# Agenda

## Inaugural Meeting

<table>
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<tr>
<th>Item</th>
<th>Action</th>
<th>Lead</th>
<th>Papers</th>
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<tr>
<td>1</td>
<td>Introduction</td>
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<td>1.1</td>
<td>Apologies</td>
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<td>1.2</td>
<td>Declarations of interest</td>
<td>Chair</td>
<td>Verbal</td>
<td>4.00</td>
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</table>

All Committee members and attendees may have interests relating to their roles. These should be declared in the register of interests. While these general interests do not need to be individually declared at meetings, interests over and above these where relevant to the topic under discussion should be declared.

| 2    | Governance |      |        |      |
| 2.1  | Terms of Reference | To agree | SH | 2.1 | 4.10 |

| 3    | Achieving strategic objectives |      |        |      |
| 3.1  | Primary Care Resilience and Provider Development Programme - update | To note | KM | 3.1 | 4.15 |
| 3.2  | PMS review: | To approve | SH/GM | 3.2 | 4.25 |
|      | a) Transition Funding Model |      |        |      |
|      | b) Commissioning Intentions for Year 1 |      |        |      |

| 4    | For information |      |        |      |

| 5    | Any other business | Chair | 4.55 |
West London CCG’s Primary Care Commissioning Committee

Terms of Reference

1. Purpose and statutory framework

1.1 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 these Terms of Reference to West London CCG.

1.2 The CCG has established the West London 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.

1.3 Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

1.4 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);

1.5 The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those in accordance with the relevant provisions of section 13 of the NHS Act, such as regards impact on services in certain areas and variation in provision of health services.

1.6 The Committee is established as a committee of the Governing Body of West London CCG in accordance with Schedule 1A of the “NHS Act”.

1.7 The Committee is formally accountable for furnishing the Finance and Audit Committees with the formal reports it requires to assure the CCG Governing Body that Primary Care delegation is being effectively governed and managed. It will additionally report to the Quality Committee in order that the CCG’s approach to quality is consistent and can be understood alongside the CCG’s other areas of commissioning responsibility.

2. Secretariat

2.1 The CCG will provide secretariat support to the Committee including preparation and distribution of papers, the taking of minutes and facilitating agendas. Additionally, the secretariat will support
the pro-active and careful management of conflicts of interest, in accordance with the CCG’s conflicts of interest management policy.

2.2 The secretariat will be responsible for supporting the Chair in the management of the Committee’s business and for drawing the Committee’s attention to best practice, national guidance as it emerges, and other relevant documents as appropriate.

2.3 A record of actions and decisions will be circulated by the secretariat to the Committee within five working days. The minutes/notes as agreed by the Committee Chair, will be circulated to attendees of the Committee at the latest within 15 working days of each Committee meeting.

3. **Frequency and notice of meetings**

3.1 The Committee will typically convene monthly and in public.

3.2 Papers will be issued no later than five working days before each meeting. The dates of the meetings and papers will be available on the CCG’s website.

3.3 The Committee may resolve to exclude the public from a meeting that is open to the public (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 and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4. **Authority and reporting**

4.1 The Committee is established under West London Clinical Commissioning Group’s constitution as a committee of the Governing Body and will make decisions within the bounds of its remit.

4.2 The Committee will present its minutes and an executive summary report to NHS England London Region and the Governing Body for information.

4.3 There is a statutory requirement that the Committee publishes a register of its decisions, outlining the management of any Conflicts of Interest. This shall be made available via the CCG’s website.

4.4 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 agreement entered into between NHS England and West London CCG, are recorded in a scheme of delegation, are governed by appropriate terms of reference and reflect appropriate arrangements for the management of conflicts of interest.

5. **Membership**

**Voting members** (lay and executive majority)
- Governing Body Lay Member, West London CCG (Chair)
- Governing Body Lay Member, West London CCG (Vice Chair)
- CCG Managing Director/Chief Operating Officer, West London CCG, or their deputy
- CCG Chief Finance Officer, or their deputy
- Non-conflicted clinicians x 2 (secondary care doctor / nurse / out-of-area GP / allied health professional)
Non-voting members

- NHS England representative
- Three elected Governing Body members, West London CCG
- Heads of Primary Care (CCG; seconded NHSE staff)
- Public Health borough representative
- Local authority representative of borough Health and Wellbeing Board
- HealthWatch borough representative
- Local Medical Committee representative

No person who is a practising GP in the CCG area may be a voting member of the Committee.

6. Quoracy, voting and confidentiality

6.1 The quorum shall comprise of a minimum of three voting members and include at least one lay member, one CCG officer and one clinician.

6.2 The Committee shall have a non-conflicted majority at all times.

6.3 Each voting 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.

6.4 Members of the Committee, with agreement from the Chair, may send a designated deputy with full authority if they cannot attend in person.

6.5 Members of the Committee shall respect confidentiality requirements as set out in the CCG Constitution or Standing Orders.

7. Remit and responsibilities

7.1 The Committee recognises that the rationale for NHSE’s delegation of primary care medical services commissioning to the CCG is to increase quality, efficiency, productivity and value for money, and to remove administrative barriers, which in turn will serve to strengthen and stabilise general practice.

7.2 In performing its role, the Committee will exercise its management of the functions in accordance with its terms of reference, delegation of authority and the agreement entered into between NHS England and West London CCG.

7.3 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:

   a. 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);

   b. Providing assurance to the Governing Body and NHS England on quality, performance and finance of all services commissioned from primary care which incorporate the delegated funding and funding from the core CCG allocation (for example prescribing, incentive schemes and local primary care contracts).
c. Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
d. Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
e. Decision making on whether to establish new GP practices in an area;
f. Approving practice mergers; and
g. Making decisions on ‘discretionary’ payment (e.g., returner/retainer schemes).
h. Agreeing and monitoring a financial plan and budget; risk assessment, performance framework and annual workplan.

7.4 The CCG will also carry out the following activities, in collaboration with other NWL CCGs:
a. To plan, including needs assessment, primary medical care services in the [name] area;
b. To undertake reviews of primary medical care services in the [name] area;
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 the [name] area;

7.5 The Committee is accountable for exercising the agreed delegated functions from NHS England. The agreed delegated functions are set out in Schedule 2. NHSE retains the responsibility for individual practitioner performance whilst the CCG will have responsibility for practice contract performance.

8. Governance structure and effectiveness

8.1 The Committee will be responsible for seeking assurance in order that strategy, commissioning, performance, quality and finance considerations guide and inform effective primary care medical services commissioning.

8.2 The Committee will ensure, on behalf of the Governing Body, the effective design and delivery of primary care medical services to meet the needs of our local population, in line with the CCG’s long-term strategic objectives, as expressed in the Sustainability and Transformation Plan (STP) for the borough and for North West London.

8.3 The Committee shall remain the decision-making committee for all areas within its remit, whilst taking due account of any recommendations and reviews that may from time to time be provided by other committees of the CCG’s Governing Body.

8.4 The Committee may appoint ad-hoc members to advise it on specific matters within its terms of reference from time to time as appropriate.

8.5 The Committee shall review its own effectiveness after its first six months and annually thereafter, and submit any proposed changes to its terms of reference to the Governing Body for ratification.

9. Sub-structure

The joint committee may establish local task and finish groups as required (which will operate as non-decision making working groups); these will be properly constituted with terms of reference approved by the Committee. Where appropriate, existing committees will be reviewed and refreshed to support the effective delivery of the new functions of this Committee.
The Committee is asked to:

Note the update as described, for both the WLCCG resilience programme and the plans for the provider development programme (sustainability and transformation funding - £3 per head).

Summary of purpose and scope of report

GP Resilience:

The General Practice Resilience Programme was announced as part of the General Practice Forward View. The programme will provide £40 million over four years (until 2020) to support GP practices and to build resilience into the system.

The purpose of the fund is to deliver a wide menu of support that will help practices to become more sustainable and resilient, better placed to tackle the challenges they face now and into the future, and securing continuing high quality care for patients. The Resilience support was flexible enough to be able to offer support in a variety of ways, whether this was direct funding to third party organisations (such as federations etc), backfill to help practices develop their organisations, or to fund a variety of activities such as:

- Diagnostic services to quickly identify areas for improvement support
- Specialist advice and guidance e.g. HR IT
- Coaching/supervision/mentoring
- Rapid intervention and management support for practices at risk of closure
- Coordinated support to help practices struggling with workforce issues
- Change management and improvement support to individual practices or groups of practices

For West London CCG, the 2016/17 allocation amounted to a sum of £110,000.

In West London CCG, a small working group consisting of Head of Primary Care Development, Dr Naomi Katz (as clinical lead for primary care and GB vice chair), and Dr Rachael Garner (as clinical lead for Training and Workforce Development, Quality and GB vice chair), together with the West London Federation (LMA) chair and MD, undertook initial scoping to determine appropriate spend of this funding for our practices. These initial discussions were further developed into a part engagement part active support process consisting of the following:
£11,000 spend to facilitate, run and backfill two engagement workshops in January, to determine from our practices what support they felt they needed, to actively transform to meet the workforce, patient demand and budgetary challenges they faced in the coming years. These workshops were held one in the north and one in the south and attended by 27 GPs, PMs and a practice nurse. Agenda items for these sessions were:
  - Reminder of GPFV funding availability and parameters for use of funding locally / national support / programmes
  - Workforce mapping information to highlight anticipated gaps
  - Overview of 10 high impact changes
  - Table discussions – prioritising Transformation Development funding

£99,000 to commission an organisation for a period of 6-9 months to provide diagnostic, improvement and rapid turnaround support for up to 10 GP practices, with a range of needs, identified and nominated for support by NHS West London CCG. The aim of this support will involve provision of a range of expert, technical and professional resources and improvement solutions, specific to the General Practice setting, together with an experienced MDT peer support staff who will work with, and in those GP practices, helping to identify and implement key actions that will provide future stability and secure improvements.

The expected outcomes for this support provision are:
  - Support deployed to provide targeted help and assistance to GP practices, as identified within a diagnostics process; this may include the provision of a peer led support team.
  - Actions that will support GP practice turnaround and improvement are identified, prioritised and agreed with practices.
  - Resource and support to GP practices to implement agreed actions and delivery of improvements.

A provider has now been chosen within a tender process (via Contract Finder), and initial meeting has been held with the provider, to plan commencement of the support provision.

Practices were identified for this resilience support based on a combination of factors consisting of CQC outcome (for example “requires improvement”), status on NHS England Heat Map (for example high on the list and “declining” compared to previous year), or if they had previously applied to NHS England vulnerable practice fund and were on the waiting list. WLCCG locality team and clinical lead where possible attended meetings with the identified practices to determine practice needs aligned back to resilience programme criteria. 6 out of the 10 practices have so far agreed their programme of support, 2 practices are still to confirm and 2 further practices to be newly identified as the initial practices on the list declined the offer of support.

GPFV Sustainability and Transformation Package

The GPFV, published on 21 April 2016, sets out the national investment and commitments to strengthen general practice in the short term and support sustainable transformation of primary care for the future. It includes specific, practical and funded investment in five areas – investment, workforce, workload, practice infrastructure and care redesign.

Within the “investment” are of the FV, CCGs are required to plan to spent a total of £3 per head as a one off non-recurrent investment in 2017/18 and 2018/19, for practice transformational support, as set out in the GPFV.
investment should commence by July 2017 and can take place split over two years or be undertaken in either year.

The investment is designed to be used to:

- stimulate development of at scale providers for improved access,
- stimulate implementation of the 10 high impact actions to free up GP time, and
- secure sustainability of general practice.

In West London CCG, the CCG based provider development working group as described above, have drafted a proposed programme within the £3 per head to support practices. It is proposed that the £3 per head is split across two years, 17/18 and 18/19 with straight split of £1.50 per year. The proposed plan is attached in appendix 1.

The programme is undergoing further practice engagement during April (within CLS process), for practice overview. There will be further engagement in year 2017/18 to develop the programme for 2018/19 to ensure fit for purpose and meeting practice needs.

**Quality & Safety/ Patient Engagement/ Impact on patient services:**

There are many specific outcomes as aligned to the individual areas of the programme, as detailed within the plan attached in appendix 1. In summary, the programme is intended to release GP time and more appointment availability thereby improving patient access, give patients access to information/self-care advice, improved management of long term conditions, opportunities to expand on service delivery with joint working increasing quality of care provided and overall improved patient satisfaction, therefore an improved quality of service for patients.

**Financial and resource implications**

West London CCG is required to fund the £368,000 each year for two years from the CCG baseline. Investment has been agreed and budgeted for in 17.18

**Equality / Human Rights / Privacy impact analysis**

n/a

**Risk**

Lack of engagement from practices. We have mitigated this risk by assigning backfill to enable practices to take time out from their day jobs to undertake the required development. For 2018.19 funding, the working group will undertake an assessment of the success of the 2017/18 programme, and will undertake further engagement with practices on the process and content of the programme to ensure fit for purpose programme for 2018.19.

**Supporting documents**

n/s
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<tr>
<th>Committee name</th>
<th>Date discussed</th>
<th>Outcome</th>
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Appendix 1

**GPFV summary of 17/18 Programme**

<table>
<thead>
<tr>
<th>Stimulation implementation of 10 high impact actions - free up GP time</th>
<th>Funding</th>
<th>Expected Impact</th>
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### Stimulate development of at scale providers

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### Secure sustainability of general practice to improve in hours access

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### The Committee is asked to:

Approve the proposed transitional funding model and commissioning intentions for Year 1 developed as part of the PMS Review for West London CCG.

### Summary of purpose and scope of report

**Purpose & Scope:**

To seek approval for the 3 service specifications that form the first year of Commissioning Intentions developed for GP Practices as part of the PMS Review, as well as the associated transitional funding model. Progress reports on developing Commissioning Intentions for Years 2-5 will be provided regularly to the Primary Care Commissioning Committee in future meetings ahead of any formal approval processes.

**Transitional Funding Model:**

Transition funding aims to support PMS practice stability as they move to new income and service arrangements as part of the PMS Review. It is calculated by considering the difference between the current 16/17 PMS contract values and the GSE (global sum equivalent), as well as the income offered through newly commissioning services.

Potential income loss (e.g. the difference between current income and GSE + Commissioning intentions) for year 1 determines each practice’s ‘transition pathway’, allowing transitional offers to be calculated for the full PMS review period. There are 3 transition pathways, with each offering different lengths of funding based on magnitude of income lost. In West London CCG the proposed methodology means all PMS Practices qualify for the full 4 year transition offer due to the size of the CCG’s PMS premium. Final Practice offers will be based on updated 17/18 figures when available, with initial ‘baseline letters’ using 16/17 figures as an interim measure, however this will not alter the transition pathway of any Practices within the CCG.

This recommended transition methodology, calculating transition by taking account of income from newly commissioned services, was recommended for all CCGs at the 2nd February 2017 NWL PMS Review Steering Group, which has an advisory function to each CCG’s Primary Care Commissioning Committee. For West London CCG this represents the release of more monies for services in Year 1 (£1.1million versus £500,000-£600,000 under other options), and therefore faster progress towards releasing funds to support GMS Practices. Crucially however it maintains the four year transition path for maximum stability of PMS Practices.
On this basis the West London Primary Care Commissioning Committee is asked to approve this transition methodology as the basis for the PMS Review and Practices offers in West London CCG.

Commissioning Intentions for Year 1:

The CCG has worked collaboratively with local stakeholders since last year to shortlist a number of potential commissioning intentions for GP Practices as part of the PMS Review. The CCG facilitated a local Primary Care Commissioning Intentions Steering Group, several clinically-led workshops, attended a number of patient fora, and engaged in early discussions with NHS England and the LMC prior to the London-wide ‘pause’ in the Autumn.

Following the resumption of the PMS process at the end of 2016 the CCG reconvened the local Primary Care Commissioning Intentions Steering Group, which includes representation from PMS, GMS and APMS Practices, as well as NHS England and the LMC. The initial ‘London Offer’ of mandatory services and KPIs was withdrawn during the process pause, and as a result the CCG has had to revisit the previously worked up Commissioning Intentions.

The size of the PMS premium in West London CCG, at approx. £6million, is one of the largest in London, and therefore the programme of commissioning new services is necessarily more complex than elsewhere. Due to this the CCG has chosen to focus on finalising and commissioning services from the financial envelope available in Year 1 initially, at approx. £1.1million, with commissioning intentions for subsequent years to be finalised during 2017/18.

Three services have been developed and recommended through the local Steering Group, and are tabled here for the approval of the Primary Care Commissioning Committee:

1. **Support for Carers:**
   a. The CCG is commissioning a service to improve the identification and support of carers, ensuring that high quality care is delivered as close to the patient's home as is appropriate. The service aims to offer a range of support in maintaining good mental and physical health in order for the patient to continue in their caring role. The service will do this by:
      i. Improving the number of carers identified by GP practices in West London.
      ii. Targeting 'hidden carers' who, despite having a caring responsibility, do not recognise themselves as carers, feel that they are simply carrying out ordinary responsibilities as part of a family, or face specific issues.
      iii. Ensuring that carers who are identified have access to the health care they need including access to health checks.
      iv. Ensuring that all carers identified are referred effectively for the provision of ongoing advice, information and support.
   b. The CCG is working with local leads for patient engagement and the voluntary sector to discuss provision of support for Practices in accessing materials and services for carers – e.g. with the Carers Network
   c. The service is provisionally priced at £1pwp (per weighted patient)

2. **Supportive Care - Last Phase of Life:**
   a. The CCG is commissioning a service which aims to:
      i. Improve identification of patients thought to be in their last year (or 18 months) of life, to avoid unnecessary hospital admissions.
      ii. Increase the number of patients with advance care planning, leading to better care and ultimately dying in their preferred place of death through earlier assessment and anticipatory planning, in line with the implementation of the Gold Standards Framework
   b. The CCG is working with the local end of life clinical lead, Dr Oisin Brannick, to align the new service
specification with local pathways and services

   c. The service is provisionally priced at £1pwp (per weighted patient)

3. Reducing High Attendance at A&E:

   a. The CCG is commissioning a service to support the identification and care of frequent attenders to A&E to ensure that high quality care is delivered as close to the patient’s home as is appropriate. The service will do this by:
      i. Identifying patients who have attended A&E departments 3 or more times from the start of the service
      ii. Proactively highlighting alternatives to A&E – including texting of all patients, and clear messaging on Practice websites and Practice NHS Choices entries
      iii. Ensuring that all patients identified are referred effectively for the provision of ongoing advice, information and support.

   b. The CCG is working with local leads for urgent care to discuss alignment with other initiatives and any public messaging on alternatives to A&E
    
   c. The service is provisionally priced at £2.75pwp (per weighted patient)

The CCG is currently working to secure resource to develop the associated SystmOne templates, searches, codes and cribsheets to support Practices in delivering the new services, and expects to make progress with this imminently to keep to the mandated timescales of October 2017.

The committee is asked to approve the service specifications in advance of their submission to the joint NHS England/Londonwide LMC assurance process, and subsequent communications and negotiations with GP Practices.

Quality & Safety/ Patient Engagement/ Impact on patient services:

The PMS review will lead to an equalisation in GP Practice funding between holders of different contract types, and so should lead to a more equitable provision of service for patients. The CCG is committed to using this opportunity to increase the quality of services, while also maintaining stability for its GP Practices

Patient engagement is being sought via the CCG Patient & Public Engagement leads.

Financial and resource implications

The overall net effect to CCG finances is neutral due to the funding model and ‘transitional funding’ methodology adopted by the CCG for the PMS Review.

Equality / Human Rights / Privacy impact analysis

The PMS review will lead to an equalisation in GP Practice funding between holders of different contract types, and so should lead to a more equitable provision of service for patients. The CCG is committed to using this opportunity to increase the quality of services, while also maintaining stability for its GP Practices

Risk

There are inherent risks to the timescales associated with commissioning of these new service specifications, in
particular the NHSE-mandated deadline of 1st October 2017 for delivery of Year 1 services following completion of all contract negotiation stages with General Practices. If the Primary Care Commissioning Committee does not formally endorse the service specifications on 18th April 2017 this will further delay formal communications with Practices, and subsequent timescales.

Supporting documents

1) Service Specification: Support for Carers
2) Service Specification: Supportive Care: Last Phase of Life
3) Service Specification: Reducing High Attendance at A&E
4) Summary of PMS Review Transitional Funding Model

Governance and reporting (list committees, groups, or other bodies that have discussed the paper)

<table>
<thead>
<tr>
<th>Committee name</th>
<th>Date discussed</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Commissioning Intentions Steering Group</td>
<td>15/02/17, 15/03/17 and 12/04/17</td>
<td>Recommended for submission to Primary Care Commissioning Committee</td>
</tr>
<tr>
<td>Transformation Board</td>
<td>11/04/18</td>
<td>Noted and endorsed</td>
</tr>
</tbody>
</table>
PMS Review: Transition Methodology

Primary Care Commissioning Committee
18th April 2017
How has the transitional offer been calculated?

This slide provides an overview of the approach to transition proposed for West London CCG, and consistent with all NWL CCGs. The approach is that:

- Transition aims to support practices to move to new income and service arrangements as per the new PMS contract and local commissioning intentions.
- It is calculated by considering the difference between PMS contract values and the GSE (global sum equivalent), as well as the income offered through newly commissioning services stemming from the PMS Review, against the current income of a PMS practice (e.g. before the review).
- Potential income loss (e.g. the difference between current income and GSE + Commissioning intentions) for year 1 determines each practice’s transition pathway (see next slide).
- Transitional offers can then be calculated for all years.

Please Note:
- Year 1 is the first year following the new contract start date – e.g. from 1st October 2017 to 30th September 2018.
- The ‘CIs for the year’ investment is based on the CIs and expected achievement offered, there are no additional transitional payments if practices do not take up these services.
- The PMS premium against which the income loss and transition payments are calculated is considered constant (i.e. based on final 2017/18 figures) throughout the period.

The approach to calculating Practice Payments is shown below:

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>PMS Contract - Global Sum Equivalent = PMS Premium</td>
</tr>
<tr>
<td>2</td>
<td>PMS Premium - CIs for year = Potential income loss</td>
</tr>
<tr>
<td>3</td>
<td>Potential income loss (Yr1) x Yr 1 Transition %* = Transition Payment to Practice (Yr 1)</td>
</tr>
<tr>
<td></td>
<td>Potential income loss (Yr2) x Yr 2 Transition %* = Transition Payment to Practice (Yr 2)</td>
</tr>
<tr>
<td></td>
<td>Potential income loss (Yr3) x Yr 3 Transition %* = Transition Payment to Practice (Yr 3)</td>
</tr>
<tr>
<td></td>
<td>Potential income loss (Yr4) x Yr 4 Transition %* = Transition Payment to Practice (Yr 4)</td>
</tr>
</tbody>
</table>

* Number of years of transition and % offered is as per the transition pathway for the practice (see next slide). Four years of transition illustrated here is maximum.
What is the transition pathway?

The Transition Year % Pathway policy was recommended across NWL at the 2nd February 2017 PMS Review Steering Group, for local ratification by CCG Primary Care Committees.

- This is to determine the number of years (up to four) and amount of transition that each practice is eligible for. This is based on their potential income loss (to ensure practices potentially losing the most are supported for the longest).
- This policy outlines that all Practices with over a 5% potential income loss in year 1 will receive Payment of 90% of the Potential Income Loss in Year 1 with tapered amounts from Year 2 depending on the percentage of their potential income loss.
- This is called the Transition Pathway.

Please Note:

- All CCGs are committed to reinvesting at least the value of the premium back into General Practice.
- Commissioning Intention investment in many areas will grow over time as they invest the additional released funding (e.g. funding not spent on transition). Some CCGs are investing more than just the released premium in year 1, and their investment may be more constant over the 4 years.
- The ‘Premium’ calculation is fixed in Year 1 and held constant for 4 Years.
- The Transition Pathway is determined in Year 1 and held for the period of the review.

Transition Pathway

If practices will lose **between 5 – 9.9% income** in year 1 they get:

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>90%</td>
<td>55%</td>
</tr>
</tbody>
</table>

If practices will lose **between 10 – 14.9% income** in year 1 they get:

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>90%</td>
<td>70%</td>
<td>40%</td>
</tr>
</tbody>
</table>

If practices will lose **Over 15% income** in year 1 they get:

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>90%</td>
<td>70%</td>
<td>40%</td>
<td>20%</td>
</tr>
</tbody>
</table>
NHS Standard Contract 2017/18

Particulars – Reducing High Attendance at A&E
SCHEDULE 2 – THE SERVICES

A. Service Specifications

<table>
<thead>
<tr>
<th>Service Specification No.</th>
<th>&lt;insert&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service</td>
<td>Reducing High Attendance at A&amp;E</td>
</tr>
<tr>
<td>Commissioner Lead</td>
<td>Louise Proctor (MD, West London CCG)</td>
</tr>
<tr>
<td>Provider Lead</td>
<td>&lt;insert&gt;</td>
</tr>
<tr>
<td>Period</td>
<td>&lt;insert&gt;</td>
</tr>
<tr>
<td>Date of Review</td>
<td>1 Year from Service Start Date</td>
</tr>
</tbody>
</table>

1. Population Needs

1.1 National/local context and evidence base

Increasing pressure has been put on urgent care services across the country in recent years, with rising numbers of attendances in A&E Departments. In 2015 – 2016, 22.9 million attendances were recorded at major A&E departments, single A&E departments, walk-in centres and minor injury units in England, compared to 19.1 million attendances in 2007 – 2008, an increase of almost 20%.

During 2016 patients registered with a West London GP Practice accounted for 48,901 A&E attendances. Of this total
- 3,559 patients attended A&E 3 times or more
- 1,745 patients attended A&E 4 times or more
- 963 patients attended A&E 5 times or more

The issue with frequent attenders highlights the question of whether the healthcare needs of these patients are being met by current service provision. Although these frequent attenders do not represent all the service users, a significant amount of resource could be saved if the number of frequent attendances could be reduced.

Numerous studies have looked at factors associated with A&E usage. These can be categorised into population factors, e.g. demographics, health state and socioeconomic status; and provider factors, e.g. access to primary care, continuity of care and proximity to urgent care facilities. A retrospective review of the top ten attenders at West Middlesex A&E from 2013 showed that the majority had multifactorial reasons for presentation including medical (87%), alcohol (31%), psychiatric (28%) and social (25%). General practice plays an important role in preventing unnecessary hospital attendances and admissions. A number of areas where general practice can influence patient health outcomes include:
- Better identification of patients at risk and development of individual care plans
- Support for self-care and referrals to support services
• Clear pathways and patient information
• Health promotion education

Strategic Alignment

• Strategic Commissioning Framework for London (SCF): This new service aligns with all three of the priority areas set out in the SCF:
  o Proactive Care: The service aims for better identification of patients frequently attending A&E and working with them to reduce future such attendances where clinically appropriate.
  o Coordinated Care: The service asks GP Practices to work collaboratively with other providers involved in urgent care, such as A&E Departments and Urgent Care Centres.
  o Accessible Care: The service encourages Practices to offer specific appointments for frequent attenders if clinically appropriate.
• GP Forward View (GPFV): The new service aligns with the promotion of Practice sustainability through contributing to the overall aims of equitable funding for all GP Practices as part of the wider PMS review.
• North West London Sustainability & Transformation Plan (STP): This new service forms part of the CCG’s wider strategic plans as set out in the STP. Specifically it aligns with the following ‘Delivery Areas’ in the STP: 1) DA 2: Eliminating unwarranted variation and improving LTC management (by review of avoidable A&E attendances and looking at ways to reduce future such attendances if not clinically appropriate; 2) DA 5: Ensuring we have safe, high quality sustainable acute services (by reducing clinically unnecessary attendances at A&Es and UCCs, contributing to demand management and sustainability at those facilities)

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local defined outcomes

<table>
<thead>
<tr>
<th>Individual Empowerment and Self Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enable General Practice to support individuals so that they do not need to attend A&amp;E departments unless clinically necessary</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Access, Convenience and Responsiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>The specification requires the provider to deliver the service as close to a patient’s home as possible.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Planning and Multidisciplinary Care Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>The specification requires the service to be provided in a setting where the patient is also receiving other aspects of care at the same time. Individuals will experience coordinated, seamless and integrated services using evidence-based care pathways, case management and personalised care planning where their primary care clinician has access to their results through SystmOne.</td>
</tr>
<tr>
<td><strong>Population- and Prevention-oriented</strong></td>
</tr>
<tr>
<td>----------------------------------------</td>
</tr>
<tr>
<td>The specification sets out the requirement for Providers to identify patients frequently attending A&amp;E departments, and support them so that future such attendances can be reduced where possible. The CCG expects the service provider to ensure that the service is accessible to all patients registered with GP providers within the CCG.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Safe and High Quality</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The provider should have access to the whole patient records, where clinically indicated and with patient consent, so they can contextualise patient results and advise on next steps.</td>
</tr>
</tbody>
</table>

### 3. **Scope**

#### 3.1 **Aims and objectives of service**

The CCG is commissioning a service to support the identification and care of frequent attenders to A&E to ensure that high quality care is delivered as close to the patient’s home as is appropriate.

The service will do this by:

- Identifying patients who have attended A&E departments 3 or more times from the start of the service
- Proactively highlighting alternatives to A&E – including texting of all patients, and clear messaging on Practice websites and Practice NHS Choices entries
- Ensuring that all patients identified are referred effectively for the provision of ongoing advice, information and support.

This service is in addition to those services that GMS, PMS and APMS providers are contracted to provide to their registered patients. The specification of this service is designed to cover the enhanced aspects of clinical care of the patient, which are considered beyond the scope of essential services and additional services within the GMS, PMS and APMS contract.

#### 3.2 **Service description/care pathway**

The practice will:

- Identify patients who have attended A&E departments at least 3 times from the start of the service by acting on discharge summaries received and coding appropriately
- Inform the patient's case manager of the attendances via SystmOne if they are already being case managed
- Contact identified frequent attender patients directly and if clinically appropriate, following discussion with the patient, offer a routine or sooner appointment for a review (including on the day and longer appointments)
- Hold a monthly clinical review meeting to review all patients attending A&E where there might have been a more appropriate option.
- Proactively highlight alternatives to A&Es through clear messaging by text to all patients, and via Practice websites and Practice NHS Choices entries
3.3 Population covered

This service is commissioned for all patients registered with a GP Practice in West London CCG.

3.4 Any acceptance and exclusion criteria and thresholds

Exclusions:

None

3.5 Governance requirements

Minimum Workforce Competency

- The service provider must ensure that there are appropriately competent, qualified and trained staff to deliver the specified level of service/intervention in each delivery point.
- There must be an appropriately qualified health care professional, named as the service lead who has overall responsibility for ensuring the service is delivered in accordance with the specification.
- Staff delivering the service must be trained on all appropriate policies relating to the delivery of the service.

Clinical governance requirements

- The provider should ensure that all delivery points meet CQC requirements for the delivery of medical services which as a minimum should be those required for the delivery of general medical services.
- The provider should ensure that all standards of communication should adhere to Caldicott and Data Protection guidelines.
- The service provider must ensure that staff are CPR trained (adults and paediatrics) when they start to provide the service and should attend annual refresher training thereafter.
- The service provider must ensure that staff delivering the service must have undergone the relevant DBS checks before delivering the service.
- The service provider should comply with commissioner requests for clinical audit.
- The service provider must ensure that staff have access to refresher training as required to maintain clinical competence in delivering the specified service.

3.6 Interdependence with other services/providers

The service provider will be expected to work in close partnership with a range of health and social care providers, including:

- Local Accident & Emergency Departments
- Local Urgent Care Centres
- London Ambulance Service
- GP Out of Hours Service
- NHS 111
- Social Care
- Secondary Care Teams
- Community Care Teams
- Mental Health Teams
Where appropriate and using locally agreed guidelines (where these exist) the provider will refer patients to other health and social care services and to relevant support agencies.

4. **Applicable Service Standards**

4.1 **Applicable national standards (e.g. NICE)**
   - NHS England Standard General Medical Services Contract
   - Relevant NICE standards

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

N/A

4.3 **Applicable local standards**

**Locally defined, general requirements for providers**

Service providers will need to confirm compliance with the standards below:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Applicable service category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider is CQC registered with no relevant conditions</td>
<td>All</td>
</tr>
<tr>
<td>Practice has an open list.</td>
<td>General Practice</td>
</tr>
<tr>
<td>Same day appointments are available for patients clinically assessed as requiring them.</td>
<td>All</td>
</tr>
<tr>
<td>Provider must be fully compliant with the Accessible Information Standard</td>
<td>All</td>
</tr>
<tr>
<td>Provider must ensure that all staff are aware and can access interpretation and translation services for patients who are non-English speaking during service operation hours.</td>
<td>All</td>
</tr>
<tr>
<td>Provider shares information with commissioners to support quality improvements (subject to IG rules).</td>
<td>All</td>
</tr>
<tr>
<td>Provider actively collects, analyses and acts on feedback from patients and carers.</td>
<td>All</td>
</tr>
<tr>
<td>Provider must operate an accessible complaints procedure that is consistent with the principles of the NHS complaints procedure. They will report anonymised details of each complaint, and the manner in which it has been dealt with, to the commissioning CCG. All complaints must be audited in relation to individual staff so that, where necessary, appropriate action can be taken.</td>
<td>General Practice</td>
</tr>
<tr>
<td>Practice participates in clinical audit cycles and peer review external to their practice.</td>
<td>General Practice</td>
</tr>
<tr>
<td>Section</td>
<td>Content</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>5. Applicable quality requirements and CQUIN goals</strong></td>
<td></td>
</tr>
<tr>
<td>5.1 Applicable Quality Requirements (See Schedule 4A-D)</td>
<td>See Appendix 1</td>
</tr>
<tr>
<td>5.2 Applicable CQUIN goals (See Schedule 4E)</td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>6. Location of Provider Premises</strong></td>
<td></td>
</tr>
<tr>
<td>• The service provider’s delivery points should be from sites where GMS, PMS and APMS services are delivered, and where the primary function of the APMS contract is for the delivery of primary medical services.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 1: Outcomes and Measurement

Outcomes

The overall aims of the service are to ensure that:

- Improve the identification by General Practices of patients who have attended A&E departments 3 or more times from the start of the service
- Increase the proactivity of General Practices in highlighting alternatives to A&Es – including texting of all patients, and clear messaging on Practice websites and Practice NHS Choices entries
- All patients identified are referred effectively for the provision of ongoing advice, information and support.

Pricing

Practices will be paid £2.75 per weighted patient for:

- Identifying patients who have attended either A&E departments at least 3 times from the start of the service by acting on discharge summaries received and coding these patients appropriately
- Informing the patient’s case manager of the attendances via SystmOne if they are already being case managed
- Contacting identified frequent attender patients directly and if clinically appropriate, following discussion with the patient, offer a routine or sooner appointment for a review (including on the day and longer appointments)
- Holding monthly clinical review meetings to review all patients attending A&E where there might have been a more appropriate option.
- Proactively highlighting alternatives to A&Es through clear messaging by text to all patients, and via Practice websites and Practice NHS Choices entries

<table>
<thead>
<tr>
<th>Activity</th>
<th>Calculation</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Identifying A&amp;E frequent attenders via discharge summaries received and coding these patients appropriately</td>
<td>226,958* x £2.00 pwp</td>
<td>£453,916</td>
</tr>
<tr>
<td></td>
<td>*WLCCG weighted patient list at 1.10.16</td>
<td></td>
</tr>
<tr>
<td>2) Informing the patient’s case manager of the attendances via SystmOne if they are already being case managed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) Contacting identified frequent attender patients directly and if clinically appropriate, following discussion with the patient, offer</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
a routine or sooner appointment for a review (including on the day and longer appointments) 

4) Holding monthly clinical review meetings to review all patients attending A&E where there might have been a more appropriate option.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Evidence Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients identified and coded as A&amp;E frequent attenders according to the requirements of the specification</td>
<td>Figures submitted by Practice via CCG collection template</td>
</tr>
<tr>
<td>Number of frequent attender patients reviewed in the year*</td>
<td>Figures submitted by Practice via CCG collection template</td>
</tr>
<tr>
<td>Monthly clinical review meetings held to review all patients attending A&amp;E where there might have been a more appropriate option</td>
<td>Self-Declaration by Practice via CCG collection template. CCG will randomly audit in the year also</td>
</tr>
<tr>
<td>Text messaging on appropriate alternatives to A&amp;E**</td>
<td>Self-Declaration by Practice via CCG collection template. CCG will randomly audit in the year also</td>
</tr>
<tr>
<td>Practice website and Practice NHS Choices entry updated with clear messaging on appropriate alternatives to A&amp;E</td>
<td>Self-Declaration by Practice via CCG collection template. CCG will randomly audit in the year also</td>
</tr>
</tbody>
</table>

5) Proactively highlighting alternatives to A&Es through clear messaging by text to all patients, and via Practice websites and Practice NHS Choices entries 

<table>
<thead>
<tr>
<th>226,958*</th>
<th>£0.75 pwp</th>
</tr>
</thead>
<tbody>
<tr>
<td>*WLCCG weighted patient list at 1.10.16</td>
<td>£170,219</td>
</tr>
</tbody>
</table>

Total | £624,135 |
| **pwp | £2.75 |

Practices will achieve payment for the service in any given year by providing the following:

*All frequent attender patients should be reviewed – NB – does not require an appointment unless clinically indicated

**Messages to be monthly to all patients during Winter – defined as October-March – and quarterly thereafter – e.g. 8 messages a year
NHS Standard Contract
2017/18

Particulars – Support for Carers
Particulars Version 1
SCHEDULE 2 – THE SERVICES

A. Service Specifications

<table>
<thead>
<tr>
<th>Service Specification No.</th>
<th>&lt;insert&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service</td>
<td>Support for Carers</td>
</tr>
<tr>
<td>Commissioner Lead</td>
<td>Louise Proctor (MD, West London CCG)</td>
</tr>
<tr>
<td>Provider Lead</td>
<td>&lt;insert&gt;</td>
</tr>
<tr>
<td>Period</td>
<td>&lt;insert&gt;</td>
</tr>
<tr>
<td>Date of Review</td>
<td>1 Year from Service Start Date</td>
</tr>
</tbody>
</table>

1. Population Needs

1.1 National/local context and evidence base

National context and evidence base

Carers look after family, partners or friends who are ill, frail, have a disability, or need help because of substance misuse, and without getting paid for the care they provide.

Nationally there are 6.5 million unpaid carers, accounting for 1 in 8 adults, and estimates suggest they save the state £132\(^1\) billion a year. However, research has found that those providing care are more likely to be in poor health than those not providing care. Carers can often suffer social deprivation, isolation and ill health. They may have fewer opportunities to do the things other people may take for granted, such as having access to paid employment or education, or having time to themselves or with friends. For young carers, it can often mean life chances are severely limited.

Carers UK (2014) have highlighted that:
- 72% of carers are worse off financially as a result of caring;
- 54% have given up employment to care;
- 21% have had to reduce their working hours due to caring responsibilities;
- On average, carers retire 8 years earlier, thereby missing out on years of income and pension contributions;
- Those caring for 50 hours a week or more are twice as likely to experience poor health, particularly mental health problems.

The 2001 Census indicated that 11,000 people provide unpaid care in Kensington & Chelsea (6.9% of the resident population) of whom 200 were children. However this is likely to be an underestimate as the term ‘carers’ is not recognised by many people providing such care - as many as 65% in the first year of providing it – making it difficult for services to identify them. Our health and social care systems

\(^1\) Carer’s UK, September 2015
depend on carers supporting patients when our health economy systems often cannot. This is reflected in support for carers being a priority area in the Health & Wellbeing Strategies for Westminster and Kensington & Chelsea over the next five years².

The publication ‘Supporting Carers: An action guide for general practitioners and their teams’, a collaboration between the Royal College of General Practitioners (RCGP) and The Princess Royal Trust for Carers, identified the crucial role GP Practices can play in identifying and supporting carers. GPs and their teams are usually the first place that carers have contact with the NHS. They are uniquely placed to recognise that someone is, or is about to become, a carer. Embedding this identification and support within General Practice will ensure carers are supported at an earlier stage, enabling real benefits for both carers and patients alike.

This service has an increase in the identification of carers on Practice registers, and support for those carers, as its central aim.

**Strategic Alignment**

- **Strategic Commissioning Framework for London (SCF):** This new service aligns with all three of the priority areas set out in the SCF:
  - Proactive Care: The service aims for proactive identification and support of carers to better manage their physical and mental health.
  - Coordinated Care: The service strongly encourages Practices to work with other agencies such as the voluntary sector to signpost and support carers.
  - Accessible Care: The service promotes GP Practices offering specific appointments for carers, including longer or outside core hours if needed.

- **GP Forward View (GPFV):** The new service aligns with the promotion of Practice sustainability through contributing to the overall aims of equitable funding for all GP Practices as part of the wider PMS review.

- **North West London Sustainability & Transformation Plan (STP):** This new service forms part of the CCG’s wider strategic plans as set out in the STP. Specifically it aligns with the following ‘Delivery Areas’ in the STP: 1) DA 1: Radically upgrading prevention and wellbeing (by identifying and supporting carers so they maintain good physical and mental health); DA 3: Achieving better outcomes and experiences for older people (many Older People are also carers); 3) DA 4: Improving outcomes for children & adults with mental health needs (caring can be stressful and carers have a high incidence of mental health problems)

### 2. Outcomes

#### 2.1 NHS Outcomes Framework Domains & Indicators

<table>
<thead>
<tr>
<th>Domain 1</th>
<th>Preventing people from dying prematurely</th>
<th>✔</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 2</td>
<td>Enhancing quality of life for people with long-term conditions</td>
<td>✔</td>
</tr>
<tr>
<td>Domain 3</td>
<td>Helping people to recover from episodes of ill-health or following injury</td>
<td>✔</td>
</tr>
<tr>
<td>Domain 4</td>
<td>Ensuring people have a positive experience of care</td>
<td>✔</td>
</tr>
</tbody>
</table>

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2.2 Locally defined outcomes

<table>
<thead>
<tr>
<th>Individual Empowerment and Self Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>The specification requires the provider to make available appropriate information and support for carers’ specific needs to support them in their caring role and in achieving better health outcomes.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Access, Convenience and Responsiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>The specification requires the provider to deliver the service as close to the carer’s home as possible.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Planning and Multidisciplinary Care Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>The specification requires the service to be provided in a setting where the carer is also receiving other aspects of care at the same time. Individuals will experience coordinated, seamless and integrated services using evidence-based care pathways, case management and personalised care planning where their primary care clinician has access to their results through SystmOne. Effective care planning and preventative care will anticipate and avoid deterioration of conditions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Population- and Prevention-oriented</th>
</tr>
</thead>
<tbody>
<tr>
<td>The specification sets out the requirement for the provider to proactively engage with the carer, as appropriate, to support uptake for screening, medical review, attendance at forthcoming appointments and prevent infection/complications. The CCG expects the service provider to ensure that the service is accessible to all carers registered with GP providers within the CCG.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Safe and High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provider should have access to the whole patient records, where clinically indicated and with patient consent, so they can contextualise patient results and advise on next steps.</td>
</tr>
</tbody>
</table>

3. Scope

3.1 Aims and objectives of service

The CCG is commissioning a service to support the identification and support of carers, ensuring that high quality care is delivered as close to the patient’s home as is appropriate.

The service aims to offer a range of support in maintaining good mental and physical health in order for the patient to continue in their caring role.

The service will do this by:

- Improving the number of carers identified by GP practices in West London.
- Targeting ‘hidden carers’ who, despite having a caring responsibility, do not recognise themselves as carers, feel that they are simply carrying out ordinary responsibilities as part of a family, or face specific issues. This is the case particularly with:
  - Young carers
  - Black and minority ethnic carers
  - Carers of people with learning disabilities who have continued their caring role well into their child’s adulthood
Particulars Version 1

- LGBT carers who may have additional issues such as not being identified as the carer as the service doesn’t recognise non-traditional relationships
- Carers of people with stigmatised conditions (e.g. mental health problems, drug and alcohol problems) who may be reluctant to make their needs known.

- Ensuring that carers who are identified have access to the health care they need including access to health checks.
- Ensuring that all carers identified are referred effectively for the provision of ongoing advice, information and support.

This service is in addition to those services that GMS, PMS and APMS providers are contracted to provide to their registered patients. The specification of this service is designed to cover the enhanced aspects of clinical care of the patient, which are considered beyond the scope of essential services and additional services within the GMS, PMS and APMS contract.

3.2 Service description/care pathway

Care pathway

The service provider will:

- Identify a Carers Lead within the practice. The role of the carers lead is to:
  - Promote carer awareness among all staff, including receptionists, so they have a basic understanding of support available;
  - Consider ways of keeping carers informed and up-to-date on available support on a regular basis, with support from the CCG. This could be through posters, newsletters, mailshots and messages on the right hand slip of prescriptions, and involvement of carers in local PPG activities, and the CCG will support and advise Practices with this
  - Maintain links with local carer organisations, social services and the voluntary sector

- Proactively identify carers at registration and from the list of registered patients, and ensure the carer status is correctly recorded within the clinical record (gaining consent from the carer to be recorded as such). This should include proactively checking if patients newly diagnosed with a health condition will now have a ‘newly diagnosed carer’

- Maintain and regularly update a carers register – An average of 2% of the patient population across any given year of the service should be identified as carers. For an average list size of 4,863 patients, it is expected that practices will have at least 97 registered carers across the year.

- Display information in the waiting room to help carers identify themselves and to highlight available support and information. The Practice’s carers lead should also consider a variety of different media most appropriate to their practice population, with support and advice from the CCG

- Invite those not on chronic disease registers and those not otherwise eligible for the NHS health check a formal carer health check. The physical health check will include health promotion and height; weight; BMI; BP; Urinalysis; cardiovascular risk factors; medication review and flu immunisation.

- Proactively invite carers to have an annual influenza immunisation

- Allocate specific appointments at times and of an appropriate length to suit the carer and enable arrangements to be made to have the person cared for looked after.
Particulars Version 1

- If appropriate, complete a mental health screening and onward referral

- Proactively signpost carers to available support services, including onward referral (if appropriate) – with support and advice from the CCG. This could include:
  - Specialist services
  - Self-help groups
  - Carers support services
  - Local Authority for a Carer’s Assessment
  - Information for carers to support them in their caring role – e.g. Administering medication, moving and handling, PEG feeding, supporting someone with a severe and enduring mental health condition.

Targets

- The service should be offered between 08:00 and 18:30 Monday to Friday, excluding Bank Holidays, as a minimum. Providers should consider the needs of working carers, and offer appointments outside core hours where possible.
- The service provider should provide bookable appointments for this service.
- Health review appointments should be a minimum of 20 minutes and the provider should allow more time if the complexity of the carer’s needs requires this. The review should be completed using the commissioners’ approved template on SystmOne

Minimum reporting and data collection requirements

See Appendix 1

3.3 Population covered

- This service is commissioned for all patients registered with a GP Practice in West London CCG

3.4 Any acceptance and exclusion criteria and thresholds

Excludes:
- Patients who have not consented.

3.5 Governance requirements

Minimum Workforce Competency

- The service provider must ensure that there are appropriately competent, qualified and trained staff to deliver the specified level of service/intervention in each delivery point
- There must be an appropriately qualified health care professional, named as the service lead who has overall responsibility for ensuring the service is delivered in accordance with the specification
- Staff delivering the service must be trained on all appropriate policies relating to the delivery of the Support for Carers service

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3 Such as via the ‘People First’ website - http://www.peoplefirstinfo.org.uk/looking-after-someone/support-to-look-after-someone/
Clinical governance requirements

- The provider should ensure that all delivery points meet CQC requirements for the delivery of medical services which as a minimum should be those required for the delivery of general medical services
- The provider should ensure that all standards of communication should adhere to Caldicott and Data Protection guidelines
- The service provider must ensure that staff are CPR trained (adults and paediatrics) when they start to provide the service and should attend annual refresher training thereafter
- The service provider must ensure that staff delivering the service must have undergone the relevant DBS checks before delivering the service.
- The service provider should comply with commissioner requests for clinical audit.
- The service provider must ensure that staff have access to refresher training as required to maintain clinical competence in delivering the specified service

3.6 Interdependence with other services/providers

This service is part of a wider integrated care pathway. The provider will support an integrated approach between services and providers, ensuring that patient records are transferred appropriately to support a seamless patient transfer and service provision.

The service provider will be expected to work in close partnership with a range of health and social care providers, including:

- Children and Families services
- Adult Social Care
- Carers UK Kensington and Chelsea
- Age UK (formerly Age Concern)
- Full of Life
- Equal People
- Kensington and Chelsea Mental Health Carers Association
- Carers Network Westminster
- Carers Network Kensington & Chelsea
- Kensington and Chelsea Social Council
- Open Age
- Portobello Green Fitness Centre
- CLCH (Carer’s Counselling Service)
- Citizens Advice
- Healthwatch Central West London

4. Applicable Service Standards
4.1 Applicable national standards (e.g. NICE)
- NHS England Standard General Medical Services Contract
- Relevant NICE standards

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)
- The RCGP has a number of resources to support carers in general practices including *Supporting Carers: An Action Guide*. Together with The Princess Royal Trust, the RCGP has also produced a self-assessment checklist
- *Integrated approach to identifying and assessing Carer health and wellbeing* is a toolkit published by NHS England that clarifies the new duties on NHS organisations under the Care Act 2014 and the Children and Families Act 2014
- National Carers Strategy 'Carers at the heart of 21st-century families and communities 2008-2018'

4.3 Applicable local standards

Locally defined, general requirements for providers

Service providers will need to confirm compliance with the standards below:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Applicable service category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider is CQC registered with no relevant conditions</td>
<td>All</td>
</tr>
<tr>
<td>Practice has an open list.</td>
<td>General Practice</td>
</tr>
<tr>
<td>Same day appointments are available for patients clinically assessed as requiring them.</td>
<td>All</td>
</tr>
<tr>
<td>Provider must be fully compliant with the Accessible Information Standard</td>
<td>All</td>
</tr>
<tr>
<td>Provider must ensure that all staff are aware and can access interpretation and translation services for patients who are non-English speaking during service operation hours.</td>
<td>All</td>
</tr>
<tr>
<td>Provider shares information with commissioners to support quality improvements (subject to IG rules).</td>
<td>All</td>
</tr>
<tr>
<td>Provider actively collects, analyses and acts on feedback from patients and carers.</td>
<td>All</td>
</tr>
<tr>
<td>Provider must operate an accessible complaints procedure that is consistent with the principles of the NHS complaints procedure. They will report anonymised details of each complaint, and the manner in which it has been dealt with, to the commissioning CCG. All complaints must be audited in relation to individual staff so that, where necessary, appropriate action can be taken.</td>
<td>General Practice</td>
</tr>
<tr>
<td>Practice participates in clinical audit cycles and peer review external to their practice.</td>
<td>General Practice</td>
</tr>
</tbody>
</table>

5. Applicable quality requirements and CQUIN goals
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5.1</strong></td>
<td><strong>Applicable Quality Requirements</strong></td>
</tr>
<tr>
<td></td>
<td>See Appendix 1</td>
</tr>
<tr>
<td><strong>5.2</strong></td>
<td><strong>Applicable CQUIN goals (See Schedule 4 Part [E])</strong></td>
</tr>
<tr>
<td></td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

**6. Location of Provider Premises**

- The service provider’s delivery points should be from sites where GMS, PMS and APMS services are delivered, and where the primary function of the APMS contract is for the delivery of primary medical services.
Appendix 1: Outcomes and Measurement

Outcomes

The overall aims of the service are to improve the quality of life and health for carers by proactive identification and support. In addition to this the Service Provider should ensure that their services are helping carers to achieve the following outcomes from the National Carers Strategy ‘Carers at the heart of 21st-century families and communities 2008-2018’:

1. Carers are respected as expert care partners;
2. Carers have access to the integrated and personalised services they need to support them in their caring role;
3. Carers can have a life of their own alongside their caring role;
4. Carers are supported so that they are not forced into financial hardship by their caring role;
5. Carers are supported to stay mentally and physically well and treated with dignity.

The Service Provider should evidence that their services are helping carers to achieve the following outcomes from the Care Act 2014:

Carers are:
1. Able to carry out any caring responsibilities the carer has for a child;
2. Able to provide care to other persons;
3. Able to maintain a habitable home environment;
4. Able to manage and maintain nutrition;
5. Able to develop and maintain family or other personal relationships;
6. Able to fulfil their educational and employment potential, including engagement in training and volunteering opportunities;
7. Able to access facilities or services in the local community;
8. Able to engage in recreational activities.

Payment & Minimum Data Set - Assessment / KPIs

Practices will be paid £1.00 per weighted patient for delivery of the specification, provided that an average of 2% of the patient population are identified as carers across any given year of the service. For an average list size of 4,863 patients, it is expected that practices will have at least 97 registered carers on average across the year.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Calculation</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 minutes additional GP time for each carer identified and supported beyond core services</td>
<td>226,958* x £1.00</td>
<td>£226,958</td>
</tr>
<tr>
<td>Epwp</td>
<td></td>
<td>£1.00</td>
</tr>
</tbody>
</table>
Practices will achieve payment for the service in any given year by providing the following:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Evidence Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of carers identified on the practices register*</td>
<td>Figures submitted by Practice via CCG collection template</td>
</tr>
<tr>
<td>This must include figures for age, gender and ethnicity to help tackle 'hidden carers'</td>
<td></td>
</tr>
<tr>
<td>Number of carers on the register provided with an annual physical health check with identified health outcomes</td>
<td>Figures submitted by Practice via CCG collection template</td>
</tr>
<tr>
<td>Number of carers on the register offered an annual flu vaccination as a priority group, who are not already eligible for seasonal flu vaccination</td>
<td>Figures submitted by Practice via CCG collection template</td>
</tr>
<tr>
<td>Provision of specific appointments for carers</td>
<td>Self-Declaration by Practice via CCG collection template</td>
</tr>
<tr>
<td>Number of onward referrals to the local carers network for carers on the register</td>
<td>Figures submitted by Practice via CCG collection template</td>
</tr>
<tr>
<td>Details of the identified Practice Carers Lead</td>
<td>Name and role, via CCG collection template</td>
</tr>
<tr>
<td>Information regularly provided for carers in the Practice – e.g. posters, leaflets, PPGs</td>
<td>Self-declaration via CCG collection template</td>
</tr>
<tr>
<td>Training undertaken by Practice staff on Carers needs and how to offer support</td>
<td>Self-declaration via CCG collection template</td>
</tr>
</tbody>
</table>

*Must be an average of 2% of the patient population identified as carers across any given year of the service, based on best practice identified by the carers network*
NHS Standard Contract
2017/18

Particulars – Supportive Care-Last Phase of Life.
## 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>Supportive Care-Last Phase of Life</td>
<td>Louise Proctor (MD, West London CCG)</td>
<td>&lt;insert&gt;</td>
<td>&lt;insert&gt;</td>
<td>1 Year from Service Start Date</td>
</tr>
</tbody>
</table>

### 1. Population Needs

#### 1.1 National/local context and evidence base

Identification of people approaching the last phase of life is key to providing good quality end of life care. Approximately 500,000 people die in England each year – just under 1% of the population. Across the tri-boroughs, 30% of deaths per year are due to cancer, 27% due to circulatory disease, 12% due to respiratory disease and 31% due to other causes.

The NICE Commissioning Guide for End of Life Care describes a lack of open and honest communication between health and social care staff and individuals as a hindrance to this identification – a barrier often related to the taboo around discussing death and dying. In studies of earlier integration of palliative care with disease-oriented management, palliative patients have reported:

1. Improved satisfaction with care.
2. Less acute interventions
3. Patients are more likely to die at home

Currently 75% of Practices in West London CCG (33 out of 44) have palliative care registers of just 0.2% or lower. The CCG also has a greater percentage of people dying in hospital as opposed to their preferred place of death (54% of deaths are in hospital compared to a national average of 46%). Additionally the tri-boroughs JSNA Report on End of Life Care identified several key themes and recommendations for General Practice, such as: 1) GPs do not always identify people approaching end of life until shortly before death, resulting in patients referred too late in their trajectory, and 2) that identification of the end of life care needs for patients with a non-cancer diagnosis needs improvement.

This service is designed to ensure GP Practice palliative care registers reflect these prevalence statistics by being maintained at 0.3% of the registered population (as an average across the year), and ensure that there is earlier identification of people approaching their last phase of life, with advance care planning in line with the Gold Standards Framework, and people dying in their preferred place of death wherever possible.

**Strategic Alignment**

*Strategic Commissioning Framework for London (SCF):* This new service aligns with all three of the priority areas set out in the SCF:
Proactive Care: The service aims for proactive early identification of people approaching their last year of life, rather than waiting until the last few weeks or days.

Coordinated Care: The service requires each Practice to have a clinical lead for the service, and promotes patients and their families having a single point of contact as reflected in best practice.

Accessible Care: The service encourages Practices to offer tailored appointments for patients in or approaching the last year of life, and to help access further support from specialist palliative care services when needed.

- GP Forward View (GPFV): The new service aligns with the promotion of Practice sustainability through contributing to the overall aims of equitable funding for all GP Practices as part of the wider PMS review.

- North West London Sustainability & Transformation Plan (STP): This new service forms part of the CCG’s wider strategic plans as set out in the STP. Specifically it aligns with the following ‘Delivery Area’ in the STP: 1) DA 2: Eliminating unwarranted variation and improving LTC management (by improving the symptom control and improving the quality of life of people in their last phase of life).

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>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domain 2</td>
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<td>X</td>
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<td>Domain 3</td>
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<td>Domain 4</td>
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<tr>
<td>Domain 5</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
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</tr>
</tbody>
</table>

2.2 Local defined outcomes

**Individual Empowerment and Self Care**
Enable General Practice to support individuals in the last year of their life and to make and record decisions about their preferred place of care and death.

**Access, Convenience and Responsiveness**
The specification requires the provider to deliver the service as close to a patient's home as possible.

**Care Planning and Multidisciplinary Care Delivery**
The specification requires the service to be provided in a setting where the patient is also receiving other aspects of care at the same time. Individuals will experience coordinated, seamless and integrated services using evidence-based care pathways, case management and personalised care planning where their primary care clinician has access to their results through SystmOne.

**Population- and Prevention-oriented**
The specification sets out the requirement for Providers to increase early identification of patients approaching the end of life, maintain registers at 0.3% of the registered population (as an average across the year), and support those patients with their care needs. The CCG expects the service provider to ensure that the service is accessible to all patients registered with GP providers within the CCG.
Safe and High Quality

The provider should have access to the whole patient records, where clinically indicated and with patient consent, so they can contextualise patient results and advise on next steps.

3. Scope

3.1 Aims and objectives of service

The CCG is commissioning a service which aims to:

- Improve identification of patients thought to be in their last year (or 18 months) of life, to avoid unnecessary hospital admissions.
- Increase the number of patients with advance care planning, leading to better care and ultimately dying in their preferred place of death through earlier assessment and anticipatory planning, in line with the implementation of the Gold Standards Framework.

This service is in addition to those services that GMS, PMS and APMS providers are contracted to provide to their registered patients. The specification of this service is designed to cover the enhanced aspects of clinical care of the patient, which are considered beyond the scope of essential services and additional services within the GMS, PMS and APMS contract.

3.2 Service description/care pathway

Service Enablers:

Register of patients: The practice must have a register of palliative care patients.

Care Pathway:

The practice will:

- Proactively identify patients who might be eligible for inclusion on the palliative care register using the Gold Standards Framework Prognostic Indicator Guidance. The guidance follows a three step process to support earlier recognition of patients nearing the end of life:
  - The Surprise Question: ‘Would you be surprised if this patient were to die in the next few months, weeks, days’?
  - General indicators of decline - deterioration, increasing need or choice for no further active care.
  - Specific clinical indicators related to certain conditions.
- Maintain the register at 0.3% of the GP practice’s weighted registered population (measured across the year). Providers will need to ensure that they manage any in-year risk associated with changes in practice list size and regularly review patients to ensure that all patients who can benefit from the appropriate care have the opportunity to access this.
• Identify and regularly review the GSF indicator stage using Needs Based Coding to prioritise need. If a change is required, the GP should additionally review the care plan with a focus on giving the right care at the right time.

• As part of the advanced care planning review with the patient and their family / carer, the provider should provide an anticipatory care plan, particularly for those identified as yellow to red on the Gold Standards Framework. Communication and information sharing will be done through CMC or by information sharing with out of hours and London Ambulance Service.

• The provider should make available to the patient and carer a lead clinician as a single point of contact, who can access support from specialist palliative care services when needed.

3.3 Population covered

This service is commissioned for all patients registered with a GP Practice in West London CCG

3.4 Any acceptance and exclusion criteria and thresholds

The service provider should ensure that all patients on the palliative care register are supported to create a care plan either at the patient’s registered practice or in the patient’s own home, as appropriate.

Excludes:
• Patients under the age of 18
• Patients who have not consented.

3.5 Governance requirements

Minimum Workforce Competency

• The service provider must ensure that there are appropriately competent, qualified and trained staff to deliver the specified level of service/intervention in each delivery point
• There must be an appropriately qualified health care professional, named as the service lead who has overall responsibility for ensuring the service is delivered in accordance with the specification
• Staff delivering the service must be trained on all appropriate policies relating to the delivery of the Supportive Care-Last Phase of Life service

Minimum clinical governance requirements

• The provider should ensure that all delivery points meet CQC requirements for the delivery of medical services which as a minimum should be those required for the delivery of general medical services
• The provider should ensure that all standards of communication should adhere to Caldicott and Data Protection guidelines
• The service provider must ensure that staff are CPR trained (adults and paediatrics) when they start to provide the service and should attend annual refresher training thereafter
• The service provider must ensure that staff delivering the service must have undergone the relevant DBS checks before delivering the service.
• The service provider should comply with commissioner requests for clinical audit.
• The service provider must ensure that staff have access to re-fresher training as required to maintain clinical competence in delivering the specified service.
3.6 Interdependence with other services/providers

Better symptom control and carer support can be achieved by a multi-disciplinary approach and improved anticipatory care, enabling all professionals involved in the care to work together as a team and have access to the patient’s care plan at all times. This includes patients with cancer and non-malignant conditions such as severe heart failure, COPD, long-term neurological conditions, severe frailty and dementia.

The service provider will be expected to work in close partnership with a range of health and social care providers, including:

- End of Life and Palliative Care teams
- Secondary Care teams
- Macmillan Nurses
- District Nursing and Community Teams
- Hospices
- London Ambulance Service
- Social Care Teams

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

- NHS England Standard General Medical Services Contract
- Relevant NICE standards:
  - NICE quality standard: End of life care for adults (QS13)
  - NICE guideline: Care of dying adults in the last days of life (NG31):
    https://www.nice.org.uk/guidance/ng31

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

- The GSF Prognostic Indicator Guidance – National GSF Centre for Palliative Care
- The Gold Standards Framework (GSF)

4.3 Applicable local standards

Locally defined, general requirements for providers

Service providers will need to confirm compliance with the standards below:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Applicable service category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider is CQC registered with no relevant conditions</td>
<td>All</td>
</tr>
<tr>
<td>Practice has an open list.</td>
<td>General Practice</td>
</tr>
<tr>
<td>Same day appointments are available for patients clinically assessed as requiring them.</td>
<td>All</td>
</tr>
<tr>
<td>Provider must be fully compliant with the Accessible Information Standard</td>
<td>All</td>
</tr>
</tbody>
</table>
Provider must ensure that all staff are aware and can access interpretation and translation services for patients who are non-English speaking during service operation hours. All

Provider shares information with commissioners to support quality improvements (subject to IG rules). All

Provider actively collects, analyses and acts on feedback from patients and carers. All

Provider must operate an accessible complaints procedure that is consistent with the principles of the NHS complaints procedure. They will report anonymised details of each complaint, and the manner in which it has been dealt with, to the commissioning CCG. All complaints must be audited in relation to individual staff so that, where necessary, appropriate action can be taken. General Practice

Practice participates in clinical audit cycles and peer review external to their practice. General Practice

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-D)
See Appendix 1

5.2 Applicable CQUIN goals (See Schedule 4E)
Not applicable

6. Location of Provider Premises

- The service provider’s delivery points should be from sites where GMS, PMS and APMS services are delivered, and where the primary function of the APMS contract is for the delivery of primary medical services.
Appendix 1: Outcomes and Measurement

Outcomes

The overall aims of the service are to ensure that:

- GP Practice palliative care registers are maintained at 0.3% of the registered population (measured across the year)
- There is earlier identification of people approaching their last phase of life
- There is advance care planning in line with the Gold Standards Framework
- People have their care, and ultimately death, in their preferred place wherever possible.

Pricing

Practices will be paid £1.00 per weighted patient for maintaining their register at 0.3% of the registered population (measured across the year) and completing the templates in line with the specification. This means that they need to manage any in-year risk associated with changes in practice list size and regularly review patients to ensure that all patients who can benefit from the appropriate care have the opportunity to access this.

For an average list size of 5000 patients, it is expected that practices will have at least 15 patients on the palliative care register.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Calculation</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case finding of suitable patients for supportive care.</td>
<td>226,958* x £1.00</td>
<td>£226,958</td>
</tr>
<tr>
<td>Advanced planning discussions with patient and carer.</td>
<td>*WLCCG weighted patient list at 1.10.16</td>
<td></td>
</tr>
<tr>
<td>Regular review of needs assessment*.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communications, care planning and co-ordination with other services in final days of life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>£pwp</td>
<td></td>
<td>£1.00</td>
</tr>
</tbody>
</table>

*At least once in each year of the service in accordance with the Gold Standards Framework, and ideally much more regularly in line with patient needs
Practices will achieve payment for the service in any given year by providing the following:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Evidence Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients identified on the practices register*. This must include figures for age, gender and ethnicity to help tackle ‘hidden carers’</td>
<td>Figures submitted by Practice via CCG collection template</td>
</tr>
<tr>
<td>Number of patients on the register provided with an advance or ‘anticipatory’ care plan</td>
<td>Figures submitted by Practice via CCG collection template</td>
</tr>
<tr>
<td>All patients on register regularly reviewed, with the ‘GSF indicator stage Coding’ completed on every patient to prioritise changing need**</td>
<td>Figures submitted by Practice via CCG collection template</td>
</tr>
<tr>
<td>Co-ordination and information sharing with other services to support patients in their last year of life</td>
<td>Self-Declaration by Practice via CCG collection template</td>
</tr>
<tr>
<td>Details of the identified Practice Lead for End of Life</td>
<td>Name and role, via CCG collection template</td>
</tr>
</tbody>
</table>

*Must be at least 0.3% of the Practice’s registered population (measured across the year)

**At least once in each year of the service in accordance with the Gold Standards Framework, and ideally much more regularly in line with patient needs
Appendix 2

Prognostic Indicator Guidance, The Gold Standards Framework Centre In End of Life Care

This guidance aims to clarify the triggers that help to identify patients who might be eligible for inclusion on the register (supportive/palliative care/ GSF/ locality registers). Once identified and included on the register, such patients may be able to receive additional proactive support, leading to better co-ordinated care that also reflects people’s preferences.

The full guidance for clinicians to support earlier recognition of patients nearing the end of life can be found at the following website: