NHS
Wiltshire
Clinical Commissioning Group

Clinical Commissioning Group
Governing Body
Paper Summary Sheet
For: PUBLIC session ☒ PRIVATE session ☐
Date of Meeting: 22 March 2016
For: Decision ☒ Discussion ☐ Noting ☐

Agenda Item and title:	**GOV/16/03/14 Wiltshire CCG Primary Care Offer 2016-2019**
Author:	Jo Cullen, Director of Primary Care and Urgent Care, Group Director WWYKD, WCCG Steve Collins, Chief Accountant, WCCG Alex Goddard, Deputy Head of Medicines Management, WCCG Victoria Stanley, Commissioning Manager, WCCG Susan Rest, Commissioning Manager, WCCG
Lead Director/GP from CCG:	Jo Cullen, Director of Primary Care and Urgent Care, Group Director WWYKD Primary Care Operational Group – chaired by LMC and CCG GP Executive and Medical Director membership.
Executive summary:	This proposal sets out a proposal to move to a different and more flexible way of commissioning enhanced services from member GP Practices in Wiltshire from April 2016 referred to as the Wiltshire Primary Care Offer (PCO). We believe that moving away from providing care in a transactional activity driven model at individual practice level will result in a more efficient and effective use of resources. Developing a single CCG framework incorporating and aligning all of the currently commissioned local enhanced services (potentially including some currently commissioned Direct Enhanced Services by NHS England under joint commissioning arrangements) there is an opportunity to provide more robust, locality based commissioning with patient focussed quality measures and responsive services; adding improved incentives and driving quality initiatives to ensure a reduction in unnecessary variation across our constituent practices and between individual clinicians. This paper updates the Governing Body on the development and purpose of the Primary Care Offer and recommends formal approval to proceed to implementation from 1 April 2016.

	Wessex Local Medical Committee (LMC) view: The LMC broadly supports the principles of the PCO, in particular securing the funding for three years, reducing bureaucracy and encouraging the development of locality based services where appropriate. The impact of the PCO on practices and localities will need to be reviewed and the PCO refined and modified as necessary during the three year period. We look forward to working closely with the CCG to do this.
Evidence in support of arguments:	Five Year Forward View CCG Strategic Plan
Who has been involved/contributed:	Supported through Primary Care Operational Group (PCOG): chaired by Dr Gareth Bryant, Wessex LMC, Group GP representatives, CCG Medical Director and NHS England representatives; with CCG finance, quality and commissioning managers. Discussion with Group Executives, Localities, Core Practice Managers and GP Practices.
Cross Reference to Strategic Objectives:	Wiltshire CCG Operational Delivery Plan NHS England South Central Primary Care Delivery Plan 2016/17 "Building the Workforce – the new Deal for General Practice" NHS England, RCGP and BMA
Engagement and Involvement:	Not at this stage, although this supports the delivery of the proposed model of care which has been through public, patient and stakeholder engagement.
Communications Issues:	Localities will be expected to develop robust communications plans with all stakeholders and public as part of their wider locality implementation. CCG Communications can support this.
Financial Implications:	The funding for Enhanced Services and Transforming Care of Older People (TCOP) for 2016/17 is £9.44m at the CCG weighted list size of 487,843, giving an indicative price of £19.36 per registered patient. The CCG will retain 0.5% contingency in line with NHS Business Rules. This includes all of the CCG commissioned enhanced services and TCOP only, not those commissioned from NHS England or Public Health, Wiltshire Council.
Review arrangements:	The Governance process, in relation to the Primary care Offer will replace the previous arrangement for the

	Transforming care for Older People Panel. It is suggested that it is constituted as follows: •Distribution, collection, assessment and review of data, by the CCG •Internal review and scrutiny, including the Group Executives and Group Directors where appropriate •Primary Care Oversight Board •Primary Care Joint Commissioning Board (in public) •CCG Governing Body (in public)
Risk Management:	The CCG will retain a 0.5% financial contingency in line with NHS Business rules.
National Policy/ Legislation:	Five Year Forward View Everyone Counts, DH 2014
Other External Assessment:	Representatives from NHS England and Wessex LMC are members of PCOG.
What specific action do you wish the Governing Body to take at the meeting?	**The Governing Body are asked to note:** i. the work undertaken to date to develop the PCO and engagement across the member practices through Practice Manager meetings and discussions, Locality meetings, GP Forums, Group Executives and Clinical Executive. ii. The statement from Wessex LMC on the PCO. **The Governing Body are asked to approve:** i. The implementation of the PCO from April 2016 ii. The proposed governance process to set up a Primary Care Oversight Group to replace the TCOP panel reporting to the Out of Hospital programme Board/Clinical Executive.

PROPOSAL FOR A WILTSHIRE CCG
PRIMARY CARE OFFER: ENHANCED SERVICES – 2016-2019

1. CONTEXT:

The Five Year Forward View states that "The foundation of NHS care will remain list-based primary care. Given the pressures they are under, we need a 'new deal' for GPs. Over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years".

The challenges facing primary care are well documented[1],[2] including workload pressures with an ageing population and increasing complexity of presenting conditions and multi-morbidities; workforce pressures of recruitment, retention and skill mix; capacity and state of primary care premises; increasing bureaucracy and regulation demands; pressure on practice development; and the national and local resource challenge to maintain the level of high quality services provided by our general practices in Wiltshire.

This is a proposal to move to a different and more flexible way of commissioning enhanced services from member GP Practices in Wiltshire from April 2016 referred to as the Wiltshire Primary Care Offer (PCO). We believe that moving away from providing care in a transactional activity driven model at individual practice level will result in a more efficient and effective use of resources. Developing a single CCG framework incorporating and aligning all of the currently commissioned local enhanced services (potentially including some currently commissioned Direct Enhanced Services by NHS England under joint commissioning arrangements) gives an opportunity to provide more robust, locality based commissioning with patient focussed quality measures and responsive services; adding improved incentives and driving quality initiatives to ensure a reduction in unnecessary variation across our constituent practices and between individual clinicians.

2. PROPOSAL:

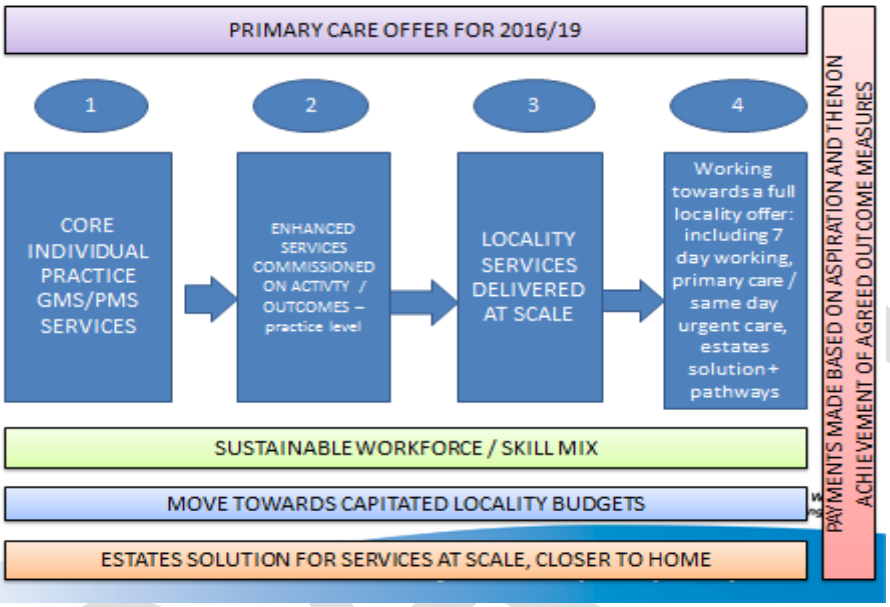
- To develop a three year programme 2016-2019 (allowing for transition and some pace of change);
- To transform the commissioning, delivery and monitoring of the CCG commissioned enhanced services from GP Practices in Wiltshire, over and above core GMS/PMS[3] services to deliver responsive, safe and sustainable services;
- To move towards "placed based commissioning" and the CCG vision of integrated out of hospital services;
- To support the development of locality working to deliver primary care services at scale to support increased efficiencies, and to address issues of recruitment and retention of a competent, capable and resilient primary care workforce to deliver high quality services;

[1] https://www.somersetlmc.co.uk/outcomebasedcommissioning

[2] https://www.wessexlmcs.com/email3794

[3] General Medical Services (GMS) is a nationally held contract and Personal Medical Services (PMS) is a locally held contract – currently held by NHS England. https://www.england.nhs.uk/commissioning/gp-contract/

- To move towards a "block contract" type arrangement - setting out the total funding available for 2016 to cover the specified services to be delivered to meet the needs of their locally registered population in return for meeting the outcomes required (moving from year 1 with KPIs and agreed metrics towards a full outcome based model by year 3);
- To use 2016/17 as a shadow transition year before delegated commissioning of primary medical services from April 2017.



3. PRINCIPLES:

i) To reimburse work on a consistent, transparent and fair funding stream (i.e. remove inconsistencies of payment for activity vs capitation, raw vs weighted, geography) so commissioning is based on equity not equality.

ii) To commission certain services to be provided at scale not by individual practices e.g. leg ulcer care, care homes, and Transforming Care of Older People (TCOP) to encourage delivery of sustainable services at scale

iii) To move towards a full "locality offer" over the next three years, based on capitated or place based budgets including 7 day services, same day urgent primary care hubs, clinical integrated pathways, and agreed estates solutions aligned across the county i.e. NOT 56 practices, and integrated with other out of hospital services.

iv) To support the development of collaborative organisations with general practice at their heart, such as groups of practices, localities, networks or federations – for a resilient new model of primary care service delivery, whilst maintaining the independent contractor status to improve outcomes for patients.

v) To ensure the recording of activity will be proportionate and kept at practice level to ensure records will be available for auditing but minimising the bureaucracy in the system.

vi) To further develop the work programme under Joint Commissioning with NHS England focussing on the key drivers of enhanced services, workforce and flexible estates solutions.

3.1. **AMBITION**

The ambition of the CCG is that services commissioned in primary care under the PCO will:

- Maintain the current high quality primary care service across Wiltshire in the face of growing population and demand;
- Protect the core values of general practice of contact, co-ordination of care, comprehensive services and continuity of care;
- Deliver improved patient safety and clinical outcomes across Wiltshire;
- Deliver an improved experience for patients and their carers;
- Encompass clinical best practice and reduce variation;
- Be sustainable;
- Be innovative and promote skill-mix within primary care providers;
- Deliver a demonstrable return on investment (financial or otherwise);
- Be delivered "at scale" (i.e. at Practice, Locality or Group level as appropriate);
- Be monitored and funded on the basis of outcomes achieved rather than of activity.

4. LOCAL CONTEXT:

Wiltshire CCG has developed a clear vision that Heath and Social Care services in Wiltshire should support and sustain independent living and the future system will see:

- Increased personal responsibility to maintain/enhance well-being;
- Care provided as close to home as possible; and
- A reduced reliance on bed-based care.

The CCG's Five Year Plan, and the supporting transformation programmes, place primary care alongside patients, at the centre of the health and social care economy. The aim is that not only will primary care continue to lead the design of the health care system via clinical commissioning, but will also provide a greater range and improve the quality and safety of services delivered to patients. This is essential to our plans for integration (community services, social care, and mental health); moving care out of hospital; and our reconfiguration of community services.

Following the Health and Social Care Act in 2012, CCGs replaced Primary Care Trusts (PCT) on 1 April 2013 as the clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area. The commissioning of Locally Enhanced Services (LES) from GP Practices was transferred from PCTs to CCGs (whilst others were transferred to Local Authority and the Directed Enhanced Services were transferred to NHS England). In Wiltshire, these LES covered;

- Anti-coagulation monitoring
- Near patient testing
- Basket of Goods
- Care Homes
- Dementia Assessment:
- Insulin Initiation Type II Diabetes
- Level 2 Leg Ulcer Management
- Neo-natal checks
- Ring Pessary fittings
- Venesection
- Homeless (covering one hostel)
- Minor Injury

Some of these services were commissioned on an activity basis (such as Anti coagulation and Near Patient Testing) whilst other schemes (such as Basket of Goods for secondary care initiated investigations) are based on capitation (i.e. paid per number of patients registered with a GP Practice). These capitation payments can be made on a raw or weighted list size. Raw list sizes are the actual number of patients registered with a GP practice (taken from the Open Exeter system). The raw list size of the CCG as of 31.12.15 is 483,705. The weighted population, based on the Car-Hill Formula[4] is the number of patients registered with each practice (from Open Exeter system) adjusted for 6 criteria:

- age and sex
- if they live in a care home
- if they joined the practice in the previous 12 months
- if the patient's postcode ward has "Additional Needs" score (from the Ward's Statutory Long Term Sickness and Mortality indexes)
- their rurality which is driven by a combination of population density for the patient's Ward and the distance between the patient's postcode address and the practice's main surgery
- market forces factor (this is GP based and is a cross reference to the GP practice address Ward Code)

The GP practice raw list is multiplied by these 6 index values to create a "Practice Weighted List Size". The weighted list size of the CCG as of 31.12.15 is 487,843. The main GMS Contract is based on weighted list size and PMS is currently based on raw; but from 01.04.16 PMS Contract will be based on weighted as per the PMS review changes.

The CCG funding allocation is based on a forecast weighted population (not exactly the same weighting indexes as the practice weighted list size from Open Exeter).

If the CCG decides to use either weighted list size or raw list size consistently, some practices will lose out significantly (up to 2000 patient difference in the 2 extremes). A pace of change policy could be agreed for practices adversely affected by agreeing a single approach.

As part of the contract negotiations for 2015/16, the British Medical Association (BMA) and NHS Employers agreed to re-examine the Carr-Hill Formula with the aim of adapting it to better reflect deprivation. This work began in 2015 and is currently underway. There is still no way to assess properly individual practice workload, so the formula review will be based on an assessment of workload across a sample of practices. The current review will however be able to look at more up to date information to assess differences in workload at practice level. The review group is likely to report in time to inform contract negotiations for 2017/18, but implementation will be dependent on negotiation.

[4] www.bma.org.uk Focus on the global sum allocation formula (Carr-Hill Formula) July 2015

Current LES commissioned on a capitation basis are as follows with the proposed funding basis under the PCO for 2016:

SERVICE	CURRENT FUNDING BASIS	PROPOSED PCO BASIS FROM 2016
Basket of Goods	Raw capitation	Weighted capitation
Leg Ulcer Level 2 Management	Mixture of weighted and raw	Weighted capitation from April 2016 moving to activity from 2017.
Transforming Care of Older People	Raw list size (all patients)	On over 75 population
Group SLA	Raw capitation	Raw capitation

5. BUDGETS:

The funding for Enhanced Services and TCOP for 2016/17 is £9.44m at the CCG weighted list size of 487,843, giving an indicative price of £19.36 per registered patient.

The CCG will retain 0.5% contingency in line with NHS Business Rules.

This includes all of the CCG commissioned enhanced services and TCOP only, not those services commissioned from NHS England or Public Health.

Budgets for GP Practices under the PCO will be set partly against 2015/16 activity outturn (for those services paid on activity) and partly on capitation; it will be paid in 1/12 monthly payments to practices from April and based on the 31.12.15 list sizes. There will be a quarterly reconciliation of activity, as in the current system, and payments adjusted accordingly. A detailed spreadsheet setting out funding to individual practice level and built up by localities, showing variance from 2015/16 and 2016/17 has been developed and shared.

The total funding available will include the full value of the Group SLA and the reinvestment of PMS Premium (£109K in 2016/17 = £0.22pp increasing to a total £547K by 2020/21 = £1.12pp).

The PMS Premium [5] is a result of NHS England currently undertaking a review of all PMS practices with a view to ensuring equitable funding per patient across GMS and PMS practices. The 'PMS Premium' is funding removed from PMS practices and has to be reinvested in general practice via CCGs but this reinvestment can be for services in both GMS and PMS practices. The premium will be removed over a period of a five year period to match the withdrawal of MPIG funding from GMS contract holders. The CCGs is tasked with ensuring any reinvestment is in line with our strategic plans.

[5] https://www.england.nhs.uk/wp-content/uploads/2014/02/rev-pms-cont.pdf

Financial Controls: The majority of services and funding streams within the PCO reimburse GPs for the delivery of clinical services and are monitored on activity which can be audited to individual patient level. The process is that funding is made in 1/12 payments and reconciled quarterly on actual activity with further payment made or withdrawn, as in the current process. Plans and demonstration of delivery for the locality work (£2 per patient) and the locality services (£3 per patient) elements of the Group SLA will be agreed through the three Group Executives and brought to Clinical Executive for approval and quarterly monitoring.

Scrutiny and control will be through the suggested Primary Care Oversight Group, as in section 9 on Governance.

6. PROPOSED CHANGES FROM 2016

6.1 Transforming Care of Older People (TCOP)

The context for TCOP was the national guidance "Everyone Counts" in 2014/15 where there was a specific focus on patients aged 75 years and over and those with complex needs; and the CCG was expected to support GP practices in transforming the care of patients aged 75 or older and reducing avoidable admissions by providing funding for practice plans to do so.
In Wiltshire from 2014, TCOP proposals were assessed and signed off against their ability to meet following criteria:

- The CCG strategic vision;
- Improved care for vulnerable older people;
- Reduced avoidable admissions;
- Continuity of care for older people;
- Improved overall quality and productivity of services;
- Greater integration of health & care services, in particular out of hospital care.

Currently, 19 schemes (predominantly locality-based) have been supported and funded since 2014 - subject to successful delivery of the agreed outcomes for patients aged over 75 years. These schemes cover every GP Practice across the whole of Wiltshire. There is evidence of local and clinically-led initiatives with some collaborative working across practices and engagement/alignment with the wider MDTs, reviewing and addressing the individual practice variation and learning from best practice. The nature of the challenge in terms of reducing non-elective admissions in the over 75s meant that many of the schemes were unproven, so at the outset of the funding allocation it was made clear that on-going funding would be subject to successful delivery of the outcomes. That said, the CCG was keen to support locality based schemes that improve care for older people and in particular prevent avoidable admission; and so for that reason the process of project evaluation is to review progress in terms of implementation and outcomes and then work with projects to refine proposals where necessary to ensure the greatest chance of success. Learning from the schemes to date has shown:

- Issues and challenges of recruitment of most groups of clinical staff
- Development of new roles such as the ERP, and new ways of employment (secondment, one practice on behalf of others)
- Links and synergy between TCOP and the Better Care Plan schemes and integrated community teams
- Focus on over 75s, but impact of under 75

- Release of GP capacity and implications of this
- Implications for providing services aligned to primary care at scale, which is a number of practices working together
- Links to other programmes and projects such as work with Care Homes, End of Life, Long term conditions, prevention and Musculo-Skeletal services (MSK)
- Impact of the social care model as in the Leg Club schemes
- Impact of medications reviews on health outcomes and costs

The proposal is to align TCOP funding under the PCO with a locality focus to give sustainability to the current successful schemes within a 3 year framework, to ensure integration as appropriate with other service lines, such as community services and Care Homes. A Quarter 4 TCOP Panel is planned for 31.03.16 to provide an end of year update from the schemes to give the CCG assurance and scrutiny on delivery of the agreed outcomes, local KPIs and return on investment ; and sign off any changes to schemes going into 2016. Future funding from April 2016 will be based on registered patient over 75 years (not full list sizes as in 2015/16) to ensure alignment to the intended cohort of patients over 75.

6.2 Basket of Goods enhancement/ Secondary Care Initiated Pre and Post-Operative (Out of Hospital Care) Procedures Service

The Basket of Goods LES has been in place in Wiltshire since 2004, covering secondary care initiated procedures and investigations and secondary care wound care funded at 0.75 pp.

The Minor Injury LES is an arrangement with 11 GP Practices (all GMS) in the South (furthest away from SFT) since 2004 and not paid consistently on activity or capitation with a budget of £72,852.

The PMS Premium has to be re-invested across all general practices (GMS and PMS) at 0.22 pp from April 2016. This will increase year on year over the next five years.

The services to be provided under this service are:

- Secondary Care initiated investigations and phlebotomy (for pre-operative assessment)
- Planned care of secondary care wounds and removal of clips / sutures
- Secondary care initiated ECG
- Secondary care initiated procedures aimed at preventing admission
- Prompt provision of effective patient treatment where necessary

(NB this is over and above the duty on GP practices under the GMS Regulations provide that GP practices must provide a limited range of emergency services. Regulations 15(6) and (7) provide:
"A contractor must provide primary medical services required in core hours for the immediately necessary treatment of any person to whom the contractor has been requested to provide treatment owing to an accident or emergency at any place in its practice area". This is an obligation to react to requests for assistance made at any time throughout the core hours including:
a) Physical examination for the purpose of identifying the need, if any, for treatment or further investigation; and

b) The making available of such treatment or further investigation as is necessary and appropriate, including the referral of the patient for other services under the Act and liaison with other health care professionals involved in the patient's treatment and care).

The PCO proposal is to give notice to those practices commissioned to provide the Minor Injury LES and align the £0.15 pp to the Basket of Goods; to align the PMS Premium reinvestment of £0.22 pp; add CCG investment into this element to reflect the current workload to uplift the payment to £1.50 per patient and make payment on a weighted capitation basis.

6.3 Leg Ulcer Level 2 Management

The Leg Ulcer LES the specification is for providing a leg ulcer assessment and on-going planned care in-between six and twelve weeks; and is currently paid on both raw and weighted capitation at £1.20 per patient. One provider (Bradbury) covers 9 practices in West Wiltshire and this provider has been set up as a registered company (requiring separate CQC registration as a service provider and indemnity for its staff as they provide services to patients registered with other GP practices from town based premises); the service is provided directly from all other practices across the CCG.

Under the PCO, the commitment is to working towards a funding calculation based to reflect activity, with the cost for first assessment and then 12 follow up appointments and overhead costs. The plan for transition during year 1 is to ensure viability of services, affordability to CCG and transparency of funding; whilst not destabilising the delivery of the service across the CCG. There will be development of outcome measures (such as healing rates and recurrence) and assessment of nurse competencies and training. An audit to provide fuller information is planned in Quarter 1.

The CCG intention is to commission this service on a locality basis (not necessarily for the base to be in one place but to ensure staff covering a wider area) to ensure recruitment and retention of competent staff. The primary care based leg club has successfully been developed in some areas[6] and primary care needs to work closely with the mobilisation of the Adult Community Services Provider re: Level 3 provision.

6.4 Near Patient Testing

The current NPT service remunerates General Practice for monitoring those patients currently being prescribed a range of drugs particularly focussed in the field of Rheumatology, following an agreed shared care plan with secondary care. The current specification has not been reviewed since the introduction under nGMS inception in 2004 and is not an up to date reflection of the drugs that require regular monitoring in practice. Depending on the level of service provided, practices are paid either £81.64 or £87.08 per patient per annum for the monitoring of five shared care drugs (Penicillamine, Sulfasalazine, Methotrexate, Sodium Aurothiomalate).

[6] https://www.legclub.org/leg-club-directory/view/30

The proposal is to update the range of drugs specified within the service based on current guidance and align payments based on the monitoring intensity of involved with each drug.

Monitoring Intensity Level	**Drug**	**Payment**
Level One - routine monitoring only	Sulfasalazine (Year Two only) Denosumab Sodium Aurothiomalate Dronedarone (Year Two onwards)	£15.00
Level Two - medium/low intensity blood monitoring. Monitoring including blood testing	Leflunomide Mycophenolate Penicillamine Sulfasalazine (Year One only)	£40.00
Level Three - high intensity blood monitoring required. A shared care drug monitoring service including frequent blood testing	Azathioprine Ciclosporin Mercaptopurine Methotrexate Dronedarone (Year One only)	£85.00

6.5 Group SLA

The Group SLA (less Care Homes) funding will be badged against clinical leadership of locality development and monitored by Group Execs with reports to Clinical Exec:

- £1pp for PIS (gateway as per Prescribing Incentive Scheme);
- £2pp for locality work (e.g. locality lead GP time, reimbursement for locality meetings with PM and admin, delivery of locality plan etc.);
- £3 pp for Group agreed locality services in line with CCG Operational Plan – e.g. diabetes;
- 0.10p ring fenced for Group GP Forums and AGM held by Groups

Plans and demonstration of delivery for both the locality work and the locality services elements will be agreed through the three Groups and brought to Clinical Executive for approval and monitoring. The funding will be made on raw capitation basis as this service does not need to reflect population demographics.

6.6 Prescribing Incentive Scheme

From April 2016, a Prescribing Incentive Scheme will form part of the PCO with £1 a patient funding for the clinical (either GP or pharmacist) input contained within the PCO and practices able to draw down up to £2 a patient achievement payment from the net savings to the CCG from the prescribing budget. The budgets will be set (to be ratified through CCG Governing Body) by excluding 'accessories' chapters of BNF (CCG budget) e.g. Stoma, Continence, Wound Management, Feeds, and keeping a CCG reserve for 'high cost' or 'new' drugs (Horizon scanning). Performance against budget then directly related to prescribing that can be influenced in GP practices.

Specific requirements for actions and outcomes include a nominated prescriptions lead (GP, Pharmacist or senior prescription clerk); expectation that the prescriptions lead can

demonstrate actions (e.g. actions from newsletter, practice meeting discussions). This will be phased through from year 1 to 3.

7 CONTRACTUAL GOVERNANCE

All practices are expected to provide essential and those additional services they are contracted to provide to all their patients under core GMS/PMS. The service specifications within the PCO outline the more specialised services to be provided. The specifications of these services are designed to cover the enhanced aspects of clinical care of the patient, some of which are beyond the scope of essential services. No part of the specification by commission, omission or implication defines or redefines essential or additional services.

Practices signing up to providing these enhanced services should be aware they are signing up to a contractual arrangement and are agreeing to the full requirements stated in the specification.

It is assumed that practices signing up to providing the services confirm that they meet the requirements of the specification in relation to the competence of the staff employed to perform the services and record keeping, and evidence of such will be made available at the request of the CCG as per contractual obligations and responsibilities under the GMS/PMS Contracts held with GP practices. Practices should ensure all their staff responsible for providing enhanced services should be aware of the specification and relevant criteria.

7.1 PCO Contract Issues (Chief Clinical Information Officers' view)

The PCO is a framework being developed over the next three years, and there will be a step process in the transition. The ambition is that:

i) Contracts – All held centrally and signed electronically by each practice. Each practice then visits website and signs up to whichever contracts they wish.
ii) Templates – All of Wiltshire using the same templates so GPs are collecting the correct read code to ensure accurate payment.
iii) Reports – Reports run centrally to identify what activity has been performed by each practice.
iv) Business Intelligence – To easily see who is doing what and challenge activity if needed.
v) Payment – To ensure each practice is paid appropriately.

8 NHS England – alignment of Extended Hours Directed Enhanced Service from April 2016

This is a DES commissioned by NHS England and the CCG cannot alter the specification as NHS England has to be sighted on plans to monitor and pay. The specification is to provide 30 minutes of "extended hours" per 1000 patients with minimum 30 min session which can be both routine and urgent and provided by all clinical staff either face to face or via the phone and has to be in addition to core in hours provision. It is funded at £1.90 per pt. (£930K for CCG). Practices have to demonstrate the provision is in line with patient preference (i.e. for mornings, evenings or Saturday mornings).

National guidance already states that Practices can deliver this service for their own practice solely or choose to offer as a group of practices.

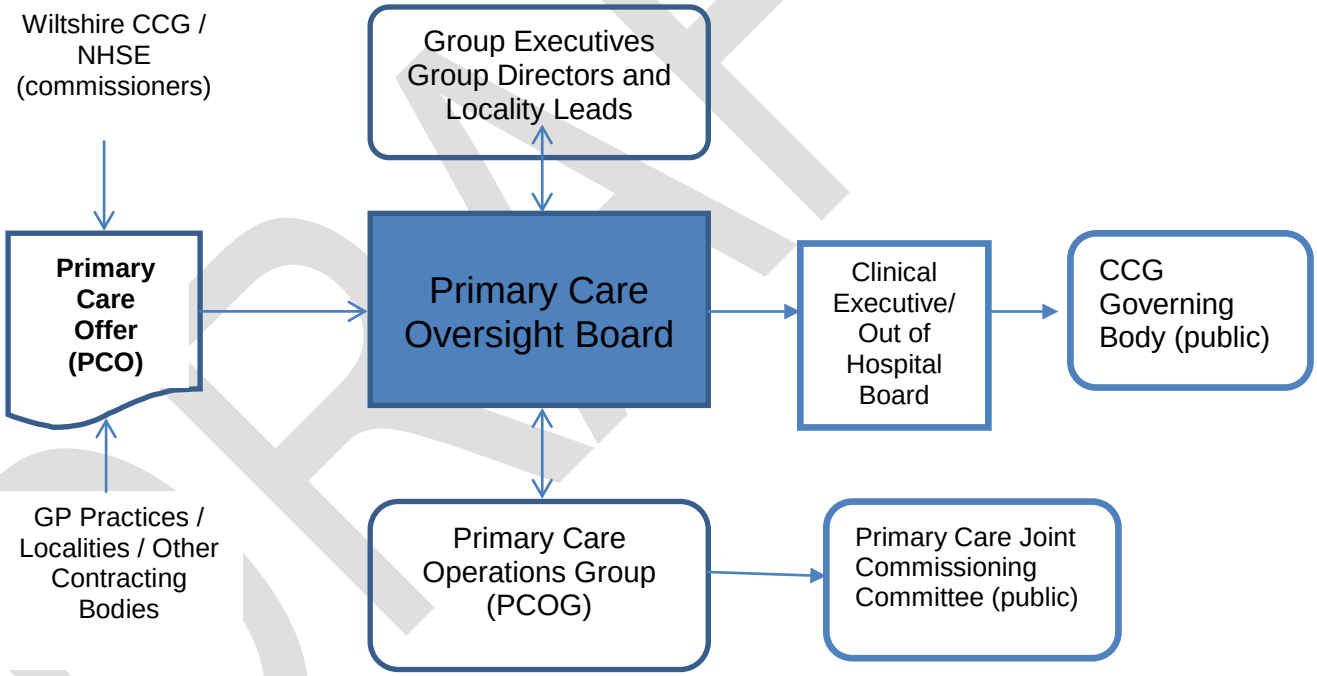
NHS England has agreed that this can be aligned to PCO with locality plans for delivery (could remain at individual practice level) from April 2016.

9 GOVERNANCE of PCO DELIVERY

The Governance process, in relation to the PCO, will replace the previous arrangement for the TCOP Panel. It is suggested that it is constituted as follows:

- Distribution, collection, assessment and review of data, by the CCG
- Internal review and scrutiny, including the Group Executives and Group Directors where appropriate
- Primary Care Oversight Board
- Primary Care Joint Commissioning Board
- CCG Governing Body

Proposed structure:



The membership for the proposed Primary Care Oversight Board has to be confirmed but it is recommended that this is a similar make up to TCOP Panel - CCG Governing Body members (non GPs), Healthwatch, LMC and NHS England. This will ensure a robust and non-conflicted process of evaluation, and monitoring, supported through CCG officers from quality, finance, and information. This will provide regular reports and learning both to the CCG Clinical Executive / Out of Hospital Board and to the Primary Care Joint Commissioning Committee, meeting in Public. This will be particularly important in 2016/17, before moving into delegated responsibilities for primary medical care services and core GMS/PMS Contracts.

Recommendations to Governing Body:

The Governing Body are asked to note:

i) the work undertaken to date to develop the PCO and engagement and input across the member practices through Practice Manager meetings and discussions, Locality meetings, GP Forums, Group Executives and Clinical Executive.

ii) The statement from Wessex LMC on the PCO.

The Governing Body are asked to approve:

i) The implementation of the PCO from April 2016

ii) The proposed governance process to set up a Primary Care Oversight Group to replace the TCOP Panel reporting to the Out of Hospital Programme Board/Clinical Executive.

NHS
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Equality Impact Analysis – the EIA form

Title of the paper or Scheme: PRIMARY CARE OFFER 2016-2019

For the record	
Name of person leading this EIA: Jo Cullen	Date completed: 07.03.16
Names of people involved in consideration of impact Member of the Primary Care Operational Group	
Name of director signing EIA: Jo Cullen	Date signed 07.03.16

What is the proposal? What outcomes/benefits are you hoping to achieve?

PROPOSAL**:**

- to develop a three year programme 2016-2019 (allowing for transition and some pace of change)
- to transform the commissioning, delivery and monitoring of the CCG commissioned enhanced services from GP Practices in Wiltshire, over and above core GMS/PMS services
- to move towards “placed based commissioning” and the CCG vision of integrated out of hospital services
- to support the development of locality working to deliver primary care services at scale to support increased efficiencies, and to the address issues of recruitment and retention of a competent, capable and resilient primary care workforce to deliver high quality services.
- to move towards a "block contract" type arrangement - setting out the total funding available for 2016 to cover the specified services to be delivered to meet the needs of their locally registered population in return for meeting the outcomes required (moving from year 1 with KPIs and agreed metrics towards a full outcome based model by year 3)
- to use 2016/17 as a shadow transition year before delegated commissioning of primary medical services from April 2017

The ambition of the CCG is that services commissioned in primary care under the PCO will:

- Maintain the current high quality primary care service across Wiltshire in the face of growing population and demand;
- Deliver improved patient safety and clinical outcomes across Wiltshire;
- Deliver an improved experience for patients and their carers;
- Encompass clinical best practice and reduce variation;

- Be sustainable;
- Be innovative and promote skill-mix within primary care providers;
- Deliver a demonstrable return on investment (financial or otherwise);
- Be delivered “at scale” (i.e. at Practice, Locality or Group level as appropriate), allowing more effective and efficient outcome based services and
- Be monitored and funded on the basis of outcomes achieved rather than of activity.

Who’s it for?
The proposal covers services commissioned from all member GP Practices and their registered patients in Wiltshire CCG.

How will this proposal meet the equality duties?
It covers all registered patients.

What are the barriers to meeting this potential?
None identified

2 Who’s using it? *Refer to equality groups*
All registered patients, part of the funding is aligned to the Transforming Care of Older People programme aimed at registered patients aged over 75 years of age.

What data/evidence do you have about who is or could be affected (e.g. equality monitoring, customer feedback, current service use, national/regional/local trends)?

All Wiltshire registered patients covering the full range of protected characteristics will be covered within this service.

Some of the funding streams, such as the budget for the Transforming Care of Older Peoples service are being aligned to an equitable basis i.e. the number of actual practice registered over 75 year olds, not the full list size. This will provide more equitable funding for all practices across Wiltshire but ten practices in Wiltshire will be adversely affected by this change in funding.

How can you involve your customers in developing the proposal?
General Practitioners, Practice managers and other practice staff have constantly input into the shaping of this proposal. All general practices have their own Patient Participation Groups. Healthwatch Wiltshire is a member within the TCOP Evaluation Panel.

Who is missing? Do you need to fill any gaps in your data? (pause EIA if necessary)
None at this stage.

3 Impact Refer to dimensions of

equality and equality groups

Show consideration of: age, disability, sex, transgender, marriage/civil partnership, maternity/pregnancy, race, religion/belief, sexual orientation and if appropriate: financial economic status, homelessness, political view

Using the information in parts 1 & 2 does the proposal:

a) Create an adverse impact which may affect some groups or individuals. Is it clear what this is? How can this be mitigated or justified?

Whilst some surgeries are adversely affected by the funding mechanism for over 75's TCOP funding, other practices will be receiving 'more equitable funding' as this will be clearly aligned to their over 75s population size rather than their full list sizes.

What can be done to change this impact?

Practices could look to work together on a wider locality basis to provide the TCOP scheme, reducing the impact on individual practices. This has been the CCG's preference and is being provided in this manner across 8 other localities.

b) Create benefit for a particular group. Is it clear what this is? Can you maximise the benefits for other groups?

None identified.

Does further consultation need to be done? How will assumptions made in this Analysis be tested?

None

4 So what? Link to business planning process

What changes have you made in the course of this EIA?

No changes have been made

What will you do now and what will be included in future planning?

Performance monitoring of the offer will be discussed at the Out of Hospital Board on a quarterly basis

Access into services funded through 'Transforming Care of Older People (TCOP)' will be monitored in terms of access and usage, as well as a series of other outcome measures to ensure the population is not being adversely affected.

When will this be reviewed?

A standing agenda item will be included on the CCG Out of Hospital Board; and the Primary Care Joint Commissioning Committee and CCG Governing Body both held in public.

How will success be measured?

Key performance measures will monitor both the individual services within the offer as the overarching principles of the primary care offer.