<td>3</td>
<td>Helping people to recover from episodes of ill-health or following injury</td>
</tr>
<tr>
<td>4</td>
<td>Ensuring people have a positive experience of care</td>
</tr>
<tr>
<td>5</td>
<td>Treating and caring for people in safe environment and protecting them from avoidable harm</td>
</tr>
</tbody>
</table>

Delivery of better health outcomes within these domains underpins the strategic priorities of the CCG.

2. Outcomes

2.1 The Local defined outcomes are:

1. To reduce the number of patients referred to secondary care for ECGs
2. To reduce the un-necessary use of other health care resources by the conduct of ECGs in Primary Care.
3. To Improve patient satisfaction – with primary care offer of ECG
4. To ensure patient complaints about ECGs are dealt with in line with the practice Complaints procedure

3. Scope

3.1 Introduction

The purpose of this specification is to set out the requirements for a GP led community based service including:
- Static simple 12 lead ECG
- Domiciliary ECG

Practices that do not wish to participate in this service will refer patients to a participating practice within their town that has agreed to accept referrals from other practices within their town. A list of GPs accepting referrals will be sent to practices not participating in this service. Investigations and interpretive reports will be sent securely back to the referring clinician.

In cases where the results of a cardiology investigation and the GPs medical diagnosis mean that a patient needs to be referred for an outpatient cardiology appointment, the ECG report will be forwarded to secondary care and not repeated unnecessarily.

Aims and objectives of service

The aims and objectives of the service are to:
- Provide early reassurance to patients in GP Practices.
- Provide early identification of rhythm abnormalities
- Provide an ECG recording and interpretation service from primary care.
- Reduce the need to refer patients for routine ECG recording and interpretation into secondary care services.
- Provide timely diagnosis and management which complies with the standards set out by the Clinical Guidelines by Consensus – Recording a standard 12-lead electrocardiogram (British cardiovascular society).

Specifically this relates to the following:

1. Prevent unnecessary referrals to hospital for 12 – lead ECG and delays in interpretation
2. Detect atrial fibrillation and offer treatment to prevent strokes
3. Detect people with conduction abnormalities requiring pacemakers
4. Safely monitor patients taking drugs that affect the conduction system
5. Provide timely ECG recordings when people present with palpitations, chest pain, breathlessness or transient loss of consciousness.
6. Identify serious conduction problems in people with transient loss of consciousness requiring urgent referral for pacemakers or further electrophysiological testing
7. Identify the heart rhythm present when people present with palpitations
8. Provide part of the risk assessment of people presenting with hypertension
9. Practice based ECGs will be undertaken according to the patient’s clinical
condition clinical judgement and clinical care pathways.

10. Screen those people with a family history of sudden cardiac death

The objectives of establishing an ECG service in primary care are to:

1. Establish a 12 lead ECG service in every general practice
2. To develop ECG interpretation and reporting either in practice or with the use of telemedicine
3. To provide necessary investigations prior to patient attendance at OP clinics e.g. cardiology/ general medical /, memory clinics/ pre op assessment
4. The service will be available from the practice premises during usual working hours

3.2 Service description/care pathway

1. An ECG should be undertaken if clinically required. The following are examples of when the service may provide a 12 Lead Electrocardiograph (ECG) intervention and recording at the GP practice:
   - for the initial diagnosis and management of Suspected Atrial Fibrillation
   - for the diagnosis and management of Hypertension.
   - for the initial diagnosis and management of Suspected Angina.
   - for the management of some emergency chest pain presentations.
   - for patients in whom it is clinically indicated with no high risk factors and frequent symptoms
   - when cardiac disease is suspected
   - When it is necessary to exclude cardiac disease
   - When it is indicated as part of a patients routine assessment for a long term
   - When required for the Later Life and Memory Service (LLAMS)

2. ECG machines must be used in accordance with the manufacturer’s guidelines and instructions.

3. Within this service, practices can choose whether to participate in domiciliary ECGs for their practice patients.

4. Specialist interpretation will be available. The clinician shall use XXX, the specialist interpretation service commissioned by the CCG.

5. Every interpretation is to be made by a registered clinician, with expertise in ECG interpretation. There should be documented evidence of ECG interpretation expertise for each such member of staff.

6. The service shall take appropriate action based on the results of the ECG.

7. The service shall obtain informed consent from all patients undertaking an ECG.

8. All practice ECGs will be reported within 24 hours either by a trained clinician or by a telemedicine service. The ECG interpretation will be reported to the patient on the same working day where it is clinically indicated.
3.3 Training

The ‘responsible clinician’ should have the basic skills needed to interpret a 12 lead ECG including determining whether the ECG is normal or abnormal and decide what further action is required.

All staff performing and/or interpreting ECGs will be expected to take part in professional development to ensure they are familiar with current best practice.

Training and Accreditation

Those doctors who have previously provided services similar to this enhanced service and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as is necessary to enable them to contract for the enhanced service shall be deemed professionally qualified to do so.

There must be evidence that non medically trained practitioners have received training and are competent to undertake ECG monitoring.

Equipment – Installation Testing and Calibration

The Provider will be responsible for supplying all necessary equipment to deliver the service, installing the equipment and testing its functionality. The Provider’s equipment and software needs to be totally compatible and integrate seamlessly with the Halton GPs IT practice systems and meet NHS IT standards.

3.2.15 Consumables

The Provider will be responsible for supplying all necessary consumables including patches and leads to deliver the service. The Provider must arrange for timely stock replenishment and delivery of consumables to assure service continuity.

3.2.16 Equipment Maintenance

The Provider shall make adequate arrangements for a repair/replace facility for all devices, enabling any equipment problems to be resolved within 48 hours by repairing or replacing said equipment. In the event of equipment failure GP practices will refer their patients to other GP providers of this service.

Population covered

The service will be provided to registered patients of Halton GP practices.

3.4 Any acceptance and exclusion criteria and thresholds

Exclusion criteria will be:

- Patients presenting with acute chest pain typical of an Acute Coronary Syndrome will be referred immediately to the A&E Department. NICE recommend doing an ECG in practice for those with chest pain query acute coronary syndrome, which should be sent to hospital in advance of the patient – however doing the ECG should not delay the transfer to hospital.
- Patients with infrequent symptoms.
3.5 Interdependence with other services/providers

Secondary Care.

In cases where the results of a cardiology investigation and the GPs medical diagnosis mean that a patient needs to be referred for an outpatient cardiology appointment, the ECG report will be forwarded to secondary care and not repeated unnecessarily.

3.6 Activity for submission to the CCG

Practices are expected use the following read codes as follows:

- Patients who have received ECG testing at the GP Practice 321B
- Referral tag on patient record if referred to a secondary care provider 8H7a
- Refer for ECG recording for all secondary care referrals 8HR1
- Refer to other doctor 8H6Z including free text for referral

3 Reporting / Monitoring

The service shall report the following to the CCG:
- Quarterly number of ECGs, domiciliary ECGs performed
- Annual Number of repeats undertaken and reasons why repeats were necessary
- Annual number of patients subsequently referred to Cardiology
- Quarterly Number of ECGs interpreted by the specialist interpretation service
- Annual Number/detail of related significant events
- Annual number related complaints/compliments

The following KPIs shall apply:

- 10% ECG interpretation reports to be quality checked by a second clinician. Number of ECGs requiring amendment following such a check should be less than 2%
- Less than 0.5% of reports shared with secondary care disputed for clinical interpretation findings.

The CCG will monitor referrals into secondary care for ECG services.

Validation process

The practice must record the following information for audit purposes.
- Patient ID Number (anonymised).
- Read code.
- Date of treatment.

Participating practices shall collate and monitor activity related to the Local Enhanced Service.

Full records of all procedures, screening and tests should be maintained in such a
way that aggregated data and details of individual patients are readily accessible.

Practices will ensure their recording processes enable them to monitor and undertake an annual review and clinical audit of outcomes and to provide the results of this to the CCG. This shall include: patients’ clinical criteria for this investigation.

**Part 2: Payment Mechanism**

For providing ECGs to all the practice’s registered patients (including domiciliary ECGs for housebound patients) the practice shall be paid £1.50 per registered patient.

For providing ECGs to the practice registered patients (excluding domiciliary ECGs for housebound patients) the practice shall be paid £1.20 per registered patient.

For providing ECGs within the practice to patients registered with another practice within the town the practice shall receive the amount the non-participating practices would be paid if they participated divided by the number of practices providing this referral service within the town.

Payment will be quarterly on CCG receipt of a completed claim form.

**3.2.1 Quarterly** anonymised patient activity data produced from the clinical system should be submitted to the CCG using the quarterly claim form.

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### 4. Applicable Service Standards

#### 4.1 Applicable national standards

NICE guidelines CG180 update June 2014

The service provider will employ and maintain liability for all clinical staff and ensure that they are professionally competent, have the necessary records clearance and are appropriately accredited to carry out their duties, in this case ECG recording and interpretation.

The service provider will ensure that formal and informal supervision and mentorship is undertaken and that clinical supervision is provided to staff in line with the organisations Clinical Supervision Framework.

#### 4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

#### 3.3 Applicable local standards

Members of staff who undertake and report on ECGs must be trained to an appropriate standard in ECG recording and interpretation.

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### 5. Applicable quality requirements and CQUIN goals

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### 6. Location of Provider Premises
7. Individual Service User Placement
SCHEDULE 2 – THE SERVICES

A. Service Specifications

Mandatory headings 1 – 4: mandatory but detail for local determination and agreement
Optional headings 5-7: optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

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<td>NHS Halton CCG</td>
<td></td>
<td>1 April 2017 – 31st March 2018</td>
<td>Annual</td>
</tr>
</tbody>
</table>

1. Population Needs

1.1 National/local context and evidence base

1.1.1 National context

Several publications at the national level have recommended earlier and accurate diagnosis of COPD via quality-assured spirometry.

The Outcomes Strategy for COPD and Asthma and the subsequent NHS Companion Document to the Strategy suggested the NHS could:

- perform quality-assured diagnostic spirometry on those identified and confirm diagnosis, together with other investigations to assess severity and coexistence of other conditions

The NICE Clinical Guideline for COPD highlights diagnosis as a priority for implementation, recommending:

- ensuring that people have an appropriate diagnosis of COPD confirmed by a competent professional performing spirometry

The NICE Quality Standard for COPD also highlights the importance of diagnosis through quality-assured spirometry:

- Quality Statement 1: People with COPD have one or more indicative symptoms recorded, and have the diagnosis confirmed by post-bronchodilator spirometry carried out on calibrated equipment by healthcare professionals competent in its performance and interpretation.
1.1.2 Local context

The 2014 Halton Respiratory Health Profile details the significant respiratory health issues within Halton. The key issues identified within the health profile include:

- It is estimated about 3,916 people aged 16+ living in Halton had Chronic Obstructive Pulmonary disease (COPD) in 2010. By 2020 this figure may be as much as 4,420.
- There have been improvements in case finding since 2009/10 closing the gap between the modelled expected number of people with COPD and those known about on GP disease registers. However, the number of people on the asthma register remains lower than the expected number.
- Death rates for COPD have been falling but are above the North West and England rates. Death rates from respiratory causes in those aged under 75 years and pneumonia are also higher than England but similar to the North West.
- Halton has high rates of smoking. In 2014, 22.6% of the adult population smoked compared to an England average of 19.5%.
- The rate of smoking related deaths was 416 (per 100,000 population), worse than the average for England. This represents 248 deaths per year and is considerably worse than the England average smoking related death rate of 292 (per 100,000 population).

In addition, the incidence and mortality from cancer is higher in Halton than in many other parts of the country. Lung cancer represents the greatest proportion of all cancers within Halton (almost 17% of all cancers) and incidence fluctuates unequally across the Borough. While the incidence amongst men has seen a decline since the early 1990s, the incident rate amongst women continues to increase (increasing by 15.43 cancers per 100,000 population, from 1993-95 to 2009-11). Lung cancer represents a significant burden of respiratory illness for the population of Halton.

Halton’s Respiratory Strategy 2015 – 2020 identifies five strategic aims:

**Prevent respiratory ill health**
Increase awareness of how to maintain good respiratory health so that people are aware how to live healthy lifestyles and make informed healthy choices to minimise the risks to poor respiratory health. Ensure that services and agencies activities support activities to prevent poor respiratory ill health.

**Earlier detection of respiratory diseases**
Make sure people are aware of the signs and symptoms of respiratory diseases to encourage positive health seeking behaviours and ensure robust services and pathways are in place to enable access to early investigation and treatment.

**Primary Care and Community based support**
Provide a fully integrated approach to primary care and community based services, to ensure all community treatment and support services are aligned to best meet the needs of patients and carers, and facilitate seamless community services.

**High Quality Hospital Services**
Ensure that pathways and services are in place so that people who need them receive prompt effective treatment for their respiratory condition and have the best chance to optimise their quality of life and survival.
Promoting Self Care and Independence

Ensure that people are placed at the centre of their own respiratory care, able to identify their individual needs and provided with appropriate information, support and interventions to help them manage their own respiratory health issues.

Successful delivery of the Respiratory Strategy means that by 2020 Halton will see;

I. A decline in prevalence of a number of key preventable respiratory illnesses.
II. Improved smoking quit rates and increased numbers of people referred to smoking cessation services.
III. Increased uptake of flu vaccination amongst those with existing respiratory conditions and amongst those with other on term health conditions, including those with learning disability, to mitigate the effects of flu on general respiratory health.
IV. Improved awareness within the general population of factors that prevent and protect against respiratory ill health, enable earlier identification of problems and health seeking behaviours.
V. Improved recognition, diagnosis and management of a variety of respiratory illnesses (including COPD, asthma, lung cancer) within primary care.
VI. A range of interventions and support to enable individuals and their carers to better ‘self–manage’ their respiratory condition.
VII. More individuals and their carers involved in the planning and quality assurance of respiratory health services.
VIII. Improved pathways between primary, acute, residential, nursing and social care for individuals and their carers.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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<thead>
<tr>
<th>Domain 1</th>
<th>Preventing people from dying prematurely</th>
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</thead>
<tbody>
<tr>
<td>Domain 2</td>
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</tbody>
</table>

2.2 Local defined outcomes

NHS Halton CCG, together with Halton Borough Council have a clear focus on achieving the following objectives with regards to patients with respiratory disease;

- Reductions in accident & emergency attendances
- Reductions in avoidable emergency admissions to hospital
- Reductions in delayed transfers of care for patients who have been admitted to hospital
- Reduction in length of stay for patients who have been admitted to hospital
- Reductions in permanent admissions to nursing and residential care (including at End Of Life)
- Reductions in readmissions to hospital
- Increases in the number of people who use services and their carers, who
reported that they had as much social contact as they would like
• Increases in the number of carers who report that they have been included or consulted in discussions about the person they care for

3. Scope

3.1 Aims and objectives of service

This Service is commissioned to deliver quality-assured spirometry within general practices in Halton. The aim is that patients are effectively screened for, and monitored with, COPD.

The high-level objectives of the Service are:

• to ensure the accuracy of diagnosis and severity assessment in people with COPD through the provision of a quality assured spirometry service.
• to increase the proportion of people with COPD who are diagnosed comparing recorded prevalence with predicted prevalence
• to increase the number of people accurately diagnosed at an early stage of disease
• to help to decrease the number of people dying prematurely from COPD
• to ensure that users of the Service have a positive experience of care and to offer a service which is accessible and convenient for patients
• to enhance the quality of life for people with COPD
• to ensure effective communication between relevant health professionals

3.2 Service description/care pathway

In the delivery of this service, the Practice will adhere to Primary Care Commissioning’s Guide to Performing Quality Assured Diagnostic Spirometry (2013).

Patients will be identified as follows:

• Patients who present to a clinician with clinical features that suggest the possibility of COPD:

  Such features might include exertion breathlessness, chronic cough, regular sputum production, frequent winter “bronchitis” and wheeze.

  The clinician should refer all such patients directly to someone within the practice who is competent to deliver Spirometry and be advised on how to prepare for the appointment.

• Case finding for symptomatic patients with airflow obstruction (i.e. audit of primary care register).

The Practice shall ask the patient to avoid, if possible:

• smoking for at least 24 hours before the test
• eating a large meal before the test
• exercise or exertional activity before the test
• wearing tight clothing
• bronchodilators prior to the test
The Practice shall ask the patient to bring all prescribed inhalers to the appointment (in the event that the patient has been prescribed inhalers but has not undergone quality-assured diagnostic spirometry).

The content of the spirometry procedure should include:

- An appropriate review of patients’ health, including checks for potential contra-indications, that the patient is safe to undergo the test and meets the criteria.
- Interpretation of the results.
- Results of patients diagnosed with COPD are classified and recorded (including scanning of hard copies where generated) as mild, moderate, severe or very severe.
- Arrange access to Halton’s Community COPD Service as required according to diagnosis and severity of condition including Respiratory Consultant MDTs/ Primary Care MDT’s/ Pulmonary Rehabilitation/Rapid Response nursing and physiotherapy.
- Prescribed and administered medication, where & as appropriate.
- Provide advice and support to patients with regard to inhaler technique and therapy optimisation.
- For patients who smoke, onward referrals to the smoking cessation service should also be offered at the point of diagnosis.
- Identify issues impacting on respiratory health & wellbeing and work, and refer on to social, third sector and lifestyle services as appropriate.
- Operate a call & recall system to ensure annual review for all patients on the COPD register in line with relevant Quality Outcomes Framework or other quality standards in place for primary care Practices throughout the period of the contract.
- Record results of spirometry in patient’s notes using ........check with Chris Woodforde.

3.2.1 Reversibility Testing

In most patients, routine spirometric reversibility testing is not necessary as a part of the diagnostic process or to plan initial therapy with bronchodilators or corticosteroids. However in some cases reversibility testing may need to be undertaken if asthma is suspected. In all cases spirometry results should be recorded & interpreted 20-30’ post bronchodilator [400mg salbutamol via volumatic spacer] and this should be documented.

3.3 Training / Staffing

To be of clinical value, diagnostic spirometry has to be performed to a high standard. If it is not, there is a significant risk that the diagnosis will be incorrect and patients may receive inappropriate and potentially harmful treatment as a result, or be denied appropriate treatments that could potentially improve their condition. To be valid, diagnostic spirometry must be quality-assured and only be performed by people who have been appropriately assessed as competent, and have completed an approved competency-based training course in spirometry.

They will also be expected to keep their skills up to date.

Diagnostic spirometry tests and interpretation of the results can be separate
functions performed by different individuals. There are different competences associated with each function.

Staff undertaking spirometry only and do not have a role in interpretation or treatment should either hold one of the following:

- Association for Respiratory Technology and Physiology [ARTP] - Foundation Certificate in Spirometry
- Education for Health - A range of courses written by experts.
- Or Equivalent.

Staff responsible for performing spirometry and interpreting results should hold:

- Association for Respiratory Technology and Physiology [ARTP] – Full Certificate in Spirometry
- Education for Health - A range of courses written by experts.
- Or Equivalent.

Staff responsible for interpreting results only should hold:

- Association for Respiratory Technology and Physiology [ARTP] – Interpretation Certificate in Spirometry
- Education for Health - A range of courses written by experts.
- Or Equivalent.

Staff who are already highly experienced at performing spirometry but are not ARTP Accredited should be confirmed as competent by having their skills assessed against ARTP standards via the:

- Association of Respiratory Technology and Physiology [ARTP] – Experienced Practitioner Scheme

3.3.1 The National Register

To provide assurance that those undertaking spirometry assessments and interpretation have achieved the required standard of practice, the ARTP will maintain an up-to-date national register of certified healthcare professionals/operators.

The Register lists individuals’ names according to whichever of three categories of certification that person has achieved: Foundation (=Performing Only), Full (=Performing and interpretation) or Interpretation Only.

Once certified as competent, all those performing and/or interpreting diagnostic spirometry will be required to record their qualification on the National Register. Implementation will be phased over four years from 1 April 2017.

It is expected that all staff currently performing and interpreting spirometry will have until 31 March 2021 to ensure they have been assessed and entered on to the national directory of certified healthcare professionals and should be working towards achieving this.

3.4 Equipment
Purchasing of spirometers and consumables will be the responsibility of the Practice and is included with the service price. This includes replacing spirometers that have reached the end of their lifespan. There are several makes of equipment and all spirometers need as a minimum to meet the standards of measuring and recording as specified in international guidelines. The Practice will ensure that spirometers used meet the following standards and requirements:

- Meet ISO standard 26782
- One-way mouthpieces and nose clips
- Bacterial and viral filters (as indicated in selected patients)
- Height measure and weighing scales – calibrated according to manufacturer’s instructions.
- Nebuliser or single patient use volumatics (for post bronchodilator spirometry and reversibility testing).
- Single-patient use mask/mouthpiece for nebulizer
- Short acting bronchodilators as per guidelines, must be able to calculate fev1 % as well as actual numbers (see below)

It is the Practice’s responsibility to calibrate, clean and arrange for servicing of the device in line with the manufacturer’s guidance and in line with PCC’s Guide to Quality Assured Spirometry. Calibration should be verified prior to every clinic/session or after every 10th patient (whichever comes first). A calibration log should be maintained.

It is the Practice’s responsibility to monitor the quality of tests performed using each spirometer and to purchase a new device as and when required. Again this cost will be borne by the Practice as it is built into the service price.

Any necessary cleaning and maintenance processes should be carried out on a regular basis according to manufacturer’s instructions with reference to local guidelines and protocols. A record of cleaning and calibration must be kept accordingly by the Practice accordingly as evidence which will be verified annually.

3.5 Population covered

The service is available for people over 16 years of age with suspected or known respiratory disease who are registered with a Halton CCG member practice or are a Halton resident.

3.6 Any acceptance and exclusion criteria and thresholds

Patients should not undergo spirometry when the test may be harmful due to other medical conditions.

3.7 Interdependence with other services/Practices

- Halton’s Community COPD Service
- Map of Medicine (Appendix 1)
- Pulmonary Rehabilitation
- Domiciliary care Practices in Halton
- Out of Hours Practice UC24
- Breathe Easy
- Community Pharmacists
- Local Fire & Rescue Service
• North West Ambulance Service
• Air Liquide

Please note that this list is not exhaustive; the Practice will be required to work with other local services as required throughout the life of the contract.

### 3.8 Payment

The Practice will receive a block payment of £1.50 per registered patient based on the list size at 1 April 2017.

In recognition that 2017/18 is a transition year, and that activity has not previously been closely monitored, the Practice will be expected to carry out at least the same activity as during 2016/17 (baseline activity to be clarified at 31 March 2017). Activity will then be monitored on a quarterly basis. Any significant under or over activity may result in a discussion with the Commissioner to understand the reason and discuss how this can be addressed.

### 4. Applicable Service Standards

#### 4.1 Applicable national standards (eg NICE)

- Chronic obstructive pulmonary disease: Management of chronic obstructive pulmonary disease in adults in primary and secondary care (partial update) (CG1010) – June 2010
- Quality standard for patient experience in adult NHS services NICE quality standard [QS15] Published date: February 2012
- Quality standards for asthma (QS25) - February 2013
- Idiopathic pulmonary fibrosis: The diagnosis and management of suspected idiopathic pulmonary fibrosis (CG163) June 2013
- Chronic obstructive pulmonary disease quality standards (QS10) - July 2011
- Idiopathic pulmonary fibrosis NICE quality standard [QS79] Published date: January 2015

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

- Spirometry in Practice, The British Thoracic Society COPD Consortium – April 2005
- Guidelines for non-CF Bronchiectasis, British Thoracic Society – July 2010
- A Guide to Performing Quality Assured Diagnostic Spirometry, PCC et al - 2013
- BTS/SIGN 141 • British guideline on the management of asthma – October 2014
- Improving the quality of diagnostic spirometry in adults: the National Register of certified professionals and operators, ARTP et al – September 2016

#### 4.3 Applicable local standards

The Practice will be required to evidence compliance with all standards listed above along with any further appropriate NICE guidance or Technology Appraisal
Guidance which may be published during the life of the contract.

5. Applicable quality requirements

5.1 Applicable Quality Requirements

<table>
<thead>
<tr>
<th>Data</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Names of staff providing the service (undertaking spirometry and interpretation) and confirmation that their training meets the requirements set out in section 3.3.</td>
<td>Pre contract</td>
</tr>
<tr>
<td></td>
<td>Annually</td>
</tr>
<tr>
<td>Log of equipment used to deliver the service and declaration that this meets the requirements set out in section 3.4</td>
<td>Pre contract</td>
</tr>
<tr>
<td></td>
<td>Annually</td>
</tr>
<tr>
<td>Reporting of any significant untoward events, including action taken by the Practice.</td>
<td>By Exception</td>
</tr>
<tr>
<td>Number of patients assessed</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Number of spirometries undertaken</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Number of spirometries performed with an FEV1&lt;80%</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Number of reversibility tests undertaken</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Number of patients referred onto other services and service specified</td>
<td>Quarterly</td>
</tr>
<tr>
<td>DNA rate</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Numbers of new COPD diagnoses, with spirometry, since 1st April 2017</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

6. Location of Practice Premises

The Practice’s Premises are located at:

7. Individual Service User Placement

Not applicable.
LOCAL ENHANCED SERVICE
PROVIDING ECG RECORDINGS AND INTERPRETATION IN GENERAL PRACTICE
SPECIFICATION

Part 1: Activity and Resources

Service Outline

SCHEDULE 2 – THE SERVICES

A. Service Specifications

<table>
<thead>
<tr>
<th>Service Specification No.</th>
<th>Service</th>
<th>Commissioner Lead</th>
<th>Provider Lead</th>
<th>Period</th>
<th>Date of Review</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Electrocardiograms (ECGs) in Primary Care</td>
<td>NHS Halton CCG Primary Care</td>
<td>General Practice</td>
<td>1st April 2017 – 31st March 2018</td>
<td>Annual Review</td>
</tr>
</tbody>
</table>

1. Population Needs

1.1 National/local context and evidence base

HCCG will ensure delivery of the nationally determined improvement areas as detailed within the Department of Health Our NHS Care Objectives 3 draft mandate; within the following five domains:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1</td>
<td>Preventing people from dying prematurely</td>
</tr>
<tr>
<td>Domain 2</td>
<td>Enhancing quality of life for people with long-term conditions</td>
</tr>
<tr>
<td>Domain 3</td>
<td>Helping people to recover from episodes of ill-health or following injury</td>
</tr>
<tr>
<td>Domain 4</td>
<td>Ensuring people have a positive experience of care</td>
</tr>
<tr>
<td>Domain 5</td>
<td>Treating and caring for people in safe environment and protecting them from avoidable harm</td>
</tr>
</tbody>
</table>

Delivery of better health outcomes within these domains underpins the strategic priorities of the CCG.

2. Outcomes

2.1 The Local defined outcomes are:

1. To reduce the number of patients referred to secondary care for ECGs
2. To reduce the un-necessary use of other health care resources by the conduct of ECGs in Primary Care.
3. **To Improve patient satisfaction – with primary care offer of ECG**
4. **To ensure patient complaints about ECGs are dealt with in line with the practice Complaints procedure**

### 3. Scope

#### 3.1 Introduction

The purpose of this specification is to set out the requirements for a GP led community based service including:

- Static simple 12 lead ECG
- Domiciliary ECG

Practices that do not wish to participate in this service will refer patients to a participating practice within their town that has agreed to accept referrals from other practices within their town. A list of GPs accepting referrals will be sent to practices not participating in this service. Investigations and interpretive reports will be sent securely back to the referring clinician.

In cases where the results of a cardiology investigation and the GPs medical diagnosis mean that a patient needs to be referred for an outpatient cardiology appointment, the ECG report will be forwarded to secondary care and not repeated unnecessarily.

**Aims and objectives of service**

The aims and objectives of the service are to:

- Provide early reassurance to patients in GP Practices.
- Provide early identification of rhythm abnormalities
- Provide an ECG recording and interpretation service from primary care.
- Reduce the need to refer patients for routine ECG recording and interpretation into secondary care services.
- Provide timely diagnosis and management which complies with the standards set out by the Clinical Guidelines by Consensus – Recording a standard 12-lead electrocardiogram (British cardiovascular society).

Specifically this relates to the following:

1. Prevent unnecessary referrals to hospital for 12 – lead ECG and delays in interpretation
2. Detect atrial fibrillation and offer treatment to prevent strokes
3. Detect people with conduction abnormalities requiring pacemakers
4. Safely monitor patients taking drugs that affect the conduction system
5. Provide timely ECG recordings when people present with palpitations, chest pain, breathlessness or transient loss of consciousness.
6. Identify serious conduction problems in people with transient loss of consciousness requiring urgent referral for pacemakers or further electrophysiological testing
7. Identify the heart rhythm present when people present with palpitations
8. Provide part of the risk assessment of people presenting with hypertension
9. Practice based ECGs will be undertaken according to the patient’s clinical
condition clinical judgement and clinical care pathways.

10. Screen those people with a family history of sudden cardiac death

The objectives of establishing an ECG service in primary care are to:-

1. Establish a 12 lead ECG service in every general practice
2. To develop ECG interpretation and reporting either in practice or with the use of telemedicine
3. To provide necessary investigations prior to patient attendance at OP clinics e.g. cardiology/ general medical /, memory clinics/ pre op assessment
4. The service will be available from the practice premises during usual working hours

3.2 Service description/care pathway

1. An ECG should be undertaken if clinically required. The following are examples of when the service may provide a 12 Lead Electrocardiograph (ECG) intervention and recording at the GP practice:
   - for the initial diagnosis and management of Suspected Atrial Fibrillation
   - for the diagnosis and management of Hypertension.
   - for the initial diagnosis and management of Suspected Angina.
   - for the management of some emergency chest pain presentations.
   - for patients in whom it is clinically indicated with no high risk factors and frequent symptoms
   - when cardiac disease is suspected
   - When it is necessary to exclude cardiac disease
   - When it is indicated as part of a patient's routine assessment for a long term
   - When required for the Later Life and Memory Service (LLAMS)

2. ECG machines must be used in accordance with the manufacturer's guidelines and instructions.

3. Within this service, practices can choose whether to participate in domiciliary ECGs for their practice patients.

4. Specialist interpretation will be available. The clinician shall use XXX, the specialist interpretation service commissioned by the CCG.

5. Every interpretation is to be made by a registered clinician, with expertise in ECG interpretation. There should be documented evidence of ECG interpretation expertise for each such member of staff.

6. The service shall take appropriate action based on the results of the ECG.

7. The service shall obtain informed consent from all patients undertaking an ECG.

8. All practice ECGs will be reported within 24 hours either by a trained clinician or by a telemedicine service. The ECG interpretation will be reported to the patient on the same working day where it is clinically indicated.
3.3 Training

The ‘responsible clinician’ should have the basic skills needed to interpret a 12 lead ECG including determining whether the ECG is normal or abnormal and decide what further action is required.

All staff performing and/or interpreting ECGs will be expected to take part in professional development to ensure they are familiar with current best practice.

Training and Accreditation

Those doctors who have previously provided services similar to this enhanced service and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as is necessary to enable them to contract for the enhanced service shall be deemed professionally qualified to do so.

There must be evidence that non medically trained practitioners have received training and are competent to undertake ECG monitoring.

Equipment – Installation Testing and Calibration

The Provider will be responsible for supplying all necessary equipment to deliver the service, installing the equipment and testing its functionality. The Providers equipment and software needs to be totally compatible and integrate seamlessly with the Halton GPs IT practice systems and meet NHS IT standards.

3.2.15 Consumables

The Provider will be responsible for supplying all necessary consumables including patches and leads to deliver the service. The Provider must arrange for timely stock replenishment and delivery of consumables to assure service continuity.

3.2.16 Equipment Maintenance

The Provider shall make adequate arrangements for a repair/replace facility for all devices, enabling any equipment problems to be resolved within 48 hours by repairing or replacing said equipment. In the event of equipment failure GP practices will refer their patients to other GP providers of this service.

Population covered

The service will be provided to registered patients of Halton GP practices.

3.4 Any acceptance and exclusion criteria and thresholds

Exclusion criteria will be:

- Patients presenting with acute chest pain typical of an Acute Coronary Syndrome will be referred immediately to the A&E Department. NICE recommend doing an ECG in practice for those with chest pain query acute coronary syndrome, which should be sent to hospital in advance of the patient – however doing the ECG should not delay the transfer to hospital.
- Patients with infrequent symptoms.
3.5 Interdependence with other services/providers

Secondary Care.

In cases where the results of a cardiology investigation and the GPs medical diagnosis mean that a patient needs to be referred for an outpatient cardiology appointment, the ECG report will be forwarded to secondary care and not repeated unnecessarily.

3.6 Activity for submission to the CCG

Practices are expected to use the following read codes as follows:
- Patients who have received ECG testing at the GP Practice: 321B
- Referral tag on patient record if referred to a secondary care provider: 8H7a
- Refer for ECG recording for all secondary care referrals: 8HR1
- Refer to other doctor: 8H6Z including free text for referral on

3 Reporting / Monitoring

The service shall report the following to the CCG:
- Quarterly number of ECGs, domiciliary ECGs performed
- Annual Number of repeats undertaken and reasons why repeats were necessary
- Annual number of patients subsequently referred to Cardiology
- Quarterly Number of ECGs interpreted by the specialist interpretation service
- Annual Number/detail of related significant events
- Annual number related complaints/compliments

The following KPIs shall apply:
- 10% ECG interpretation reports to be quality checked by a second clinician. Number of ECGs requiring amendment following such a check should be less than 2%
- Less than 0.5% of reports shared with secondary care disputed for clinical interpretation findings.

The CCG will monitor referrals into secondary care for ECG services.

Validation process

The practice must record the following information for audit purposes.
- Patient ID Number (anonymised).
- Read code.
- Date of treatment.
- 

Participating practices shall collate and monitor activity related to the Local Enhanced Service.

Full records of all procedures, screening and tests should be maintained in such a
way that aggregated data and details of individual patients are readily accessible.

Practices will ensure their recording processes enable them to monitor and undertake an annual review and clinical audit of outcomes and to provide the results of this to the CCG. This shall include: patients’ clinical criteria for this investigation.

**Part 2: Payment Mechanism**

For providing ECGs to all the practice’s registered patients (including domiciliary ECGs for house bound patients) the practice shall be paid £1.50 per registered patient.

For providing ECGs to the practice registered patients (excluding domiciliary ECGs for house bound patients) the practice shall be paid £1.20 per registered patient.

For providing ECGs within the practice to patients registered with another practice within the town the practice shall receive the amount the non-participating practices would be paid if they participated divided by the number of practices providing this referral service within the town.

Payment will be quarterly on CCG receipt of a completed claim form.

**3.2.1 Quarterly** anonymised patient activity data produced from the clinical system should be submitted to the CCG using the quarterly claim form.

### 4. Applicable Service Standards

**4.1 Applicable national standards**

NICE guidelines CG180 update June 2014

The service provider will employ and maintain liability for all clinical staff and ensure that they are professionally competent, have the necessary records clearance and are appropriately accredited to carry out their duties, in this case ECG recording and interpretation.

The service provider will ensure that formal and informal supervision and mentorship is undertaken and that clinical supervision is provided to staff in line with the organisations Clinical Supervision Framework.

**4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)**

**3.3 Applicable local standards**

Members of staff who undertake and report on ECGs must be trained to an appropriate standard in ECG recording and interpretation.

### 5. Applicable quality requirements and CQUIN goals

### 6. Location of Provider Premises
7. Individual Service User Placement
# Primary Care Group

**Wednesday 21st December 2016**  
1.30-3.30pm, Maple Room, RTH

## In attendance:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Gary O’Hare</td>
<td>GP/Clinical Lead (Chair)</td>
<td>Murdishaw Practice / NHS Halton CCG</td>
</tr>
<tr>
<td>Dr Salil Veedu</td>
<td>GP/Clinical Lead</td>
<td>Bevan Group/NHS Halton CCG</td>
</tr>
<tr>
<td>Sarah Vickers</td>
<td>Head of Primary and Community Care</td>
<td>NHS Halton CCG</td>
</tr>
<tr>
<td>Julie Holmes</td>
<td>Commissioning Manager – Primary Care</td>
<td>NHS Halton CCG</td>
</tr>
<tr>
<td>Jessica Saunders</td>
<td>Primary Care Administrator</td>
<td>NHS Halton CCG</td>
</tr>
<tr>
<td>Ifeoma Onyia</td>
<td>Public Health</td>
<td>Halton Public Health</td>
</tr>
</tbody>
</table>

## In attendance by invitation of the Chair:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Olukiemi Adeyemi</td>
<td>Specialist Registrar</td>
<td>Halton Public Health</td>
</tr>
</tbody>
</table>
Apologies:

Karen Hampson  Commissioning and Contracts Manager  NHS Halton CCG
Becky Birchall  Senior Pharmacist  NHS Halton CCG
Sarah Bloor  Practice Manager  Tower House Practice
Emma Alcock  Transformational Change Manager  NHS Halton CCG

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Key Issue</th>
<th>Action</th>
<th>Who</th>
</tr>
</thead>
</table>
| Key issues from previous meeting | • Lisa Birtles-Smith to be invited to a future meeting. (OPEN)  
• PCG work plan update to be brought to future meeting. (OPEN)  
• KH waiting to meet with CSU regarding PALS reporting will update at future meeting. (OPEN)  
• KH to feedback regarding GP Extra at February meeting. (OPEN)  
• Care home alignment scheme has been given the go ahead. (CLOSED) | | |
| Affordable Warmth Scheme | Dr Olukemi Adeyemi a Specialist registrar from public health provided an overview of the Affordable Warmth Scheme following a review in 2015. NICE guidelines provided some recommendations. The concept of the affordable warmth scheme was to provide support for anyone who was at risk of living in a cold home. If a patient was unable to afford to keep their home healthy and warm they were increasing their risk of having a health problem. The cost of energy was increasing and some homes were poorly insulated resulting in increased use of energy to warm a house.  
It was important to share the message of the risks of living in a cold house. There was a link between living in poverty and living in a cold home. 18 degrees was the barest minimum a house should be heated too throughout the day. During the winter there was added pressure on spending which could have an impact on debt for people.  
Risks of living in a cold home could affect lots of sectors of the population, ranging from people with disabilities, pregnant women and older people. There was also a link to mental health by living in a cold home. Estimates show in | | |
Halton 9.7% of homes were living in poverty in 2014.

What could be done:
- There were schemes available to help people change their energy provider, over 200 homes registered for this scheme and over 50 of these homes saved money.
- Help for people to improve energy resources.
- Raise awareness.
- To be proactive in identifying people who were, or potentially were, at risk, for example people who had their flu jab or people who had been in hospital.
- 3 key questions for GP’s to ask, could incorporate the questions into the COPD/ Asthma reviews.

There was a strategy being developed to support people identified as at risk where there would be a single point of access to contact. This number could be added into the map of medicine pathways and the directory of service that the CCG was developing.

Suggestion for Dr Adeyemi to link in with the chief nurse of the CCG to try and encourage practice nurses to refer into the affordable warmth scheme.

Request from OA for a CCG representative to sit on the strategy group.

<table>
<thead>
<tr>
<th>Receptionist Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCCG had been given funding for receptionist training. The training must be around either signposting or correspondence management. Seven training sessions had been booked in February and March 2017. Five sessions for signposting and two for correspondence management. Training sessions would be held in Widnes and Runcorn. Training needs analysis was being developed in the New Year looking at training needs for practice managers, receptionists and admin staff. HCCG was working with other local CCG’s from April 2017, potentially sharing training and learning.</td>
</tr>
<tr>
<td>JH to raise MoM with Steve Eastwood</td>
</tr>
<tr>
<td>Identify a representative to sit on strategy group.</td>
</tr>
<tr>
<td><strong>GPFV</strong></td>
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</tr>
</tbody>
</table>
| HCCG was required to submit a GP Forward View plan by the 23rd December. The plan went to the Primary Care Commissioning Committee on 20th December. The group discussed the appendix looking at the projects and the funding available.  

Request for this group to oversee the plan. Already working on lots of the projects in this plan following on from the Prime Ministers Challenge fund.  

Further national guidance was awaited for a number of projects: Care navigation, Mental health workers in practice, Practice Managers development programme, Practice Nurse development programme.  

Care home alignment scheme had been on hold. However following on from Service Development Committee it had now been given the go ahead to proceed.  

Money for improving access to General Practice for 7 day access would fund GP Extra, which was expanding to Runcorn in 2017.  

EMIS community and community nurses would be funded via the ETTF bids.  

The transformation scheme would be supported by the £3 per head money, which was split over 2 years, this money was included in the £5 per head.  

Action: Sarah Vickers to take hub meetings back to the PMS meeting to request agreement that practices met bi-monthly for town hub sessions and bi-monthly for all practices.  

GO’H thanked SV for a brilliant job in pulling together the GP Forward View plan. |
| Date of next meeting changed from 22nd February to 23rd February.  

IO had received positive feedback regarding practice JSNA’s. She requested that if any other information was required to support practices to let her know. JSNA’s could help to influence hub discussions, as collective themes could be looked at. |
Halton IM&T Working Group

Thursday 12th January 2016, 10.30 a.m. – 12.00 a.m.

Attendees:

<table>
<thead>
<tr>
<th>Name and Initials</th>
<th>Role</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Wilson (DW) (Chair)</td>
<td>GP and Clinical Lead</td>
<td>NHS Halton CCG</td>
</tr>
<tr>
<td>Emma Alcock (EA)</td>
<td>Transformational Change Manager</td>
<td>NHS Halton CCG</td>
</tr>
<tr>
<td>Ian Brown (IB)</td>
<td>Head of Client Development – Health Informatics</td>
<td>StHK HIS</td>
</tr>
<tr>
<td>Joanne Hughes (JH)</td>
<td>Practice Manager</td>
<td>Grove House Practice</td>
</tr>
<tr>
<td>Sarah Vickers (SV)</td>
<td>Head of Primary Care and Community Commissioning</td>
<td>NHS Halton CCG</td>
</tr>
</tbody>
</table>

Notified apologies:

<table>
<thead>
<tr>
<th>Name and Initials</th>
<th>Role</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phil Corrin (PC)</td>
<td>Deputy Director of Informatics</td>
<td>StHK HIS</td>
</tr>
<tr>
<td>Gareth Rustage (GR)</td>
<td>Medicines Management Technician</td>
<td>NHS Halton CCG</td>
</tr>
<tr>
<td>Christine Walters (CW)</td>
<td>Director of Informatics</td>
<td>StHK HIS</td>
</tr>
<tr>
<td>Claire Tenant (CT)</td>
<td>Practice IM&amp;T Manager</td>
<td>Oaks Place Practice</td>
</tr>
<tr>
<td>Jonathan Greenhough (JG)</td>
<td>Divisional Manager, ICT Services</td>
<td>Halton Borough Council</td>
</tr>
</tbody>
</table>

ITEM | Notes | ACTION

1. Introductions & apologies | Apologies noted

2 Minutes, outstanding actions and matters arising | Trend graph to be added to HIS Operational Report for Oct/Nov | Action completed
| JG to circulate dates for Care Home IMT meeting to relevant stakeholders once agreed | JG to update on care home discussion at March meeting | Action outstanding
<table>
<thead>
<tr>
<th>Action</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>JG to provide update on council network connectivity at December meeting</td>
<td>Action outstanding</td>
</tr>
<tr>
<td>EA to discuss Safeguarding governance in relation to health and social care connectivity with Jan Snoddon</td>
<td>EA queried purpose this action as it is currently still outstanding. JH advised it was linked to the expectations of the safeguarding team. SV advised that GOH and Joanne McCormack have been looking into safeguarding in detail and we need to establish a standardised way for the Safeguarding team to communicate with practices.</td>
</tr>
<tr>
<td>EA to discuss kit options for PH access to health network with JG</td>
<td>Action completed</td>
</tr>
<tr>
<td>JG to investigate email issues between council and health</td>
<td>Action completed</td>
</tr>
<tr>
<td>EA to provide update on RCAT ICE issues at December meeting</td>
<td>STHK connectivity complete, still awaiting WHHFT completion due to contact being on leave – expected completion by end of January 2016</td>
</tr>
<tr>
<td>EA to feedback ETTF discussions at December meeting</td>
<td>EA provided update – also included on project update</td>
</tr>
<tr>
<td>PC/IB to discuss iLinks agreement and sign-up internally and provide clarity to EA</td>
<td>Action completed – outstanding issues resolved and ongoing discussion with iMerseyside as part of EPACC’s project,</td>
</tr>
</tbody>
</table>
ICE
EA advised that GP Extra have requested ICE access and queried the cost implications of this based on the costs required to set up the RCAT service.

IB advised that EMIS have been having discussions with Sunquest to try and address the cost issues.

DW advised that there are some things that the Path labs could do to make the system much more user friendly and also easier to copy results to additional recipients.

IB to provide update from EMIs about ICE/Sunquest costs
EA to facilitate meeting between Path labs & GP Extra
EA to send email to IB about GP extra and the filtering issue

3.
Update/review:
- Project update
- HIS Ops Group Feedback (NHS Mail)

Infrastructure
EA advised that she was unsure where the links between council and HIS were up to as this had been largely council led.

Mobile Working – Remote Access
EA advised that a number of mobile devices were being tested as part of the slippage money including EMIS Mobile and EMIS Anywhere

JV advised that they had not had any information from EMIS but would be happy to present feedback to the group in March pending app being in place and working

Telehealth
EA advised that not much progress had been made in telehealth due to other workstreams taking priority.

DW advised that Lpool had done considerable work and it may be worth visiting them.

DW also suggested further exploring Medical Messenger in MJOG

Patient online access
Group suggested that workstream should be amber as not all practices are achieving the 10% target.

JV queried whether data will be circulated. Need to check validity of data.

EMIS have fixed search for patient online access.

IB to provide update on tested Council links at March meeting
EA/JV to present feedback from mobile device pilot sites in March
EA/DW to visit Lpool to discuss telehealth and arrange demo of MJOG Medical Messenger
EA to amend online access rating from green to amber
EA to check when data will be circulated and request practices cross-check with internal EMIS searches.
<table>
<thead>
<tr>
<th></th>
<th><strong>4. IG and Security Update</strong></th>
<th><strong>Item deferred</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5 Estates and Technology Transformation Fund (CCG Led)</strong></td>
<td>EA provided overview of 5 Halton ETTF bids and advised that although formal confirmation was still pending, it was likely that the schemes would be allocated as Cohort 1 schemes meaning that funding would be available in 16/17 pending ability to commit money in year. Kick-off meetings for the EMIS projects scheduled for beginning of February.</td>
<td></td>
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</tr>
<tr>
<td><strong>6 Call queuing update</strong></td>
<td>IB provided update on call queuing programme and advised a dedicated project manager is now in place and a gantt chart was presented showing progress by practice. All practices are now either in-progress, awaiting a visit or awaiting SIP porting IB to confirm final Virgin dates for SIP porting asap.</td>
<td>EA to provide summary update on call queuing project at January Practice Managers IB to provide call queuing update at March meeting</td>
<td></td>
</tr>
<tr>
<td><strong>7 Referral Management System - IT Requirements</strong></td>
<td>EA advised that there are a number of elements associated with the RMS implementation including RA support/ asset identification/nhs.net DW/JV suggested that practices need to map out inbound communication to make appropriate use of nhs.net inboxes.</td>
<td>EA to update with JV at practice managers and send out comms following this. DW/JV to come up with inbound electronic communications in relation to email</td>
<td></td>
</tr>
<tr>
<td><strong>8 iLinks Data Sharing Agreement Communication</strong></td>
<td>EA suggested that unified communication be distributed to support sign up to iLinks</td>
<td>EA to progress iLinks sign-up and supporting Comms as part of EPACC’s</td>
<td></td>
</tr>
<tr>
<td><strong>9 GPIT Capital</strong></td>
<td>IB advised that 16/17 GPIT capital funded the MIG</td>
<td><strong>Action:</strong> IB to bring</td>
<td></td>
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</tbody>
</table>
(EPACC’s) but there is likely to be a surplus
Need to get to the point of a definitive asset list.
updated kit refresh plan and supporting asset list

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<tbody>
<tr>
<td>10</td>
<td>AOB</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

Date, time and venue of next meeting:

Thursday 2nd March 2017
10.30 – 12noon
Rowan Room, Runcorn Town Hall
1. Welcome & introductions

SV welcomed the group and introductions were taken.

2. Notes of previous meeting

AM updated that a PID was submitted to draw up Windmill Hill plans but this was unsuccessful. The PID is going to be resubmitted with more detail.

Bridgewater have sent the EIA and communications for Halebank to the CCG, services at Halebank are likely to be relocated mid-February.

Utilisation studies are still required for Beaconsfield Primary Care Centre and Castlefields Health Centre. The cost would be approximately £5k / £6K. PIDS for these could be completed by March.

3. Terms of Reference

Due to the groups agenda expanding and the focus of the group changing it was agreed that the terms of reference would be changed. Warrington Health
Service Planning Group is looking at the council and healthcare buildings, facilities and plans. Trialling a new Terms of Reference with the Local Authority and the CCG. Need to make sure all contribute to core plans and help to conduct a review of all facilities and estates in Halton.

In order to amend the Terms of Reference it is important to be aware of what is Halton’s driver. It is important to have the right people attend the meeting, Property and Planning link from the Local Authority to be invited. The meeting will be in two parts – Strategic and Operational.

Warrington Local Authority will share meeting minutes.

Action: Karen Hampson to reshape agenda and terms of reference for the next meeting.

Action: Strategic plans for estates to be shared via presentation at the next meeting from key partners.

There are lots of benefits of sharing utilisation reports of the HCRC, council buildings and hospitals to ensure space is used effectively.

Hot spots is a software device that monitors the percentage of rooms that are used in an organisation, the device monitors each individual computers usage.

<table>
<thead>
<tr>
<th>4. CDC Proposals</th>
<th>Action</th>
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<tbody>
<tr>
<td>SMc is trying to co-locate children’s community services to help improve communications and pathway development. Still looking at options. There are 3 current proposals to look at, each with different costs. Suggestion from the group for SMc to speak to Mike Hill regarding proposals.</td>
<td>Action: SMc to speak with Mike Hill to look at scoping out the cost and help with access to capital money. SMc to speak with Emma Alcock regarding internet access Feedback on this at the next meeting.</td>
</tr>
</tbody>
</table>

The backlog of maintenance issues should be picked up by landlords to bring the building up to the correct standard.

<table>
<thead>
<tr>
<th>5. Centre Management</th>
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<tbody>
<tr>
<td>CHP are currently planning to implement a consistent approach to centre management. GP partnerships provide centre management for CHP. CHP noted that centre management improves use. Lesley to be asked for an up to date timetable for implementation.</td>
<td></td>
</tr>
</tbody>
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<thead>
<tr>
<th>6. ETTF</th>
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</table>
KH and AM met with NHS England to discuss the Estates and Technology Transformation Funds. The funding appears to concentrate on general medical service provision.

Cohort 2 of the funding, Halton CCG have submitted two improvement grants, one for Peelhouse Medical Centre and one for Murdishaw Health Centre. Halton CCG are reviewing the detail to ensure it meets the criteria such as number of rooms that will be funded and room usage.

Hallwood and Windmill Hill will be part of cohort 3, 2018/2019. The CCG considered requesting Windmill Hill scheme is brought forward to cohort 2 but Windmill Hill project work is likely to take time and therefore Windmill Hill has been left in cohort 3. A bid was submitted to support any future development of the 2 practices in Hallwood Health Centre as part of the Health New Towns project.

It was suggested that the push for this funding is to increase practice list sizes, looking at primary care at scale, and that the national pot of funding is currently underspent.

### 7. Improvement Grants

Hale Village branch has been given an improvement grant. There is an issue with Upton Rocks regarding the lease, a grant will not be given this time to Upton Rocks, may need to initiate a talk with them in relation to GPFV.

### 8. Work plan Update

The workplan will change as the group changes.

Appleton Village is in need of an estates solution, they have started to engage more with the PPG and an engagement exercise is in place. Will update at the next meeting.

St Helens Strategic Estates Group are using ‘Shape’ to look at localities and zone in on specific areas. Halton CCG will look at ‘shape’ for Halton and bring it to the next meeting.

### 9. SEGS Update

No updates from other SEGS.

### 10. AOB

An issue for Warrington was that they only find out information on estates where the work was happening. Broadening the group is helping to resolve this.

Master plan was developed for Halton Hospital, it had to be stopped because of STP.

Looking at single site solution with equipment service, equipment store. No
definite location at present.

Bridgewater now have less occupancy within Murdishaw, Health Centre.

Relocation of North 19 Bridgewater services to two locations, 1 in Widnes and 1 in Runcorn. These sites are for admin. CS to share with SV to look at implications on GP practices.

**Date & Time of next meeting – 29th March 2017. 1.30pm**
Notes of PMS Meeting held on 19th January 2017

Attendance:

<table>
<thead>
<tr>
<th>Name</th>
<th>Practice</th>
<th>Name</th>
<th>Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarah Bloor</td>
<td>Tower House</td>
<td>Angela Clague</td>
<td>Hough Green HP</td>
</tr>
<tr>
<td>Jane Gregson</td>
<td>Peelhouse</td>
<td>June Rhodes</td>
<td>Brookvale</td>
</tr>
<tr>
<td>Dr David Wilson</td>
<td>Grove House</td>
<td>Heidi Pegnam-Mason</td>
<td>Newtown Surgery</td>
</tr>
<tr>
<td>Maria Stacy</td>
<td>Castlefields/ Murdishaw HC</td>
<td>Dr Latha Meda</td>
<td>Oaks Place</td>
</tr>
<tr>
<td>Helen Patient</td>
<td>Oaks Place</td>
<td>Dr Gary O’ Hare</td>
<td>Murdishaw HC</td>
</tr>
<tr>
<td>Dawn Heggarty</td>
<td>Brookvale</td>
<td>Dr Ian Schofield</td>
<td>Appleton Village Surgery</td>
</tr>
<tr>
<td>Jan Rimmer</td>
<td>Newtown Surgery</td>
<td>Wendy Davies</td>
<td>Windmill Hill Surgery</td>
</tr>
<tr>
<td>Robin Siddell</td>
<td>Newtown Surgery</td>
<td>Faye Dixon</td>
<td>Upton Rocks</td>
</tr>
<tr>
<td>Diane Hanshaw</td>
<td>Bevan Group</td>
<td>Dr Karl Botham</td>
<td>Peelhouse</td>
</tr>
<tr>
<td>Dr Jan Breeden</td>
<td>Bevan Group</td>
<td>Dr Fenella Cottier</td>
<td>Weaver Vale</td>
</tr>
<tr>
<td>Sarah Vickers</td>
<td>CCG</td>
<td>Karen Hampson</td>
<td>CCG</td>
</tr>
<tr>
<td>Jessica Saunders</td>
<td>CCG</td>
<td>Julie Holmes</td>
<td>CCG</td>
</tr>
</tbody>
</table>

Apologies:

<table>
<thead>
<tr>
<th>Name</th>
<th>Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dawn Randles</td>
<td>Weaver Vale</td>
</tr>
</tbody>
</table>

Halton CCG

Papers were shared with attendees to discuss throughout the meeting and will be circulated with the notes.

Minor Surgery and Diagnostic Services

1. Minor Surgery

Following initial specification being shared, JH and KH have been working on the final specification around minor surgery. NHS England have confirmed that the funding for minor surgery was removed from the PMS premium baseline so practices are entitled to claim for all minor surgery activity above the baseline and up to the cap. It was raised that NHS England used to pay above the cap, KH responded and informed practices if they require for next year they can renegotiate the cap and should contact JH/KH to discuss. In order to ensure that all practices have/ are paid correctly during 16/17 it is proposed to collect all activity undertaken from 1st April 2016. KH and JH will e-mail all practices with a template for completion. Once activity for 16/17 has been confirmed new caps may be negotiated for 17/18. If any practices have an email received from NHS England paying for activity above the cap, please can they forward to the Primary Care team.
2. **ECG**

KH brought the specification for ECG some months ago to this meeting, following feedback KH has been working on costing for ECG’s in practice. The information shared today was worked up following specifications from other areas. Looked at the funding to ensure it included the consumables and equipment cost. At £24 per ECG, each practice would receive £1.50 per registered patient. The activity will be monitored and observed to ensure it matches the activity from previous years. A table detailing each practices income/ budget for ECG’s was circulated and after discussion practices felt that this level of funding was appropriate for the work required by the practice teams.

3. **Spirometry**

The draft specification had been shared at a previous meeting; the proposal includes cost of training and equipment. Halton CCG had received activity for most practices from 2014/2015. If practices are paid £1.50 per patient the cost of each Spirometry based on the activity 2014/2015 would equate to £65 per spirometry. The rationale behind the funding is that Spirometries take longer than ECG’s but practices would have higher activity of ECG’s. Activity will be reviewed. A table detailing potential income/ budget for spirometries, by practice was circulated and after discussion practices agreed that the level of funding is appropriate for the work require by the practice teams.

**Summary:** Practices agreed to receive £1.50 per registered patient for ECG’s and £1.50 per registered patient for Spirometry, which means that £3 of the PMS premium will be used to fund these two diagnostic services. It was recognised that 2017/2018 is a transition year from the former PMS contract to specific contracts and that in order to ensure the funding levels were appropriate, activity will be monitored in 2017/2018 and if required the funding levels amended in future years.

All specifications will be circulated for review prior to Primary Care Commissioning Committee in February.
**Funding Summary**

The funding table below was shared with practices:

<table>
<thead>
<tr>
<th>Potential Indictor / work stream</th>
<th>Work required by practices</th>
<th>Funding allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Supporting practices to develop a collaborative approach to care provision, reducing unwarranted variation in referrals, utilising care pathways.</td>
<td>£5 per registered patient</td>
</tr>
<tr>
<td>2</td>
<td>Workforce Planning – to support GPFV Requirements</td>
<td>50p per registered patient</td>
</tr>
<tr>
<td>3</td>
<td>Clinical Audits based on NICE Guidelines</td>
<td>£1 per registered patient</td>
</tr>
<tr>
<td>4</td>
<td>Dementia</td>
<td>20p per registered patient</td>
</tr>
<tr>
<td>5</td>
<td>End of Life – EPACS</td>
<td>30p per registered patient</td>
</tr>
<tr>
<td>6</td>
<td>Risk Management – Significant Event Analysis</td>
<td>50p per registered patient</td>
</tr>
<tr>
<td>7</td>
<td>Safe Prescribing Processes</td>
<td>£1 per registered patient</td>
</tr>
<tr>
<td>8</td>
<td>Safeguarding</td>
<td>50p per registered patient</td>
</tr>
</tbody>
</table>

The PMS Premium equals around £7.15 per registered patient.

£5 per head (which includes £1.50 GPFV Transformation monies) = £5 per registered patient

Total = around £12.15 per registered patient

For which £1.50 used for ECGs and £1.50 for Spirometry, this leaves £9.00 per registered patient for the commissioning, quality and transformation scheme.
Overview of Commissioning, Quality and Transformation Scheme 2017/18

1. **Hub Model/ collaborative approach to reducing unwarranted variation and utilising pathways**

Paper shared with the group regarding the hub model (project 1 in table). It is suggested that a meeting is held every months- one will be similar to the PMS meeting and the other will be the hub meeting. At the hub meeting it will be split Runcorn and Widnes, a GP representative from each practice, a representative from medicine management team and a representative from primary care will be in attendance. The topic of each of the hub meetings will come from ‘Right Care’ -these are clinical priority areas such as: respiratory, dermatology, pain management, frailty, cardiology and gastroenterology (see attached ‘Commissioning Value – Where to look pack)

These meetings are to help peer review and shared learning. The long term aim is to reduce unwarranted variation in General Practice. Information packs will be shared with practices in advance of the meetings. The work required will include referral audits to aid shared learning and to enable clinicians to look at other options, such as development of community care services. With medicine management and secondary care attending the amount of unwarranted variation in practices will hopefully be addressed and suggestions put in place to reduce this.

It was requested that practices discussed what would happen if practices failed to engage. Suggestions to be shared with Lynne McGugan who is leading on this element of the scheme.

Dates of meetings will be shared with practices as soon as possible. The 1st hub meeting will be in May.

2. **Quality and Transformation**

In relation to the remaining £4 per patient of funding, practices will be requested to undertake projects 2-8 in the table above.

It was recognised that further details is required regarding the level of work for indicators 2-8. The following points were noted:

- Workforce planning can help to support working together. The GP forward view has identified this as a priority. Would like to ensure all practices completed the digital workforce survey support bid application in the future such as the GP Career Plus Scheme.

- Risk management was agreed and that an SEA would be undertaken for cancer diagnosed outside the 2 week wait process, plus any specific unusual cases, but excluding BCC.

In relation to ECG specification it was raised that Ambulatory blood pressure had not been but had been included, it was discussed in a previous meeting. JH/KH will check previous minutes and decisions.
A query was raised regarding the PMS premium not being equal - will all practices be expected to complete the same work? This had been discussed at the beginning of the financial year where all practices had agreed to the PMS redistribution over 4 years in order to reduce the financial impact on practices.

SV asked the group how they would like to manage projects for the practices who receive less funding. It was suggested that those practices who currently receive less than the £7.15 PMS premium have a private discussion with SV/ JH/ KH regarding the amount of projects they complete and the suggested list of projects for these practices is shared with the wider group for agreement.

Further details will be worked up for each indicator in the incentive scheme will be shared in the February meeting for final agreement prior to final approval by PCCC in February.

Next Meeting

1.30pm, 15th February 2017, Council Chamber, Runcorn Town Hall.