Better Bolton

BOLTON QUALITY CONTRACT

Primary Care Work Programme
2015-2016

April 2015

Bolton Clinical Commissioning Group
Foreword

The National Health Service (NHS) is facing unprecedented pressures. Demand for services is growing, at a time when funding for the health service is relatively static. A significant change has to occur to health care provision to make the NHS sustainable for future generations.

An increasing share of NHS spend has been allocated to hospital care in recent years. Consequently, there has been a reduced percentage spend on Primary Care. This is at a time when demand on General Practice is growing inexorably. NHS Bolton Clinical Commissioning Group (CCG) is addressing this situation, by introducing a significant extra investment into Primary Care, despite the finite resource available. This extra resource will be largely used to increase staffing across the workforce.

The total new investment for 2015-2016 is £3.4 million. The intention is that the Bolton Quality Contract will release savings over the course of this year, at least equal to the new investment.

The aim of the Bolton Quality Contract is to deliver an improvement in the quality of services, better health for the population of Bolton, and increased value for the NHS pound. Patients will experience a more accessible service and a consistent offer across all Practices.

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Clinical Director – Primary Care Development & Health Improvement
NHS Bolton CCG

Acknowledgement

I would like to thank all the members of the Primary Care Development & Health Improvement Team at NHS Bolton CCG who have been involved in the development of the Contract and production of this document.
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Bolton Quality Contract 2015-16
SECTION 1: BACKGROUND
1.1 Introduction

1.1.1 The vision of NHS Bolton Clinical Commissioning Group (CCG) is to deliver accessible, safe, high quality care for the local population. However, increasing and unsustainable pressures on Bolton’s NHS services mean that this will be unachievable, unless there is a radical transformation. There is a growing consensus that the commissioning and provision of current health and social care is not fit for purpose (NHS England (NHSE), 2013, Ham, 2014).

1.1.2 NHSE (2013) highlights the growing challenges to the current models of Primary Care:

- Ageing population – epidemic of long term conditions, increasing co-morbidity, large growth in consultations for older people
- Rising costs, constrained financial resources, efficiency savings
- Growing dissatisfaction with access to services
- Inequalities in health – access and quality of Primary Care
- Risk factors – unhealthy lifestyles, wider determinants of health

1.1.3 The introduction in April 2013 of new commissioning structures provided a platform for the CCG to begin implementing changes which would make savings, improve productivity and reduce health inequalities. So far, Bolton CCG can report the following outcomes:

- **Improved access** – there is a willingness for collaboration between Practices to provide improved access in the evening and at weekends
- **Reduction in GP elective and non-elective referrals** – focused work on pathways e.g. Heart Failure, Chronic Obstructive Pulmonary Disease (COPD), Tonsillectomy
- **Accident & Emergency (A&E) attendance rates for Bolton’s registered population** – now lower than other Greater Manchester (GM) registered populations

![Comparing CCGs for A&E Attendance Rates](www.primarycare.nhs.uk)

**Graph 1. A&E Attendance rates (Bolton highlighted in red)**
• **Early identification** – increased prevalence on Diabetes, Primary Prevention, Chronic Kidney Disease (CKD) registers

• **Downward trend in incidence of diabetes** – systematic work with people at high risk of diabetes, supported by Health Trainers

### Estimated and Actual QOF Diabetic Register Size

![Graph 2. Trend - diabetes prevalence in Bolton (Bolton CCG, 2014)](image)

- **Reducing alcohol harm** – Bolton GPs have undertaken an industrially scaled programme of AUDIT C (102,000 over 2 years). This remit also includes the adoption of AUDIT 10, Brief Intervention and Health Trainer Interventions as standard Primary Care work

- **NHS Health Checks** – since April 2013 the percentage of health checks done in Bolton on the eligible population (40-74 years, with no existing CVD or diabetes), is the highest in GM, and fifth highest in England

<table>
<thead>
<tr>
<th>Bolton</th>
<th>Bury</th>
<th>Manchester</th>
<th>Oldham</th>
<th>Rochdale</th>
<th>Salford</th>
<th>Stockport</th>
<th>Tameside</th>
<th>Trafford</th>
<th>Wigan</th>
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<td>12.9</td>
<td>10.3</td>
<td>5.1</td>
<td>16.0</td>
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<td>22.2</td>
<td>7.3</td>
<td>11.7</td>
<td>14.2</td>
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Table 1. Numbers of health checks done in GM as a percentage of the eligible population since April 2013 (PHE, 2014)

Primary Care in Bolton has a successful track record for delivering health checks – *BIG Bolton Health Check*. During 2008-2009, 82% of the eligible population had a health check.

Despite these outcomes, NHSE (2013, p.5) suggests that current initiatives in Primary Care have not gone far enough, and there is now an urgent need to implement ‘even bolder and transformative change’. The aim is to enable General Practice to be at the forefront of this transformation, by addressing variation to raise performance.
1.1.4 Unwarranted variation is known to exacerbate inequalities in health (Bolton Council, 2013). Despite a tremendous amount of work over the last 10 years, the health outcomes for Bolton people have not improved significantly enough to equate with average life expectancy in England.

<table>
<thead>
<tr>
<th>England Average</th>
<th>Bolton Average</th>
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<tbody>
<tr>
<td>Men</td>
<td>78.6</td>
</tr>
<tr>
<td>Women</td>
<td>82.6</td>
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</tbody>
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Table 2. Average life expectancy figures – comparing Bolton with England (Bolton Council, 2014)

On average, Bolton people are still living 2 years less than people in other parts of the country. It is expected that by reducing variation, and raising performance across Primary Care, this will support the agenda to improve life expectancy and reduce health inequalities right across the social gradient (Smith et al, 2013).

1.1.5 Delivering a sustainable system, in the face of one of the most challenging financial and organisational environments ever experienced, is a daunting task. This is in the context of a local population, in which the burden of disease and cost of medical and social care is growing. If nothing changes, there will be significant unmet need and threats to quality of care (Naylor et al, 2013).

1.1.6 In order to ensure General Practice in Bolton is prepared, fit for purpose and is able to deliver the necessary transformation, Bolton CCG has developed a new set of Standards, which Primary Care will begin to deliver from April 2015. This is known as the Bolton Quality Contract.

1.2 Support from the CCG

1.2.1 The CCG aims to provide a framework of support for Practices, which will underpin the implementation of the Bolton Quality Contract. As a minimum Practices can expect:

- Individualised, quarterly reports
- Visits to discuss progress
- Data quality support
- Development of templates
- Prescribing support
- Specialist Nurse support
- Education / CCG events
- Calendar to remind Practices of all key events
- Publicity and materials about all the Standards

1.2.2 The level of CCG support, which Practices can expect for each individual Standard, is included in Section 4 of this document.

1.3 Desired outcomes

1.3.1 Improved access to General Practice

- More responsive access
- All Practices open 8.00am. – 6.30pm. Monday to Friday
- Offer minimum contacts – 75 per 1,000 Practice population per week
- Access to both male and female GP
- Children assessed by a Clinician the same day
1.3.2 **Improved health outcomes for the population**

- Early identification through screening and health checks
- Optimum care for those already living with long term conditions
- Referrals made at the right time, using evidence based pathways

1.3.3 **Reduced health inequalities**

- The Key Performance Indicators (KPIs) will reflect Practice population demographics
- Improved support and better care for carers and people with mental health needs

1.3.4 **Reduced variation**

- KPIs set for individual Practices
- Every Practice will be expected to deliver on all Standards

1.3.5 **Support for the CCGs Quality, Innovation, Productivity & Prevention Challenge (QIPP)**

- Reducing demand on Secondary Care services
- Eliminating waste in prescribing

1.4 **Benefits**

1.4.1 **For Bolton people:**

- Opportunity to see a GP when they need to
- Better experience when using General Practice
- Improved health through early intervention and the very best care
- Improved support for healthcare needs, closer to home
- Reduction in wasted journeys from unnecessary hospital appointments

1.4.2 **For Primary Care:**

- Investment to increase staffing capacity, which will meet demand and deliver responsive access and quality services
- A guarantee of Practice income, for 2015-2016. This is at a time when Practice income is under threat from contract negotiations and reviews by NHSE

**References**


Ham, C., (2014) *Reforming the NHS from within Beyond hierarchy, inspection and markets* London: The King’s Fund


NHS England (NHSE), (2013) *A Call to Action: the NHS belongs to the people*

Public Health England (PHE) (2014) *NHS Health Checks* Available at: [www.nhshealthcheck.co.uk](http://www.nhshealthcheck.co.uk)


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SECTION 2: CONTRACT BASIS
2.1 **Introduction**

2.1.1 The aim of the Bolton Quality Contract is to invest in the capacity needed to deliver a consistently higher standard of General Practice across Bolton. This will be delivered through the provision of a guaranteed income per patient, and incentives for delivery of the Standards.

2.1.2 The Contract has been developed using learning from Liverpool CCG, where a similar scheme was introduced. Liverpool Practices successfully increased staffing capacity and delivered measurable improvements in care.

2.1.3 For 2015-2016 Bolton CCG is investing an additional £3.4 million in Primary Care.

2.1.4 The CCG has extensive experience in designing incentive schemes for Practice performance and outcomes.

2.1.5 Locally Commissioned Services (LCS), commonly referred to as Local Enhanced Schemes (LES), that all Bolton Practices currently deliver, are being incorporated into the new Contract. This is in addition to the new investment of £3.4 million. Current Directed Enhanced Services (DES) and Quality and Outcomes Framework (QOF) will remain outside the Contract.

2.1.6 The total investment enables the CCG to set a guaranteed and consistent income level per weighted patient, giving Practices two clear benefits:

- Investment to increase staffing capacity. The aim being to meet rising demand and deliver improved access and better outcomes for patient care
- A guarantee of Practice income for 2015-2016

2.1.7 The Bolton Quality Contract has been developed to:

- Set a step-change requirement in quality improvements
- Support the delivery of the Greater Manchester Strategy for Primary Care 2013
- Reflect the balanced aims of improved population health, better quality and patient experience of care, and value for money
- Incorporate all LCS (except those not routinely provided by all Practices)
- Provide a consistency of offer to Bolton people, no matter which Practice they are registered with
- Meet the commissioning priority of Bolton people for improved access to General Practice

2.1.8 Bolton CCG is the Lead Commissioner for the Bolton Quality Contract. However, Bolton Council and NHS England have supported the development of the Standards.

2.1.9 Recognition of the different demands Practices are under, due to the age and deprivation of their population, is provided by applying the national weighted payment – the Carr-Hill Formula. Locally, peer clustering (based on Practices with similar populations) has been used to determine the performance requirements against each Standard.

2.1.10 The intention is for the Bolton Quality Contract to pay for itself. There is the potential to deliver 100% return on investment in Year 1. There are additional long term benefits to population health, through the prevention and early intervention Standards.

2.2 **Contract basis**

2.2.1 This Contract supports the option for Level 2 of Co-Commissioning. This has been agreed by the Joint Committee. This Committee is made up of representatives from NHS Bolton CCG Executive Team, Bolton Council Public Health, NHS England, Public Health England, HealthWatch, the Clinical Director of Central Manchester CCG, and a Lay Member of NHS Bolton CCG Board. The Chair of the Joint Committee is the Lay Member of NHS Bolton CCG Board.

2.2.2 This Contract will be **mutually dependent** upon the ‘Core’ Contract. This means that only a provider currently offering essential primary medical services to a list of patients under either a General Medical Services Contract (GMS), Personal Medical Services Agreement (PMS) or Alternative Provider Medical Services (APMS) will be capable of providing the services required under the Bolton Quality Contract to that same list of patients. This mutual dependency means that the Bolton Quality Contract may be legitimately commissioned exclusively from local General Practice, as no other provider is appropriate.
2.2.3 The contracting route used to commission this service will be via the NHS Standard Contract 2015-2016.

2.3 **Signing up to the Contract**

2.3.1 Practices who wish to sign up to the Bolton Quality Contract are required to submit the following documents to the CCG:

- Practice Action Plan
- Baseline Staffing Levels
- Project Management Plan
- Investment Plan

The CCG will provide electronic templates for Practices to complete.

2.3.2 Practices will be required to submit the above documents electronically to: lynda.helsby@nhs.net

2.3.3 The CCG will convene an internal panel to review each individual Practice submission. The panel will use set criteria.

2.3.4 The Joint Committee will scrutinise the review process, by examining a sample range of Practice plans.

2.3.5 Before signing up to this Contract, Bolton GPs should consider any potential impact this could have on the way they care for patients, and the manner in which they make decisions on behalf of patient care.

2.3.6 Bolton GPs should scrutinise the evidence on which this Contract is based. This is to satisfy themselves that participation in the Contract will be for the benefit of their patients, and not compromise in any way the standards of care which they currently offer.

2.4 **Payment**

2.4.1 **Current funding**

*From this... ‘core’ £ per weighted patient now versus NHS England intention of £78.66*

[Graph showing current funding to Bolton Practices]
2.4.2 Each Practice commissioned to provide this service will receive the difference between their ‘core’ price per patient and the proposed £95 per head.

2.4.3 The definition of ‘core’ price per patient is as follows:

- **General Medical Services Contracts (GMS)**
  
  This is the weighted list multiplied by the current Global Sum Rate. Temporary resident numbers are added to this plus any adjustment for Minimum Practice Income Guarantee (MPIG). The total is then divided by the weighted list to give the annual price per patient.

- **Personal Medical Services Agreements (PMS)**
  
  This is the PMS allocation, adjusted for removal of seniority, QOF, enhanced services, premises and any KPIs. The resulting baseline allocation is comparable to the basic GMS Global Sum Rate and is then divided by the weighted list to give an initial annual price per patient. Practices which fall below the current GMS rate are uplifted for equity. Practices over £78.66 (the target GMS rate for 2021) have a PMS ‘premium’ calculated. This is applied as an adjustment to reflect phased reduction in PMS funding over the next 4 years.

  Out of Hours (OOH) deductions have not been applied to GMS or PMS annual price per patient.

- **Alternative Provider Medical Services (APMS)**
  
  The annual price per patient is calculated by dividing the element within the contract for essential services by the current weighted list.
2.5 Payment mechanism

2.5.1 Each Practice commissioned to provide the Bolton Quality Contract will receive the difference between their ‘core’ price per patient and the proposed £95 per head. These additional payments will be processed locally by the CCG’s Finance Department.

2.5.2 Payments will be adjusted for list-size changes on a quarterly basis, based on the same principle as current GMS contractual payments.

2.5.3 Payments will be made in advance at the beginning of each quarter, acknowledging that Practices may need to recruit additional workforce from the outset to support delivery of the Contract.

2.5.4 In the first year of Contract delivery, 60% of the additional payment will be guaranteed. This guaranteed income will be paid to Practices in ‘exchange’ for:

- Signing up to the Contract
- Production of a Practice Action Plan that meets CCG and Joint Committee approval
- Implementation of the delivery aspects of the Standards
- Delivery of the mandated elements of the Contract: Membership Engagement, Phlebotomy (including shared care monitoring), Transfer of Care and Emergency Planning

2.6 Payment schedule

2.6.1 Payments will be made on a quarterly basis, as follows:

- By 15th April 2015 20% of the projected annual income per Practice (based on list sizes as at 31st December 2014)
- By 15th June 2015 20% (adjusted for list size changes as at 31st March 2015)
- By 15th September 2015 20% (adjusted for list size changes as at 30th June 2015)
- By 15th January 2016 20% (adjusted for list size changes as at 30th September 2015)

2.6.2 A final balancing payment, or claw-back, will be applied in May 2016 based on achievement of KPIs (using an average of a Practice’s yearly list size). However, in respect of any claw-back, this would apply only to a maximum 40% of a Practice’s additional annual income.

2.7 Payment for achievement (40% of total payment)

2.7.1 In the first year of the Contract delivery, KPIs are worth 40% of the total payment.

2.7.2 KPIs are not ‘all or nothing’ payments. For each KPI, payment will be made for an achievement of 25% or 50% or 75% or 100%.

2.7.3 Each Standard is weighted.

2.7.4 Where KPIs have been met, this will attract an additional payment. The payment will only apply to a proportion of the remaining 40%.
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<td>Annual reviews – Dementia</td>
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<td>Physical health checks – Mental Health</td>
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<td>Physical health checks – LD</td>
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<td>Health check - carers</td>
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<td>Patient Experience</td>
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<td>Patient forum</td>
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<td>Patient survey – recommend your GP</td>
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<td>100% (of 40%)</td>
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Table 3: Potential % achievement payments (of the 40%)

Please note: there are no KPIs with the 4 Mandatory Standards, Membership Engagement, Phlebotomy, Transfer of Care, Emergency Planning
2.8 **Principles for payment of the 40%**

2.8.1 The 40% resource has been allocated to reflect the Triple Aim of:

- Value for money
- Improved population health
- Better quality and patient experience of care

2.8.2 The CCG is committed to continuous improvement in Primary Care. Practices have been given KPIs for 15 of the 19 Standards. The 4 exceptions are the mandated Standards: Membership Engagement, Phlebotomy (including shared care monitoring), Transfer of Care and Emergency Planning.

2.8.3 To determine individual Practice KPIs, Bolton CCG’s established peer cluster methodology has been used. This method takes into account the demographics of individual Practice populations, using age, ethnicity and deprivation IMD scores.

2.8.4 Peer clustering enables the development of a taxonomy of General Practices, to support and encourage performance and quality improvement. It allows comparison of results to be made between true peers.

2.8.5 Peer clustering offers the potential to systematically improve health outcomes on a scale that can enable individual patient quality improvements to add up to a population-level change (Department of Health (DH), 2010).

2.9 **Monitoring**

2.9.1 Practices will be provided with a Data Information Pack by the Data Quality Team. The Pack will describe in detail what needs to be submitted for each Standard.

2.9.2 Practices will be expected to submit quarterly data to the CCG for the following periods:

- April - June 2015
- July - September 2015
- October - December 2015
- January - March 2016

2.9.3 Practices will be required to complete a customised CCG Data Submission Form. Each quarter, when a data submission is due, new forms will be emailed to Practices by the Data Quality Team.

2.9.4 Completed forms should be emailed to the CCG’s dedicated data return email address: BOLCCG.enhancedservicesreturns@nhs.net

2.9.5 Data submissions must be received by the CCG no later than the 5th of the month following quarter end.

2.9.6 Submissions will be sense checked by the Primary Care Data Analyst for completeness. If there are any omissions, it will be the responsibility of the Practice to correct and re-submit to the data return email address.

2.9.7 Late submissions may be approved if there are extenuating circumstances. Any requests for late submission will be dealt with on an individual Practice basis. Requests should be addressed to lynda.helsby@nhs.net, and must be received by the CCG before the deadline stated in 2.9.5.

2.9.8 Late submissions will only be accepted if prior approval has been granted.

2.9.9 The CCG will monitor and analyse the quarterly data submitted by Practices. Reports will be produced by the CCG and sent out to Practices as soon as practically possible. The CCG will need to take into account the availability of data from sources other than Practices, after quarter end.

2.9.10 Individual Practice data will be benchmarked against peer Practices, using Bolton CCG’s established peer cluster methodology.

2.9.11 Practices will be required to keep accurate records for all aspects of this Contract, for post payment verification (PPV) purposes.
2.10 Performance

2.10.1 Review of practice performance against the indicators will be carried out by the CCG, in line with the Contract Review Process laid out in the NHS Standard Contract.

2.10.2 Similarly, the Contract Management Process will follow the stages outlined in the NHS Standard Contract, with regular reference to the Joint Committee. This process recognises the interface between the CCG and NHSE, in terms of the commissioning of Primary Care, and its development and improvement.

2.10.3 The CCG will be required to present regular updates to the Joint Committee and to the CCG Board.

2.10.4 The CCG will be required to provide updates to other stakeholders as requested e.g. NHSE, Bolton Council, PHE.

2.11 Disputes

2.11.1 Wherever possible, disputes relating to KPIs will be resolved locally.

2.11.2 An Appeals Process will be set up with NHSE.

2.11.3 The whole process will be overseen by the Joint Committee. This is a requirement of Level 2 Co-Commissioning.

2.11.4 Appeals from Practices will be considered on an individual basis. Practices will be expected to provide comprehensive evidence to back up their reason for appeal. This evidence will be subject to further analysis by the CCG.

References

Department of Health (DH), (2010) How to develop a taxonomy of general medical practices to support and encourage performance development London

SECTION 3: PRINCIPLES
3.1 **Introduction**

3.1.1 NHS Bolton CCG has developed The Bolton Quality Contract to be a vital ingredient in the steps being taken to impact on the growing pressures of local health and care services. This Contract is intending to underpin the move to co-commissioning of Primary Care services, improve prescribing practice, implement strategies for reducing waste, and achieve cost effective use of clinical resources.

3.1.2 A 9 month period of consultation with local GP Members, has shaped and influenced the development of the Bolton Quality Contract.

3.1.3 The Local Medical Committee (LMC) has been regularly informed during the development stages of the new Contract for Bolton GPs. The views of the LMC have been taken into consideration in relation to the overarching principles of the Contract.

3.1.3 In order to ensure the goals of the Contract are consistent with the obligations placed on Doctors, the views of the General Medical Council (GMC) have been sought. Whilst the GMC has no role in approving Bolton’s scheme, their advice has been welcomed, and taken into consideration.

3.1.4 Recommendations from the GMC have been used to shape these overarching principles for implementation of the Bolton Quality Contract.

3.2 **General principles**

3.2.1 The Bolton Quality Contract will provide additional investment to:

• Improve the quality and consistency of Primary Care
• Improve access to General Practice
• Use NHS resources effectively
• Reduce unnecessary waste
• Improve the health of Bolton people
• Reduce inequalities in health across the town
• Level the playing field in terms of investment in Primary Care delivery of accessible, safe, high quality care for the population of Bolton

3.2.2 The GMC accepts that incentive schemes can be a legitimate way of influencing Doctors’ behaviour, when the aim is to improve quality and safety of care, and encourage the responsible use of resources.

3.2.3 To implement the Contract, NHS Bolton CCG is applying the following core principles:

• Patient safety should not be compromised
• Patients should continue to receive clinical care, specific to their individual needs
• The incentives should not encourage a uniform or blanket approach to all patients with the same condition. GPs should continue to have the flexibility to meet the individual needs of their patients
• Incentives should be paid in relation to outcomes for large groups, or populations of patients
• Incentives should not directly reward decisions relating to individual patients
• The new investment should largely be used to increase staffing capacity across Primary Care, to enable quality improvement

3.3 **Data & information**

3.3.1 Data from various sources will be used to determine individual Practice performance. Data sources include: Practice submissions, Quality and Outcomes Framework (QOF), Service Level Agreement Monitoring (SLAM), Secondary Uses Service (SUS).

3.3.2 Any data that is processed by the CCG, on behalf of Practices, will be managed appropriately and securely. The CCG has already achieved Accredited Safe Haven Status and has been successfully audited to confirm it meets the essential standards of information governance, mandated by the Health & Social Care Information Centre (HSCIC).
3.3.3 Bolton CCG has a culture of transparency. Individual Practice data and achievement is shared amongst all Practices in Bolton, using locally developed reporting mechanisms e.g. Quality Business Intelligence Tool (QBIT), Triple Aim (TA) Sheets.

3.4 Evidence base

3.4.1 In Section 4, each Standard includes a rationale. The rationale includes both the national evidence base and where appropriate, local evidence.

3.5 KPIs

3.5.1 Data, as sourced in 3.3.1, has been used to set performance measures for individual Practices. Individual practice performance will be reviewed quarterly and fed back to Practices via established reporting mechanisms.

3.5.2 The CCG will encourage and support Practices to work towards 100% achievement of all their KPIs. However, the CCG fully supports every Doctor in their obligation to make clinically appropriate decisions, which meet the needs of individual patients.

3.6 Standards of practice

3.6.1 Bolton CCG acknowledges and supports the statutory obligations on GPs, such as those set out in the NHS Constitution, GMC and other regulatory bodies.

3.6.2 A Clinical Quality Impact Assessment (CQIA) has been undertaken on this Contract.

3.7 Equality & diversity

3.7.1 An Equality Impact Assessment (EIA) has been undertaken on this Contract.

3.8 Conflict of interests

3.8.1 Clinical Commissioning Groups (CCGs) manage conflict of interests as part of their day-to-day activities. Effective handling of such conflict is crucial for the maintenance of public trust in the commissioning system. This assures patients, providers, the Government and tax payers, that CCG commissioning decisions are robust, fair, transparent and offer value for money (NHSE, 2014).

3.8.2 Bolton CCG has developed a Conflict of Interests Policy. This policy is part of a suite of important CCG documents necessary to ensure effective governance arrangements for the CCG. All CCG members, clinical directors, clinical leads and senior managers are bound by the Policy and must familiarise themselves with it. The Policy is available at: www.boltonccg.nhs.uk/about-the-ccg/what-we-do/plans-policies-and-reports

3.8.3 Bolton GPs have a duty to identify, address and declare any conflict of interests that may arise from participation in this Contract.

3.8.4 The Board Secretary, on behalf of the CCG Chair, will maintain a Register of Interests declared by all CCG members. The Register can be accessed at: www.boltonccg.nhs.uk/images/RegisterofInterestBoardClinLeadandStaffAug14.pdf

3.8.5 The Register will be refreshed every 3 months and will be checked annually for accuracy. All interests declared in the Register will be published in the CCG’s Annual Report.

3.8.6 Bolton GPs who identify conflict of interests are required to complete a Declaration of Interest Form and send to the CCG for inclusion in the Register. Forms can be requested by telephoning: 01204 462028, or by emailing: joanne.taylor14@nhs.net.
3.8.7 In relation to conflict of interests, NHS Bolton fully endorses the range of obligations set out in Good Medical Practice (GMC) (2013). The obligations include:

- GPs must make the care of their patient the first concern (p. 4)
- GPs must give priority to patients on the basis of their clinical need, if these decisions are within their power (p. 19)
- The investigations or treatment GPs provide or arrange must be based on the assessment made by the GP and the patient, of patient needs and priorities, and on the clinical judgement of the GP, about the likely effectiveness of the treatment options (p. 19)
- GPs must not allow any interests they have to affect the way they prescribe for, treat, refer or commission services for patients (p. 24)
- GPs must not ask for, or accept, any inducement, gift or hospitality that may affect or be seen to affect the way they prescribe for, treat or refer patients or commission services for patients (p. 24) (GMC, 2013)

References

General Medical Council (GMC), (2013) Good medical practice Working with doctors Working for patients Available at: www.gmc-uk.org/guidance/good_medical_practice.asp


SECTION 4: THE BOLTON STANDARDS
4.1 Introduction

4.1.1 For the 2015–2016 Bolton Quality Contract, a set of 19 Standards has been developed, through a 9 month period of consultation with local GPs, Bolton Council, Public Health England (PHE), NHS England (NHSE) and other stakeholders.

4.1.2 The Standards adopt the Triple Aim approach to ensure a balanced focus on population health, value for money and best care. They continue our Primary Care Work Programme objectives of improving access to General Practice, preventing disease where possible, early identification of long term conditions and best care of people with those conditions.

The 19 Standards are:

1. Access
2. Prescribing
3. Demand Management
4. Health Improvement
5. Screening
6. Health Protection
7. Sexual Health
8. Cancer Referral
9. Best Care - Diabetes, Heart Failure (with LVD), Chronic Obstructive Pulmonary Disease (COPD), Asthma, Patients at High Risk of Cardiovascular Disease (CVD)
10. Exception Reporting
11. End of Life Care
12. Emergency Planning
13. Patient Safety
14. Membership Engagement
15. Mental Health, Learning Disability and Military Veterans
16. Phlebotomy
17. Carers
18. Transfer of Care
19. Patient Experience

This section will outline:

- A rationale for each Standard, and why the CCG has included this within the Bolton Quality Contract
- How each Standard should be delivered, and what Practices will be expected to do
- Key Performance Indicators (KPIs). Practice baseline reports will identify the individual KPIs for your Practice
- Key links to supporting evidence for further reading

Our aim, at the CCG, is to support Practices to improve their performance.

4.1.3 The Primary Care Development Team will provide support to Practices when needed. Within each Standard there is an explanation of what support you can expect, to enable you to achieve the desired outcomes.

4.1.4 If you need any additional information about these Standards, the details of a named contact are included within each section.

For any general information regarding the Contract, please contact:

lynda.helsby@nhs.net
**Standard 1. Improving Access to General Practice**

### Rationale

There is significant coverage in the media about how the public struggle to access their GP. Popular stories include difficulties with getting through on the phone, or booking an appointment at a convenient time. Although data from the National GP Survey (Ipsos MORI, 2013) shows that 75% of patients report their overall experience of getting an appointment as good, 13% report having to call back nearer the day they want an appointment, and 10% describe their overall experience of making an appointment as poor. A further 10% of patients who cannot get a convenient appointment, do not then see or speak to anybody else about their health concerns (Rosen, 2014).

A patient’s ease of access to their Practice, and preferred GP, can affect their quality of care and health outcomes (The King’s Fund, 2012). Research suggests that high levels of patient satisfaction with access to Primary Care correlates with higher QOF scores, and also with lower rates of emergency hospital admission (Kontopantelis et al, 2010). Other studies show that inadequate capacity in General Practice can lead to unmet health needs, and also to an increase in demand for Accident & Emergency (A&E), and other hospital services (Rosen 2014).

In 2012–2013, work undertaken as part of NHS Bolton CCG’s Urgent Care Work Programme, to improve access to Primary Care, established that one third of patients attending (A&E) said they could have been treated by their GP. Similarly, when assessed by a GP, two thirds attending specifically with minor illness, could have been dealt with in Primary Care.


### Delivery

**Practices will be expected to:**

1. Provide 10 bookable sessions (am/pm). Out of Hours (OOHs) cover should not be utilised on Wednesday afternoons. Federated arrangements are acceptable to provide cover between Practices.
2. Offer access to both male and female Clinicians (not all 10 sessions). Federated arrangements are acceptable to provide cover between Practices.
3. Be open between 8.00am - 6.30pm. Monday to Friday.
4. Provide a minimum of 75 contacts per 1,000 population, per week. Contacts may be provided by a GP (including a training GP) or Nurse Practitioner, and may be face to face or by telephone.
5. Offer pre-bookable appointments 1 month in advance.
6. Have a process for unplanned or urgent appointments (extras determined by a Clinician).
7. Offer telephone consultations.
8. Ensure children under 12 are assessed by a Clinician same day.
10. Improve on patient survey measures.

### CCG Support

**The Primary Care Development Team will:**

1. Supply and review, in collaboration with the Practice, appropriate data e.g. comparative, A&E attendance, OOHs data, variation data, Patient Survey and other related outcome data.
2. Repeat a further access audit.
### Standard 1. Improving Access to General Practice

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<tr>
<th>Key Performance Indicators</th>
<th>Improve minor A&amp;E attendances in hours</th>
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<td>- Reduce to peer cluster average</td>
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<td>- Or reduce by 10%</td>
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<td>- Or reduce by 1%</td>
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<th>Reduce OOH attendances</th>
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<td>- Or match peer cluster average</td>
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<th>Satisfied with opening hours</th>
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<td>- Exceed peer average by at least 1%</td>
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<td>- Or improve by 10%</td>
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Standard 1. Improving Access to General Practice

References


The King’s Fund, (2011) Improving the quality of care in general practice London

The King’s Fund, (2012) Exploring the association between quality of care and the experience of patients London

CCG Contact – Kathryn Oddi

kathryn.oddi@nhs.net
### Standard 2. Prescribing

#### Rationale

The utilisation of medicines is one of the key interventions that Primary Care can make. There is a finite resource attached to the intervention, and every decision to prescribe carries a clinical risk. Review of clinical risk and outcomes is essential for effective prescribing (Maughan & Ansell, 2014, Webb, 2014).

Bolton CCG supports high quality prescribing by local GPs, which meets the clinical needs of individual patients. However, the CCG also acknowledges the need to change prescribing behaviour, evidenced by local and national guidelines. In 2010, the York Health Economics Consortium & School of Pharmacy (YHEC/School of Pharmacy), (2010, p.6) produced a report which recommended the development of ‘practical interventions which are capable of cost effectively improving drug use, and reducing waste in day-to-day settings’.

In the financial year 2013-2014, 5,974,766 items were issued by Bolton Practices at a cost of over £50 million. Data shows that year on year prescription growth is approximately 3.7%. This represents unsustainable growth in this area of health care. Currently, Bolton CCG spends more per ASTRO PU (average patient) than almost every other CCG in England (NHS Bolton CCG, 2014). In order to address this imbalance, there is a need to focus attention on reducing medicines waste and changing prescribing behaviours.

Bolton CCG is endeavouring to eliminate the prescribing and dispensing of medicines, paid for by the NHS, which are subsequently not taken by patients. This effort should not be construed in any way as an initiative ‘not to prescribe medicines’ which patients need, or just to reduce spend. More importantly, the aim is to develop a culture of cost effective prescribing, which provides real value to individual patients and genuinely improves the quality of their life, or their prospects for recovery.

Reducing waste will enable savings to be used more effectively elsewhere. This process should create a higher value local health care system, where resources can be released from some parts of the system, to support other arenas (Maughan & Ansell, 2014).

#### Delivery

**Practices will be expected to:**

1. Review patients and clinical records to facilitate improvement and change. Part of the review will include identification of non-adherence and waste
2. Undertake audits, to ensure safe and effective prescribing, by identifying patients who may be non-compliant with current medication
3. Prescribe the most cost-effective medicine, in line with national and local strategy and policy
4. Apply CCG standards relating to repeat prescribing processes
5. Attend 3 prescribing educational events per year. A minimum of one GP from each Practice to attend. The educational events will require pre-work, which will need to be submitted and peer reviewed at the event
6. Participate in the Prescribing Development Scheme. Submit the results to the CCG at pre-agreed intervals
Standard 2. Prescribing

CCG Support
The Primary Care Development Team will:
1. Support the Practice and prescribers to review trends in prescribing to facilitate improvement and change. This will include support to identify non-adherence and waste
2. Support the Practice to review current processes and advise potential efficiencies which can be made
3. Supply the Practice with relevant prescribing data and information. Support the Practice to review the data
4. Organise and facilitate educational events, peer reviews and discussions

Key Performance Indicators

Reduction in prescribing spend by the elimination of waste
- Reduce to 75th centile
- Or reduce by 10%
- Or reduce by 1%
(Dependent on baseline data for each Practice)

References

NHS Bolton Clinical Commissioning Group (CCG), (2014) Business Intelligence Team Available on: Telephone 01204 46203

Webb, R., (2014) Improving medicines adherence and reducing waste Pfizer Available at: www.prescqipp.info/info


CCG Contact – Ben Woodhouse
ben.woodhouse@nhs.net
The NHS is not obliged to provide every treatment that a patient, or group of patients, may demand. It does, however, have a statutory duty to take into account the resources available to it, and the competing demands on those resources (Greater Manchester Commissioning Support Unit (GMCSU), 2014). The process for prioritising resource allocation is a matter of judgement. To ensure local resources are used effectively, Bolton CCG has developed pathways which provide referral guidance for Primary Care. GPs are expected to follow these pathways when considering a referral.

In 2011, The Audit Commission reported outcomes from Primary Care Trusts (PCTS) which had considered the clinical effectiveness of treatments to help them decide what to spend their money on, and importantly, what not to spend their money on. The findings suggest that there is value in making sure that fewer treatments with a low clinical value take place, so that resource can be directed towards the delivery of higher value treatments.

There is no single, national list of procedures with limited clinical value (PLCV) to refer to. However, Bolton CCG has followed the guidance contained in the Greater Manchester Effective Use of Resources Operational Policy (EUR) (2014).

When compared nationally at the 50th centile, Bolton performs more PLCVs per 100,000 population. The following table provides information on a small selection of PLCVs. This shows Bolton’s variance from the national position:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Bolton</th>
<th>National</th>
<th>Potential for savings</th>
</tr>
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<tbody>
<tr>
<td>Tonsillectomy</td>
<td>35.77</td>
<td>22.18</td>
<td>£71,562</td>
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<tr>
<td>Hysterectomy</td>
<td>15.07</td>
<td>13.81</td>
<td>£51,090</td>
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<tr>
<td>Myringotomy</td>
<td>17.47</td>
<td>13.25</td>
<td>£36,391</td>
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Table 4: Selection of PLCVs showing variance. Information extracted from: Better Care, Better Value Productivity Dashboard Available at: www.productivity.nhs.uk/PCT_Dashboard

For 2015 – 2016, Bolton CCG is continuing with a Quality and Productivity (QP) Framework. This framework focuses on identifying areas for developing new pathways and service improvement (General Medical Services (GMS), (2013).

The main aims of this work will be to:

- Reduce potential risk to patients (outcome versus risk of procedure)
- Reduce clinical variation between GPs
- Deliver the Government ‘referral to treatment’ target of 18 weeks, by reducing demand on Secondary Care

This is a quality standard which aims to ensure that patients receive the right treatment at the right time. What can be managed in Primary Care, will be.
### Standard 3. Demand Management

#### Delivery

**Practices will be expected to:**

1. Reflect on current referral behaviour within the Practice

2. Use local data to improve referral quality. Identify opportunities to reduce unnecessary hospital attendances

3. Comply with the EUR Policy. Examples include:
   - Benign skin lesions
   - Breast augmentation
   - Elective cardiac ablation
   - Circumcision
   - Grommets
   - Hysterectomy for menorrhagia
   - Knee washout
   - Rhinoplasty
   - Tonsillectomy
   - Varicose veins
   - Vasectomy under GA
   - Wisdom teeth

4. Use DXS (2015) to access pathways and supporting information

5. Complete the 2015 – 2016 QP Project

6. Use Choose & Book when referring, and offer a choice of providers to patients

7. Attend a Bolton CCG QP Event

#### CCG Support

**The Primary Care Development Team will:**

1. Ensure the EUR policy is up to date

2. Ensure DXS is user friendly and includes all the latest pathways and supporting information

3. Provide Practices with data and information

4. Develop and facilitate a peer review event to enable Practices to take part in the QP Project

5. Work with Secondary Care to ensure services are published on Choose & Book, with availability to book appointments

#### Key Performance Indicators

**Reduce referrals for ‘Procedures of Limited Clinical Value’**

- Reduce by 20% (excluding cataract)

**Reduce first outpatient appointment**

- Reduce by 1%

**Reduce follow-up appointment**

- Reduce by 1%
<table>
<thead>
<tr>
<th>Standard 3.</th>
<th>Demand Management</th>
</tr>
</thead>
</table>
| **References** | Bolton Clinical Commissioning Group (CCG), (2014) *Effective Use of Resources* Available at: www.boltonccg.nhs.uk/about-the-ccg/what-we-do/effective-use-of-resources  
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| **CCG Contact – Helen Wright** | helen.wright1@nhs.net |
Standard 4. Health Improvement

1. NHS Health Checks
2. Screening for Diabetes/At Risk of Diabetes
3. Pulse Checks
4. Alcohol

Rationale

The Secretary of State for Health has prioritised reducing premature mortality from cardiovascular disease (CVD) and diabetes through improving prevention and early diagnosis (Public Health England (PHE) 2013). There is an economic and social case to act decisively to improve the health of the population. Diabetes costs the UK economy £14 billion per year with CVD costing £30 billion (Kanavos et al, 2012, NICE, 2013).

Preventing ill health and supporting people to stay well are key priorities identified in Bolton’s Health & Wellbeing Strategy 2013 – 2016 (Bolton Council, 2013)

1. NHS Health Checks

In England, over 4 million people are estimated to have cardiovascular disease (CVD). This is recognised as the largest single cause of long-term ill health, disability and death (DH, 2013). A steep rise in unhealthy behaviours – smoking, physical inactivity, eating a poor diet and alcohol misuse - has led to increasing levels of obesity across all sections of the population. This is magnifying the burden of vascular conditions (Murray et al, 2013).

In 2012, 80,000 deaths were due to coronary heart disease (CHD). It is estimated that 46,000 of these were premature, and could possibly have been avoided (British Heart Foundation (BHF), 2014).

Stroke is a major cause of premature mortality, with more than 12,500 per year being attributable to Atrial Fibrillation (AF). Identifying AF early could prevent 4,500 strokes and 3,000 deaths per year in the UK (Stroke Association, 2014).

Over the last 20 years, the number of people diagnosed with diabetes has increased from 1.4 million to 2.9 million. By 2025, it is estimated that 5 million people will have type 2 diabetes in England (Diabetes UK, 2012).

Over 10.5 million people are drinking at levels which increase their risk of ill-health. Liver disease, linked to alcohol misuse, is fast becoming one of the UK’s biggest killers (British Society of Gastroenterology (BSG), 2010).

There are currently 670,000 people in England living with dementia. By 2025, it is estimated this number will have risen to over 1 million. Delaying the onset of dementia by 5 years would reduce deaths directly attributable by 30,000 a year (DH, 2013).

It is estimated that an effective vascular check programme can prevent 1,600 cases of myocardial infarction (MI) and stroke, 650 premature deaths and identify over 4,000 new cases of diabetes each year (PHE, 2013).

The main cause of Bolton’s life expectancy gap is CVD. Whilst there are signs that early death rates from heart disease, stroke and cancer are falling, Bolton is still lagging behind England averages (Bolton Council, 2013).

Bolton’s ability to perform well in this arena is evidenced by achievement of the BIG Bolton Health Check 2008– 2009. Currently, Bolton’s achievement is within the top 5 Local Authorities in England.
2. Screening – Diabetes & At Risk of Diabetes

Diabetes presents a widely recognised, public health issue. The evidence highlights the need to identify people early. Estimates suggest there are 850,000 people living in the UK who are unaware they have type 2 diabetes (Diabetes UK, 2012).

Bolton’s prevalence of diabetes is higher than both the national and regional averages. Diabetes is very strongly associated with ethnicity. In some of Bolton’s South Asian communities, prevalence is over 16% (Bolton Council, 2013).

3. Pulse Checks (aged 65 years and over)

Atrial Fibrillation (AF) is the most common sustained dysrhythmia, affecting at least 600,000 people in England. It is a major cause of stroke. Every year there are approximately 152,000 strokes in the UK. Most people affected are over 65 (Stroke Association, 2014).

4. Alcohol – AUDIT C, AUDIT 10 & Brief Intervention

Alcohol misuse creates a huge burden on health, in terms of treating alcohol related disease and premature mortality. About 26% of all adults in England, equating to 10.5 million people, are drinking at hazardous and harmful levels (British Society of Gastroenterology (BSG), 2010).

Patients can, quite often, be treated for health problems such as hypertension, depression and anxiety, without ever having the contributing factor of alcohol addressed (Anderson et al, 2009).

Alcohol misuse is associated with a wide range of health problems, including cancer, heart disease and mental problems. It is also associated with a wide range of social problems, such as offending, domestic violence, suicide, deliberate self-harm, child abuse, neglect and homelessness. (All-Party Parliamentary Hepatology Group (APPHG), 2014).

In terms of healthcare provision, alcohol-related ill health is as costly to the NHS as smoking (Anderson et al, 2009). The Institute of Alcohol Studies (2014) estimates the direct costs of alcohol-related harm in England to be £12.6 billion.

Bolton is well above the national average for the prevalence of problem drinking. Digestive diseases, which include cirrhosis of the liver, are amongst the top 5 causes of the life expectancy gap for both sexes in Bolton, when compared to the England average (Bolton Council, 2013).

The Government’s Alcohol Strategy for England 2012 refers to ‘capture points’ for the opportunity to intervene with hazardous and harmful drinkers. Primary Care is viewed as the single most important capture point from the social care system as a whole.
### Standard 4. Health Improvement

#### Delivery

**Practices will be expected to:**

1. Attend a Bolton CCG Health Improvement Event
2. Offer a Bolton NHS Health Check to everyone aged 40-74 years, without existing cardiovascular disease or diabetes

2015 Bolton NHS Health Check criteria:

- **Age**
- **Gender**
- **Ethnicity**
- **Family history of CHD (first degree relative)**
- **BP** – record systolic and diastolic measurement
- **Height** – actual measurement, not patient report
- **Weight** – actual measurement, not patient report
- **Body Mass Index (BMI)**
- **Smoking** – record status
- **Bloods** – lipids, HbA1c, U&Es, LFTs, (as a minimum)
- **Alcohol** – AUDIT C. If a patient scores ≥5, complete AUDIT 10 at the same time
- **Pulse** – check rate and rhythm – to detect AF
- **Physical Activity** – record current levels
- **Dementia** – over 65s – use the screening question on the template

Elements or metrics may be added, to or removed from, the above list, as per guidance from the Department of Health (DH).

2.1 Ensure all staff undertaking health checks are competent to deliver in line with guidance issued by PHE

2.2 Submit data to Bolton CCG quarterly

3. Offer a diabetes screen (HbA1c) to everyone aged 40 years and over, without diabetes
   3.1 Practices who have patients from a South Asian background should offer screening to patients aged 30 years and over
   3.2 Submit data to Bolton CCG quarterly

4. Offer opportunistic pulse checks to patients aged 65 years and over
   4.1 Submit data to Bolton CCG quarterly

5. Undertake AUDIT C on any patient who is 16 years or over, who has not been screened in the last 2 years
   5.1 Offer AUDIT 10 to any patient who scores positive on AUDIT C (5 or more)
   5.2 Offer a brief intervention to all patients who score positive on AUDIT C, at the same time as undertaking AUDIT 10
   5.3 Offer a comprehensive 6 month Health Trainer Intervention where appropriate to any patient scoring 8-15 on AUDIT 10
   5.4 Signpost patients scoring 16-19 on AUDIT 10 to Bolton Integrated Drug & Alcohol Service (BIDAS), and offer the opportunity to make the appointment from the Surgery
   5.5 Signpost patients scoring 20+ on AUDIT 10 to BIDAS, and offer the opportunity to make the appointment from the Surgery
   5.6 Submit data to Bolton CCG quarterly
**Standard 4. Health Improvement**

**CCG Support**

The Primary Care Development Team will:

1. Support Practices with Miquet queries to extract data
2. Support Practices to identify the total eligible practice population
3. Support Practices to identify patients who haven’t had a health check in the last 5 years
4. Support Practices to identify patients who haven’t had an AUDIT C in the last 2 years
5. Support Practices to identify patients who haven’t had a pulse check in the last 12 months
6. Provide support with ad-hoc health check events, where necessary
7. Support Practices to ensure staff undertaking health checks are competent to deliver in line with guidance issued by PHE

**Key Performance Indicators**

**Reduce CVD non-elective admissions**
- Maintain
- Or reduce to peer cluster average
- Or reduce by 10%

(Dependent on baseline data for each Practice)

**NHS Health Checks completed (aged 40-74 years)**
- Achieve 82% uptake

**Numbers screened for diabetes and at risk of diabetes (aged 40 years and over)**
- Achieve 82% uptake

**Number of pulses checked (aged 65 years and over)**
- Achieve 80% uptake

**AUDIT – Screening for alcohol harm (aged 16 years and over)**
- Achieve 50% uptake
Standard 4. Health Improvement

References


British Society of Gastroenterology (BSG), (2010) Alcohol related disease: Meeting the challenge of improved quality of care and better use of resources London

British Heart Foundation (BHF), (2014) [Online] Available at: www.bhf.org.uk


Institute of Alcohol Studies, (2014) Economic Costs Available at: www.ias.org.uk/Alcohol-knowledge-centre/Economic-impacts/Factsheets/Economic-costs.aspx


Public Health England (PHE), (2014) Local Alcohol Profiles Available at: www.lape.org.uk/


CCG Contact – Lesley Hardman

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### Standard 5. Screening

| 1. Breast |
| 2. Bowel |
| 3. Cervical |
| 4. Abdominal Aortic Aneurysm (AAA) |

#### Rationale

In 2011, the Government announced its intention to focus the NHS on improving health outcomes for patients with cancer. They committed to achieve outcomes in England which compare with the best in the world. Current evidence provides some good indications of where to focus the resource to achieve this. Cancer Research UK (2014) highlights the importance of local screening programmes, which are proven to increase the chances of spotting cancers early, saving thousands of lives every year.

Whilst screening programmes are effective at targeting and inviting the right people, there are still large numbers of patients who decline the opportunity to be screened. The NHS Cancer Screening Programme (NHSCSP) (2014) suggests that more could be done on a local level to improve uptake. Pignone (2001) suggests that staff in a Primary Care setting, can encourage patients who are faced with screening decisions, to make informed choices, by providing up-to-date information about the options available.

On a local level, there are approximately 1,350 new cases of cancer diagnosed each year (2007-2009 average). One of the priorities in *Bolton’s Health & Wellbeing Strategy 2013-2016* is to identify more of these cancers earlier. The most plausible drivers for improved survival appear to be diagnosis at an early stage, through effective screening programmes, and access to early treatment (Foot and Harrison, 2011).

**Breast Screening**

Breast screening aims to detect cancer at a very early stage, when any changes in the breast would be too small to feel. For women diagnosed early in England, the chance of surviving for 3 years is better than 99%. However, for those diagnosed at a late stage, this drops to just 27.9% (Cancer Research, 2014).

The latest figures for Bolton show that in 2012-13 average coverage was 74.7% (Health & Social Care Information Centre (HSCIC), 2014).

**Facts and figures:**

- In 2012 there were 11,643 female deaths from invasive breast cancer in the UK
- 78% of adult female invasive breast cancer patients diagnosed in 2010-2011 are predicted to survive 10 or more years
- 27% of breast cancer cases each year in the UK are linked to major lifestyle and other risk factors (Cancer Research, 2014)

**The NHS Breast Screening Programme offers screening every 3 years to all women aged 50 to 70 years.**

**Bowel Screening**

The Bowel Cancer Screening Programme (BCSP) aims to reduce bowel cancer mortality by detecting and treating bowel cancer, or pre-cancerous growths early. More than 90% of people will live for at least 5 years when it is detected early. However, when found late, less than 7% survive for the same period (Cancer Research, 2014). It is estimated that the BCSP will save more than 2,000 lives each year by 2025 (NHSE, 2014).
Currently, Bolton’s screening uptake rate is 51.76%, which compares favourably to the England average, of 52%. However, uptake is variable across Practices, with particularly low uptake in the most deprived ethnic communities (Bolton CCG, 2014).

Facts and figures:
- Bowel cancer is the UK’s 2nd biggest cancer killer
- Over 40,000 people are diagnosed with bowel cancer each year
- Most cases of bowel cancer occur in people aged 60 or over, but bowel cancer can affect people of all ages
  (Cancer Research, 2014)

**The NHS Bowel Cancer Screening Programme offers screening every 2 years to all men and women aged 60 to 74 years.**

**Cervical Screening**

This programme aims to reduce the incidence, and associated mortality, of invasive cervical cancer. If an overall coverage of 80% can be achieved, a reduction in death rates of around 95% is possible in the long term (HSCIC, 2010). Screening is currently offered at different intervals depending on age, allowing the process to be targeted effectively (Sasieni et al, 2003).

Screening intervals are:

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Frequency of screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>First invitation</td>
</tr>
<tr>
<td>25 - 49</td>
<td>3 yearly</td>
</tr>
<tr>
<td>50 - 64</td>
<td>5 yearly</td>
</tr>
<tr>
<td>65+</td>
<td>Only screen those who have not been screened since age 50 or have had recent abnormal tests</td>
</tr>
</tbody>
</table>

Facts and figures:
- In 2011, 3,064 women in the UK were diagnosed with cervical cancer
- In 2013, 63% of patients were predicted to survive 10 or more years
  (Cancer Research, 2014)

**The NHS Cervical Cancer Screening Programme offers screening to all women aged 25 to 64 years.**

**AAA Screening**

The incidence of AAA is increasing, and the prognosis of ruptured AAA remains dismal (PHE, 2014). AAA causes about 2% of all deaths in men over the age of 65 years. A major improvement in operative mortality would have little impact on total mortality, so screening for AAA has been recommended as a solution.

The cost effectiveness of AAA Screening is at the margin of acceptability according to current NHS thresholds. Over a longer period, the cost effectiveness will improve substantially (HSCIC, 2014).

Facts and figures:
- There are around 6,000 AAA deaths each year in England
- Around 4% of men aged between 65 and 74 years (80,000) in England have an AAA
- Mortality rates for vascular disease include death from ruptured AAA
  (PHE, 2014)
### Standard 5. Screening

#### Delivery

**Practices will be expected to:**

**Breast, Bowel, Cervical**

1. Work with the Area Team to support the programme and increase the uptake of screening in the Practice target population
2. Follow up DNAs with individual patients to encourage uptake

**AAA**

1. Review DNA patients
2. Feedback learning to the CCG

#### CCG Support

**The Primary Care Development Team will:**

2. Liaise with the NHS England Area team on behalf of Primary Care when queries arise
3. Support Practices with data and information
4. Develop a template to enable feedback to the CCG

#### Key Performance Indicators

**Breast Screening**

- Achieve peer cluster average +10% (within 3 years)

**Bowel Screening**

- Achieve peer cluster average +10%

**Cervical Screening**

- Achieve 80%

**AAA Screening**

- Review DNA patients and feedback learning to Bolton CCG

#### References


#### CCG Contact – Lesley Hardman

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**Standard 6. Health Protection**

1. Influenza (Flu)
2. Pneumonia

**Rationale**

The *Public Health Outcomes Framework* highlights health protection as one of 3 main pillars for improving and protecting the nation’s health (PHE, 2014).

Annual immunisation programmes are a critical element of the system-wide approach for delivering robust and resilient health and care services throughout the year. This can help to reduce unplanned hospital admissions and pressure on Accident & Emergency Departments (A&E) (DH, 2014).

Immunisation is also the most important way of protecting people from vaccine preventable diseases (DH, 2014).

**1. Flu**

The best way to improve the prevention and management of flu is to increase the uptake of vaccination, especially amongst those in clinical risk groups, and health and social care workers with direct patient contact.

Those at risk include:
- Older people
- Pregnant women
- People with underlying disease, particularly chronic respiratory or cardiac disease
- Children with severe neurological disease or learning disability
- People who are immunosuppressed

**2. Pneumonia**

Pneumococcal disease is caused by the bacterium Streptococcus Pneumoniae (pneumococcus). It is a major cause of disease and death globally, and in the UK.

It particularly affects:
- The elderly
- People with no spleen or a non-functioning spleen
- People with other causes of impaired immunity and certain chronic medical conditions

There are more than 90 different pneumococcal types (serotypes) that can cause disease in humans. More than 5,000 cases are diagnosed each year in England, with the number of cases peaking in December and January (DH, 2014).

**Delivery**

**Practices will be expected to:**

1. Provide access to flu vaccination for people aged 65 years and over
2. Provide access to flu vaccination for people less than 65 years old who are in an at risk group
3. Provide access to pneumococcal vaccination for people aged 65 years and over
4. Have a system in place to follow up DNA
<table>
<thead>
<tr>
<th>Standard 6.</th>
<th>Health Protection</th>
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<tbody>
<tr>
<td><strong>CCG Support</strong></td>
<td>The Primary Care Development Team will:</td>
</tr>
<tr>
<td></td>
<td>2. Provide Practices with peer clustered data and information</td>
</tr>
<tr>
<td><strong>Key Performance Indicators</strong></td>
<td>Flu (65 years and over)</td>
</tr>
<tr>
<td></td>
<td>• Achieve 80% of target group</td>
</tr>
<tr>
<td></td>
<td>Flu (&lt;65 years and at risk)</td>
</tr>
<tr>
<td></td>
<td>• Achieve 60% of target group</td>
</tr>
<tr>
<td></td>
<td>Pneumococcal (65 year and over)</td>
</tr>
<tr>
<td></td>
<td>• Achieve 80% of target group</td>
</tr>
</tbody>
</table>


**CCG Contact – Lesley Hardman**
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Standard 7 | Sexual Health

1. Chlamydia
2. Emergency Contraception/Sexual Health Services

Rationale
The Government has an ambition to improve the sexual health of the population. This will require:

- A reduction in inequalities and improvement in sexual health outcomes
- The development of an honest and open culture where everyone is able to make informed and responsible choices about relationships and sex
- Recognition that sexual ill health can affect all parts of society – often when it is least expected

(Department of Health (DH), 2013)

Chlamydia

Chlamydia is the most commonly diagnosed sexually transmitted infection (STI) in the UK, affecting both men and women. From April 2003 to September 2013, the National Chlamydia Screening Programme (NCSP) delivered over 8,155,500 tests with 535,255 diagnoses made (15-24 year olds) (NCSP, 2014). However, whilst diagnosis rates are increasing, there is still a substantial proportion of young adults becoming infected. As chlamydia often has no symptoms, it can lead to serious long term health consequences:

- Untreated chlamydia can lead to pelvic inflammatory disease, ectopic pregnancy, and in some cases, infertility
- Young people, aged between 15-24 years, should be tested for chlamydia annually, or when they change sexual partner
- Any form of unprotected sex can put a person at risk of catching chlamydia, including oral sex

(DH), 2013)

Opportunistic screening should be established as a fundamental part of sexual health services for young adults (NCSP, 2014). Primary Care can play an important role in encouraging uptake of the screening test, to enable early detection and treatment of asymptomatic infection. This will support the agenda to reduce onward transmission, and the long term consequences of untreated infection.

The National Chlamydia Screening Programme offers screening to young people aged 15-24 years.

Emergency Contraception/Sexual Health

Some elements of sexual health have already improved in recent years, but there are important issues that still need to be addressed:

- Tackle the stigma, discrimination and prejudice often associated with sexual health matters
- Reduce the rate of sexually transmitted infections (STIs) using evidence-based preventative interventions and treatment
- Reduce unwanted pregnancies – ensure that people have access to the full range of contraception
- Support women with unwanted pregnancies to make informed decisions about their options as early as possible
- Tackle HIV through prevention and increased access to testing to enable early diagnosis and treatment
- Promote integration, quality, value for money and innovation in the development of sexual health interventions and services

(DH, 2013)
### Standard 7: Sexual Health

#### Delivery

**Practices will be expected to:**

1. Offer opportunistic or targeted chlamydia screening to all 15-24 years olds
2. Improve chlamydia screening rates within the Practice
3. Provide access to emergency contraception
4. Offer/signpost patients to a full range of contraception and sexual health services

#### CCG Support

**The Primary Care Development Team will:**

1. Provide support to Practices, via the CSU Data Quality Team, to enable the R U Clear process
2. Provide training and education in sexual health related topics

#### Key Performance Indicators

- Register as a screening centre with R U Clear
- Use the electronic form developed by R U Clear
- Screen 15-24 year olds
  - Achieve 5% of target group

#### References


#### CCG Contact – Lesley Hardman

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Standard 8. Cancer Referral

Rationale
In 2011, the Government outlined a framework to focus on improving health outcomes for cancer; recommending that England should achieve comparable outcomes with the best in the world (DH, 2011). Whilst recent trends show survival rates are improving, international comparisons show that England is worse than many other countries including Canada and Australia (Coleman et al, 2010).

To address improved survival, evidence strongly advocates for earlier diagnosis, and timely access to treatment (Foot and Harrison, 2011). GPs have been suggested as pivotal in this arena, and survival rates have been highlighted as a key index of the effectiveness of Primary Care in cancer management locally (Abdel-Rahman et al, 2009).

GPs are expected to be familiar with typical presenting features of cancers, and also alert to the possibility of cancer, when confronted by unusual symptom patterns. Following a systematic review of a patient’s history and then examination, the National Institute for Health and Care Excellence (NICE), (2007) recommends urgent referral within 2 weeks for a ‘suspected cancer’. Since the introduction of this guidance, survival rates for some cancers have greatly improved (Cancer Research, 2014).

Looking to the future, the overall picture for cancer survival is positive. However, in the short term, inequalities still exist. Evidence suggests that some groups are not taking full advantage of the opportunities to improve their health; for whatever reason. Variation, linked to health inequalities, can be seen across Bolton’s Practices (Bolton CCG, 2014). This is in relation to emergency first presentations for cancer and DNAs for appointments under the 2 week rule. The baseline data shows the following variation:

1. Emergency first presentations for cancer: 0.0 – 1.9 (per 1,000 practice population)
2. DNA for 2 week waits: 0.0 – 4.6 (per 1,000 practice population)

Reducing this variation will present challenges for both patients and clinicians alike. Urgent referral can be particularly difficult for some patients because of personal circumstances, such as age, family, work responsibilities, cultural and social issues. Primary Care may need to change established working practices and processes to meet these challenges (Cancer Research, 2014).

Primary Care has a vital role to play in the early diagnosis of cancer (Gordon-Dseagu, 2008). The aim of this standard is to demonstrate progress and impact in Bolton, by reducing cancer incidence, ensuring patients have timely access to treatment and services, and reducing cancer inequalities.

Delivery

Practices will be expected to:

1. Identify a Practice Cancer Lead
2. Develop a system to prevent DNA of 2 week waits (2ww)
   • Process referrals within 24 hours
   • Advise the importance of attendance
   • Provide written information
   • Reminders – telephone, text, letter
   • Check attendance
3. Undertake an audit with learning of 2 cancer diagnoses (particularly emergency presentations) in the last 12 month
4. Feedback learning to the CCG
5. Review patients with a new diagnosis using the Cancer Review Template
Standard 8. Cancer Referral

CCG Support

The Primary Care Development Team will:

1. Share the learning from the Practice audits
2. Develop and facilitate cancer awareness education
3. Develop a patient information leaflet
4. Develop a new diagnosis Cancer Review Template
5. Develop a template to enable feedback to the CCG

The CCG has commissioned a new Cancer and Information Support Service, which will start running in early 2015

Key Performance Indicators

Reduce DNA - 2 week waits

• Reduce DNA for 2 week waits and feedback learning to the CCG

Reduce emergency presentations of cancer

• Review any cancer diagnosis as an emergency 1st presentation and feedback learning to the CCG

Cancer awareness and education session

• Cancer Lead to attend an annual cancer awareness and education session and feedback learning to the Practice

References

Abdel-Rahman M. Stockton, D., Rachet B., (2009), What if cancer survival in Britain were the same as in Europe: how many deaths are avoidable? British Journal of Cancer Vol:100 pp.115–124

Bolton CCG, (2014) Business Intelligence, Primary Care Development Team


Foot C., Harrison, T., (2011), How to improve cancer survival The King’s Fund, London


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Standard 9.  Best Care – Long Term Conditions

1. Diabetes, Heart Failure (with LVD), Chronic Obstructive Pulmonary Disease (COPD), Asthma
2. Patients at High Risk of CVD (≥20%)

Rationale

1. **Best Care Registers – Diabetes, Heart Failure (with LVD), COPD, Asthma**

   Better management of people with Long Term Conditions (LTCs) needs transformational change, both within the system and to the culture and behaviours of NHS staff and patients themselves (DH, 2010).

   There are currently 15.4 million people in England with LTCs. Treatment and care of people with LTCs accounts for 70% of the total health and social care spend in England (DH, 2010). Due to an ageing population, it is estimated that by 2025 there will be 42% more people in England aged 65 years and over. This will mean that the number of people with at least one LTC will rise to 18 million (DH, 2010).

   Management of care for people with LTCs should be proactive, holistic, preventive and patient-centred. There should be an active role for patients, with collaborative personalised care planning and shared decision making. (The Kings Fund, 2013).

   Locally, there are an estimated 297,442 people registered with Bolton GPs (as at March, 2013). Prevalence of LTCs is higher in Bolton than both national and regional averages. A key headline in the Life Expectancy chapter of Bolton’s Joint Strategic Needs Assessment (JSNA) reflects the high levels of morbidity experienced by the local population. These levels are strongly linked with health inequalities and deprivation. (Bolton Council, 2014)

   A local Best Care initiative has been running for over 4 years, and marked improvements in the care of people on LTC registers has been noted. However, Bolton CCG aims to further improve this quality of care.

   A range of indicators has been developed for 4 conditions which will provide clarity and information on the care received by patients on the following registers:

   - Diabetes – 9 indicators
   - Heart Failure (with LVD) – 6 indicators
   - COPD – 6 indicators
   - Asthma – 5 indicators

2. **Patients at High Risk of Cardiovascular Disease (CVD) - ≥ 20%**

   Early identification of people at risk of CVD is a vital component in preventing morbidity and premature mortality from the disease (NICE, 2014). However, positive health outcomes can only be realised if people are subsequently supported to reduce their risk, through changes to behaviour and lifestyle. The latest NICE guidance recommends that high risk individuals should be offered a periodic review, to discuss how to manage their risk factors. This could be a combination of medical intervention and behaviour modification.

Delivery

**Practices will be expected to:**

1. Provide comprehensive annual reviews, and other review sessions as necessary for patients on the 4 Best Care registers
2. Improve the care of patients on the 4 Best Care registers
3. Use the Best Care templates developed by the Data Quality Team
4. Allow access to the Practice System for the Data Quality Team and Primary Care Development Team
5. Provide an annual review for patients ≥20% risk of CVD
6. Use the annual review template developed by the CSU
7. Submit data to Bolton CCG quarterly
### Standard 9. Best Care – Long Term Conditions

#### CCG Support

The Primary Care Development Team will:

1. Support Practices with Miquest queries to extract data
2. Support Practices to identify the total eligible practice population
3. Support Practices to identify patients who haven’t had an annual review in the last 12 months
4. Provide regular updates and visits to individual Practices
5. Offer telephone support as required
6. Provide Specialist Nurse support where necessary
7. Develop a template for high risk reviews

#### Key Performance Indicators

<table>
<thead>
<tr>
<th>Reduce avoidable admissions for Diabetes, Heart Failure (with LVD), COPD, Asthma</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reduce to peer cluster average</td>
</tr>
<tr>
<td>• Or reduce by 10%</td>
</tr>
<tr>
<td>• Or reduce by 1%</td>
</tr>
</tbody>
</table>

(Dependent on baseline data for each Practice)

### Best Care Scores

- **Diabetes**
  - improve to peer cluster average +5%
- **Heart Failure (with LVD)**
  - improve to peer cluster average +5%
- **COPD**
  - improve to peer cluster average +5%
- **Asthma**
  - improve to peer cluster average +10%

### CVD High Risk ($\geq$ 20%)

- Achieve 80% uptake

### National Diabetes Audit

- Participate in the National Audit for Diabetes Care (NADC)

### References

- The King’s Fund, (2013), *Delivering better services for people with long term conditions* London

### CCG Contact – Lesley Hardman

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Standard 10. Exception Reporting

Rationale
The Quality and Outcomes Framework (QOF) allows Practices to exception report (exclude) specific patients from data collected, to calculate achievement scores. Patients can be exception reported from individual indicators for various reasons e.g. newly diagnosed, newly registered with a Practice, if they do not attend appointments or where treatment is judged to be inappropriate i.e. medication cannot be prescribed due to contraindication. The General Medical Services (GMS) contract sets out the criteria which allow Practices to participate in QOF, but not to be penalised where exception reporting occurs (Health & Social Care Information Centre (HSCIC), 2011).

Patient exception reporting applies to QOF indicators where the level of achievement is determined by the proportion of patients receiving the designated level of care. The maximum achievement threshold is not constant across all clinical indicators, but varies between 50% and 90%. Setting upper thresholds below 100% was designed to reduce the risk that GPs would inappropriately treat some patients (Roland, 2004).

Research into the impact of the Quality and Outcomes Framework has shown an association between achievement of QOF indicators and some measurable reduction in costs for mortality outcomes and hospital care. This association is stronger for some QOF indicators than others. In particular, there is a strong link with stroke care (Dixon et al, 2011).

Nationally, in 2012-2013, the overall exception rate for England, across all clinical indicator groups, was 4.1%. This showed a 1.5% point decrease in 2011-2012. However, these findings should be interpreted cautiously. Further decreases might be possible, but only through systematic improvement work in Primary Care (The Health Foundation, 2010).

In Bolton, for 2015-2016, 3% has been approved as the Bolton threshold. This level was agreed taking into account that 19 Practices (38%) are already comfortably working within this threshold.

Delivery
Practices will be expected to:
1. Ensure the Practice has a policy in place for exception reporting

CCG Support
The Primary Care Development Team will:
1. Supply individualised and peer clustered data
2. Share local learning to support the Practice to achieve the KPI

Key Performance Indicators
Develop an exception reporting policy
- Maintain 3% clinical or below
- Reduce to 3% or below

(Dependent on baseline data for each Practice)

References

Health & Social Care Information Centre (HSCIC), (2011) Quality and Outcomes Framework - 2010-11, Exception reporting Available at: www.hscic.gov.uk/qofexcep1011


CCG Contact – Kathryn Oddi
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**Standard 11. End of Life Care**

**Rationale**

“You matter because you are you, and you matter to the end of your life” (Dame Cicely Saunders cited in NHSE, 2014).

The first national *End of Life Care Strategy* (2008) generated significant momentum to reverse the upward trend of people dying in hospital. However, there is still much to build on. There is inequity of access to high quality care for those whose needs are harder to define, or those who may be disadvantaged for a variety of reasons. Inconsistencies in care can lead to erosion of trust and confidence in professionals and the system (NHSE, 2014).

Current evidence suggests there is going to be an inexorable rise in the numbers of people with chronic disease. A 17% increase in the actual number of deaths in England is forecast by 2030 (Leadership Alliance for the Care of Dying People (LACDP), 2014).

End of life care in the UK is estimated to cost around £460 million, and yet there are still gaps and inefficiencies in the scope and delivery of care (NHSE, 2014). The Voices Survey of the Bereaved (2013) illustrates that Primary Care significantly underperforms when it comes to pain control, co-ordination of care and respecting preferences of the dying patient. The Government review of the Liverpool Care Pathway (2013), highlights significant issues specifically around communication with patients and families, coordinated care, and the need for education and training.

*The Quality Standard for End of Life Care* (NICE, 2011) provides a comprehensive picture of what high quality end of life care should look like. Taking into account the current needs of the population and the changing health and social care landscape, NHS England (2014) has developed a 5 year vision for end of life care beyond 2015. This strategy focuses on ‘dying well’, wherever it occurs, with Primary Care being identified as a key stakeholder.

*Bolton’s Health & Wellbeing Strategy 2013-2016* focuses on positive health outcomes right across the life course. Improving end of life care is identified as a key priority (Bolton Council, 2013).

**Delivery**

**Practices will be expected to:**

1. Identify a Practice End of Life (EOL) Lead
2. Hold a monthly Gold Standards Framework (GSF) meeting. This meeting should be led by the EOL Lead who may wish to invite relevant stakeholders e.g. the District Nurse
3. Complete the End of Life template for patients on the GSF
4. Use prognostic indicator guides to improve detection of non-cancer end of life patient

**CCG Support**

**The Primary Care Development Team will:**

1. Develop and facilitate education sessions around EOL care and communication training
2. Provide resources around prognostic indicators
3. Develop an EOL/GSF template
4. Develop a template to enable feedback to the CCG
**Standard 11.**

**End of Life Care**

**Key Performance Indicators**

Reduce avoidable non-elective admissions

- Review patients on GSF who die in hospital and feedback learning to CCG

Communications and DNACPR training

- EOL Lead to attend an annual training session and feedback to the Practice

**References**


Dying Matters (2014) [Online] Available at: [www.dyingmatters.org](http://www.dyingmatters.org/)


National Institute for Health & Care Excellence (NICE), (2011) *Quality Standard for End of Life Care for Adults* Available at: [www.nice.org.uk/guidance/qs13](http://www.nice.org.uk/guidance/qs13)


**CCG Contact – Tarek Bakht**

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### Standard 12. Emergency Planning

#### Rationale
The Civil Contingencies Act (CCA) (2004) replaced existing legislation (Emergency Powers Act 1920, Emergency Powers Act (Northern Ireland) 1926), to enable emergency power provisions to extend to the whole of the UK. This Act provides a modern definition of what constitutes an emergency; incorporating new risks and threats, which were not relevant in the 1920s, such as terrorist attacks, contamination following biological or chemical attack, and loss of communication systems.

NHS England, NHS CCG Trusts and Foundation Hospitals are all Category 1 responders under the terms of the 2004 Act. They have a duty to ensure that organisations delivering services on their behalf e.g. contracted out services, can deliver, even in the event of an emergency. All services remain part of an organisation’s functions, even if they do not provide them directly (HM Government, 2004).

GP surgeries are independent businesses, providing services to the local community on behalf of NHS England and their local CCG. All businesses are required to develop plans, so that they can continue to function in the event of an emergency, for their own benefit, and that of their customers and suppliers. This is known as Business Continuity Planning.

NHS Bolton CCG is legislated to ensure that all its services, such as GP surgeries, have adequate, and up to date, Business Continuity Plans.

#### Delivery
**Practices will be expected to:**

1. Provide a Business Continuity Plan to the CCG, that includes a process for emergency prescribing
2. Provide support to rest centres if and when required

#### CCG Support
**The Primary Care Development Team will:**

1. Develop a template for Business Continuity Planning, to be installed on the Practice system

#### Key Performance Indicators
**Submit Business Continuity Plan to the CCG**

- By September – plan to be revised annually

#### References

**CCG Contact – Lynda Helsby**

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### Standard 13. Patient Safety

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<td>Incident reporting</td>
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<td>2.</td>
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#### Rationale

Improving patient safety in the UK will require a cultural change within the healthcare system. A true safety culture is one in which every person in the organisation recognises their responsibility towards patient safety, and works to improve the care that they deliver. This is the essence of clinical governance (NHS National Patient Safety Agency, (NPSA), (2014).

This standard aims to build a culture of safety for Primary Care in Bolton.

1. **Incident reporting**

   It is widely recognised that mistakes and incidents will happen, and that healthcare is not without its risks. Evidence shows that if the culture of an organisation is safety conscious, and people are encouraged to speak up about mistakes and incidents, then patient safety and care can be improved (Vincent, 2001). NHS incidents are defined as any unintended or unexpected episode which could have, or did, lead to harm for one or more patients receiving NHS-funded healthcare (NHSE, 2013).

   Incidents in Primary Care are uncommon, but when they do occur GPs have a responsibility to ensure there are systematic measures in place for safeguarding people and NHS reputation (NHSE, 2013). Recent research has highlighted 4 main areas of concern - diagnosis, prescribing, communication and administration (NHS National Patient Safety Agency, (NPSA), 2014). Whilst this research has given some insight into the breadth of incidents, it acknowledges the need for more accurate assessment of the number and severity of patient safety incidents (Sanders & Esmail, 2001).

   The cause of incidents cannot simply be linked to the actions of individual people. Adoption of a framework, using a system wide perspective for notification, management and learning from serious incidents, will support openness, trust and continuous learning and service improvement. (NPSA), 2010).

   On-going increases in the number of reported safety incidents, especially near misses or no harm incidents, reflect an improving safety culture. However, under-reporting continues to be a major obstacle, particularly in Primary Care (The King’s Fund, 2014).

2. **Safeguarding**

   Safeguarding means the protection of health, wellbeing and human rights, and enabling people to live free from harm, abuse and neglect. This is a key part of high quality, health and social care (The King’s Fund, 2014).

   Mandatory training on safeguarding, of both children and adults at risk, should be provided for all NHS staff, to enable them to evidence core competences, key knowledge, skills, attitudes and values (Royal College of Paediatrics & Child Health (RCPCH), 2014). GP Practices are likely to be compliant with Care Quality Commission (CQC) requirements on safeguarding if all staff have had training, appropriate to their role (British Medical Association (BMA), 2013). The General Medical Council (GMC), (2012 pg.10) states that ‘Doctors must be competent and work within their competence to deal with child protection issues. They must keep up-to-date with practice through training that is appropriate to their role’. The Royal College of Paediatrics & Child Health (RCPCH), (2014) recommends that Practices develop a safeguarding plan and identify a child health and safeguarding lead. The role will:

   - Act as first point of contact for colleagues with safeguarding concerns
   - Act as local champion for safeguarding best practice
   - Produce reports as requested Children’s Social Care Child Protection Unit
   - Disseminate relevant information to the practice

   Primary care has a duty to cooperate with current legislation, and this is reinforced within the GMC guidance regarding working jointly with other agencies. This includes participating in child protection procedures and information sharing (with and without consent) (GMC, 2012).
Standard 13. Patient Safety

Delivery

Practices will be expected to:

Incident reporting

1. Submit 3 clinical incidents per substantive Clinician (GP, Nurse Practitioner, Practice Nurse (> 0.5 WTE,) using the CCG electronic reporting tool
   • 2 incidents should be related to work in Primary Care and 1 from the interface with another health care setting or provider
   • These incidents can be in any of the 4 main areas previously mentioned - diagnosis, prescribing, communication or administration

2. Identify a Safety Champion who will attend a Quality and Safety Event to discuss and disseminate key findings and contribute to action planning and developments throughout the year

Safeguarding

1. Provide access to safeguarding training for all staff at a level appropriate to their role

2. Identify a Safeguarding Lead who will attend the annual CCG Safeguarding Event and disseminate the information within the Practice

3. Produce reports as requested by Children's Social Care Child Protection Unit for initial and review Child Protection Conferences

4. Contribute to information sharing processes in the event of death or significant harm of a child or adult on their list

5. Provide assurance of improved outcomes based on implementation of recommendations from serious case reviews, safeguarding adult reviews, domestic homicide reviews

CCG Support

The Primary Care Development Team will:

1. Provide a web reporting tool for submission of incidents

2. Arrange an annual Quality and Safety Event

3. Arrange an annual Safeguarding Event

Key Performance Indicators

Number of incident reports

- Submit at least 3 incidents per substantive clinician per year
- Safety Champion to attend CCG event and feedback to Practice
- Safeguarding Lead to attend CCG event and feedback to Practice
- All staff to undertake annual training appropriate to their role
# Standard 13. Patient Safety

## References

- **British Medical Association (BMA)**, (2013) *CQC registration – what you need to know* Guidance for GPs London
- **General Medical Council (GMC)**, (2012) *Protecting children and young people The responsibilities of all doctors* Available at: [www.gmc-uk.org/static/documents/content/Child_protection_-_English_0712.pdf](http://www.gmc-uk.org/static/documents/content/Child_protection_-_English_0712.pdf)
- Sanders, J., Esmail, A. (2001) *Threats to Patient Safety in Primary Care. A review of the research into the frequency and nature of error in Primary Care*. University of Manchester

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**CCG Contact – Michael Robinson**

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Standard 14. Membership Engagement

Rationale
NHS Bolton Clinical Commissioning Group (CCG) is a membership organisation, incorporating 50 GP Practices. The CCG has a formal constitution which lays down a clear governance structure, demonstrating how the CCG will exercise its functions effectively, efficiently, economically and in accordance with accepted, good governance principles.

Each of the 50 GP Practices has identified a Commissioning Lead to sign up to the CCG’s Constitution, on behalf of their Practice. By signing up, the GP Commissioning Lead is expected to represent their Practice’s views, and act on behalf of the Practice, in matters relating to the group.

The role of each GP Commissioning Lead is to:

• Ensure communication and engagement with the CCG on behalf of the Practice to define priorities and work programmes, share information and develop ideas for commissioning services
• Ensure two way communications between the CCG, Governing Body and the wider Practice Team including provision of response from the Practice on surveys, and act as signatory on formal documents requiring responses to the Governing Body
• Represent their Practice at Annual General Meetings (AGMs). Deputies may be used with prior agreement through the Secretary of the Governing Body

Delivery

Practices will be expected to:

Practice engagement

1. Attend (a GP) at least 10 of the 12 CCG Clinical Leads meetings and feedback to the Practice Team
2. Send 2 representatives (at least 1 GP) to CCG events
3. Engage with the Primary Care Development Team

Referral management/pathways

1. Use Choose and Book for all referrals, whenever possible
2. Use the standard referral templates where they are in place, and as agreed by the membership organisation
3. Allow a review of referrals by peer GPs (via Referral Management and Booking Service (RMBS))
4. Ensure compliance with CCG Primary Care pathways and Effective Use of Resources Policy (EUR)

Urgent Care

1. Engage in the Primary Care access audit

Audit and data submission

1. Undertake 2 clinical audits (each to be determined). Each audit should take no longer than 1 session (4 hours)
2. Submit quarterly data, to timescales organised by the CCG Primary Care Development Team
### Standard 14. Membership Engagement

**CCG Support**

- The Primary Care Development Team will:
  1. Develop and produce a calendar, to include all dates for education sessions, events, training and meetings.
  2. Communicate documentation e.g. agendas/papers for CCG events.
  3. Produce summaries/notes/information to support internal feedback.
  5. Support Practices to access and use DXS.
  6. Notify Practices about referral reviews and provide feedback at Clinical Lead meetings.
  7. Provide data to support audits.
  8. Offer advice and support to improve access.

**Key Performance Indicators**

- **Attendance at Clinical Leads meetings**
  - Attend at least 10 out of 12 meetings.
  - Attend CCG education sessions.

- **Attendance at CCG events**
  - Attend 3 events per year.

- **Participate in audits**
  - 2 audits per year.

- **Submit data to CCG**
  - As requested and to pre-arranged timescales.

**References**


**CCG Contact – Helen Wright**

helen.wright1@nhs.net
<table>
<thead>
<tr>
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<td>1. Dementia</td>
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**Rationale**

Over the last 65 years, the NHS has helped deliver dramatic improvements in the health and wellbeing of the population. However, England still lags behind internationally, in the identification of, and access to treatment for, mental ill health. Every year, 1 in 4 adults, and 1 in 10 children, experience a diagnosable mental health problem. This is the single, largest cause of disability in the UK (Royal College of Psychiatrists (RCP), (2013)).

Improvement in this arena will require a fundamental change to the culture of healthcare, and in the way services are commissioned and provided. This will mean moving towards a culture where mental health and physical health are valued equally. This is known as parity of esteem (NHS England (NHSE), 2014). Primary Care will need to adapt quickly to embrace this culture of parity.

People with mental illness are at increased risk of the top 5 killers: heart disease, stroke, liver disease, respiratory disease and some cancers. This will require a holistic approach; tackling poor physical health at the same time as addressing mental health disorders. Average life expectancy in England is 79 for men and 83 for women. However, for people with mental ill health, average life expectancy is 68 and 73 respectively (Office for National Statistics (ONS), 2012).

Primary Care has a key role to play in achieving parity of esteem for physical health and mental health. This should support improved health outcomes, through annual health checks and screening, enhanced patient and carer experience, and a reduction in health inequalities (NHSE, 2013).

1. **Dementia**

In 2010, the Department of Health prioritised dementia through the Prime Minister’s 3 Year Challenge. The challenge was to diagnose earlier, drive improvement in care, create dementia friendly communities and improve research. In early 2015, this vision will be updated with the publication of a new domestic policy on dementia to 2020 (Alzheimer’s Society, 2014).

Current estimates suggest there are 850,000 people living with dementia in the UK today (King’s Fund, 2015). In 2011, The Health Foundation calculated there would be over 1 million by 2020. The cost to the UK economy for dementia is rising year on year, with current expenditure standing at £23 billion. This figure is expected to treble by 2040 (Department of Health (DH) 2013).

Primary Care should be the first point of contact for diagnosis of dementia, and subsequently, be the main healthcare provider (Villars et al (2010) cited in Connolly et al, 2012). Dementia diagnosis constitutes only a small proportion of the Primary Care workload; averaging only 1 or 2 new cases a year per GP surgery. As the population rapidly ages, this situation will undoubtedly change (Iliffe et al, 2009). Presently, there is insufficient evidence of benefit to justify population screening (Lafortune, 2013, cited in Alzheimers Society, 2104). However, several documents highlight the significant role which Primary Care can play to increase diagnosis rates, by recognising early signs and symptoms. (Royal College General Practitioners, (RCGP), (unknown date), DH, 2014). A key recommendation to come out of UK dementia policy is the fact that everyone who works in Primary Care has an important part to play, including receptionists. This will mean all staff having access to dementia education, which is consistent with their roles and responsibilities (DH, 2014).

Current guidelines require GPs to annually review, both the physical and mental health needs of patients with dementia, who are registered with their practice. (NICE, 2007). Evidence suggests that although the number of people in the UK recorded as having a review is high, the quality of these reviews is, on the whole, suboptimal (Connolly et al, 2012b).
Standard 15.
Mental Health, Learning Disability and Military Veterans

2. Learning Disability

People with learning disabilities (LD) have complex health needs. Mental ill health, cardiovascular disease, diabetes, and epilepsy, are amongst many conditions which are more common in people with LD. Yet, this group are less likely to receive regular health checks and access routine screening e.g. cervical, breast and bowel (Royal College of General Practitioners (RCGP), date unknown), (Houghton, 2010).

People with LD have a shorter life expectancy, compared to the general population (Emerson and Baines, 2010). Avoidable deaths, from causes amenable to change by quality health care, were more common in people with LD (37%), than in the general population of England and Wales (13%) (Heslop et al, 2014). These health inequalities have also been highlighted in a number of documents (Disability Rights Commission (DRC), 2006; Mencap, 2007; Emerson et al, 2011).

The interaction of physical, behavioural and mental health issues can be difficult to interpret, causing illness to be over-looked. This diagnostic overshadowing may lead to some GPs not investigating early enough, as they rationalise new symptoms as part of the learning disability, rather than the needs of the whole person (Mason, 2004, cited in Houghton, 2010). In 2008, annual health checks for adults with LD were introduced by the Government. However, recent research has shown that less than half of those entitled to a health check get one, and there are concerns around quality and consistency (Heslop et al, 2014).

In Bolton, the aim is to standardise annual health checks, and to develop a clear pathway between the check and subsequent care plan. Improving the quality of health checks and increasing screening rates for people with LD will:

- Improve health outcomes
- Improve access to prevention
- Develop improved relationships with Primary Care staff

3. Military Veterans

The Armed Forces Covenant (HM Government, 2011) sets out the relationship between the nation, the government and the Armed Forces. This document explains about removing disadvantage, so that the Armed Forces can get the same outcomes as the civilian community. In terms of the NHS this means the Armed Forces community, including Reservists, should enjoy the same standard of, and access to healthcare, as received by any other UK citizen. Veterans and Reservists should receive routine healthcare from their local NHS. However, they should receive priority treatment whenever it relates to a condition resulting from their service in the Armed Forces, subject to clinical need.

To enable Primary Care to adhere to the requirements of The Armed Forces Covenant, the status of 'Military Veteran' or 'Reservist' should be recorded in the Practice system. A Veteran is classed as someone who has served at least one full day in the armed forces (HM Government, 2011).
### Standard 15. Mental Health, Learning Disability and Military Veterans

#### Delivery

**Practices will be expected to:**

1. Undertake opportunistic dementia screening
   - 1.1 Use a screening tool as specified by the Practice e.g. 6 Item Cognitive Impairment Test (6CIT), Mini Mental State Exam (MMSE), GP Assessment of Cognition (GPCOG)
   - 1.2 Submit data to Bolton CCG quarterly
2. Undertake comprehensive annual reviews for all patients on the dementia register
   - 2.1 Use the locally developed template on the Practice system
3. Offer annual health checks to all patients on mental health and learning disability registers
   - 3.1 Ensure all staff undertaking health checks are competent to deliver
   - 3.2 Use the locally developed template on the Practice system
   - 3.3 Submit data to Bolton CCG quarterly
4. Offer access to screening initiatives to all eligible patients on mental health and learning disability registers
5. Participate in the Learning Disability Self Assessment Framework (LDSAF)
6. Record Armed Forces Veterans & Reservists on the Practice system
   - 6.1 Comply with the requirements of the Armed Forces Covenant and ensure high quality responsive services for Veterans, Reservists and their families

#### CCG Support

**The Primary Care Development Team will:**

1. Develop templates for health checks for patients on mental health, dementia and learning disability registers
2. Support Practices to run LDSAF

#### Key Performance Indicators

**Improve dementia prevalence**
- Achieve 70% of expected prevalence

**Comprehensive annual reviews for patients on dementia registers**
- Achieve 80%

**Physical health checks for patients on LD and mental health registers**
- Achieve 80%

**Practice to allow LDSAF to be run by Data Quality Team**

**Record the status of Military Veterans and Reservists**
- Report numbers to the CCG
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<tr>
<td></td>
<td>Department of Health (DH), (2014) <em>Dementia Revealed What Primary Care needs to know</em> London</td>
</tr>
</tbody>
</table>
**Standard 15. Mental Health, Learning Disability and Military Veterans**


- Royal College of General Practitioners (RCGP), (date unknown) *Dementia: diagnosis and early intervention in Primary Care* London

- Royal College of Psychiatrists (RCP), (2013) *The financial case for reinvesting in mental health* Available at: www.rcpsych.ac.uk/pdf/Bridging_the_gap_summary.pdf


### CCG Contact – Lesley Hardman

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**Standard 16. Phlebotomy**

<table>
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<th>Rationale</th>
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<tr>
<td>Effective and efficient phlebotomy services are crucial to the delivery of 70% of all clinical interventions since they affect diagnosis, treatment and long term monitoring of care (NHS Improvement, 2011). Phlebotomy services can be provided by a range of healthcare professionals in a wide variety of settings. Wherever an NHS service is provided, it is recommended that patient needs are considered to ensure samples are taken as local to the patient as possible, with ease of access and in a timely manner that allows early decision making (Royal College of Nursing (RCN), 2012). In 2006, the findings from a public consultation highlighted that people want safe services, based round their needs and closer to where they live (DH, 2006). Bolton’s Health &amp; Wellbeing Strategy 2013-2016 (Bolton Council, 2013) highlights the need for more local Primary Care based services. Further research suggests that wider, holistic benefits can be gained from providing services in a setting where patients receive other aspects of health provision. This promotes continuity of care (Freeman and Hughes, 2010). As chronic diseases are increasingly managed in Primary Care the need to provide timely and accessible blood tests is essential. As well as shifting care closer to home, there is a national drive to deliver safer, more cost effective services. Evidence suggests the same procedure in Primary Care can cost as little as one third compared to Secondary Care (DH, 2006). In line with its ‘out of hospital’ vision, Bolton Clinical Commissioning Group (CCG) is looking to enhance and standardise the scope and quality of phlebotomy delivered in Primary Care.</td>
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<tr>
<td>Practices will be expected to:</td>
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<tr>
<td>1. Provide in-house phlebotomy service to all patients 12 years and over</td>
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<tr>
<td>2. Provide all monitoring that the Practice has agreed to under a shared care agreement. This Standard includes those patients on disease modifying anti-rheumatic drugs (DMARDS) and Atypical Antipsychotics within the agreed indications, following stabilisation in secondary care. The protocols and finer detail for these locally agreed shared care areas can be accessed at: <a href="http://www.boltonccg.nhs.uk/your-services/document-store/cat_view/15-medicines-management/32-policies">www.boltonccg.nhs.uk/your-services/document-store/cat_view/15-medicines-management/32-policies</a></td>
</tr>
<tr>
<td>3. Perform oral glucose tolerance tests (OGTT), as indicated, as per the locally developed protocol for identification of diabetes, pre-diabetes and gestational diabetes. This protocol can be accessed at: <a href="http://www.boltonccg.nhs.uk/your-services/document-store/cat_view/15-medicines-management">www.boltonccg.nhs.uk/your-services/document-store/cat_view/15-medicines-management</a></td>
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<tr>
<td>4. Ensure Clinicians maintain their clinical competence for this Standard, by accessing the up-to-date monitoring requirements included within the links above</td>
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<td>5. Provide the CCG with a signed declaration to verify that the Practice has a written protocol for the provision of a phlebotomy service, in line with CQC requirements, for premises, infection control and needle stick injuries</td>
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<tr>
<td>6. Provide the CCG with a signed declaration to verify that all staff delivering this service are adequately trained, competent to deliver, have Hepatitis B protection, have phlebotomy included as a duty within their job description and the Practice has suitable indemnity</td>
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<tr>
<td>7. Provide patients, on request, with written information about their blood tests, when to expect the results, and who to contact with any queries</td>
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# Standard 16: Phlebotomy

## CCG Support

The Primary Care Development Team will:

1. Provide prescribing monitoring and guidance, where appropriate
2. Provide Read Codes for documenting in the patient record
3. Update Practices on any relevant changes to national guidance

## Key Performance Indicators

Audit activity to demonstrate:

- Service provision to patients 12 years and over
- Shared care monitoring – the Practice should keep records and Read Code appropriately for Post Payment Verification (PPV) purposes
- OGTT as indicated

## References


## CCG Contact – Ben Woodhouse

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Standard 17. Carers

Rationale

It is widely acknowledged that both informal, and family support, have an important part to play in an effective health care system. In recent years, the significant contribution of the ‘carer’ role to health and social care services has been highlighted (Carers UK, 2014).

Nationally, there are 6.5 million unpaid carers, accounting for 1 in 8 adults. Estimates suggest they save the State £119 billion a year (Carers UK, 2014). Findings from a recent study highlight that 70% of carers come into contact with the NHS, yet only 10% of these are identified as a carer (Schonegevel, L. 2013). Healthcare staff are not proactive in signposting carers to relevant support or information, and when information is given, it comes from charities and support groups. (NHS England, 2014).

There has been a growing emphasis in recent years on the need to provide more comprehensive support to carers, since they often face greater social deprivation, isolation and ill health. Also, they have fewer opportunities to do the things other people may take for granted, such as access to paid employment, learning opportunities or having quality time to spend on their own, or with friends. In terms of young carers, it can often compromise their education and social life, limiting their life chances (Carers UK, 2014).

Carers UK (2014) highlights 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 to care
- On average, carers retire 8 years early, 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

It is acknowledged that GPs are developing and improving their services for carers. However, the Royal College of General Practitioners (RCGP), (2014) highlights an urgent need to further embed the identification and support of carers within General Practice. This will ensure carers are supported at an earlier stage, enabling real benefits for both carers and patients alike.

In 2013, a local strategy was produced which highlighted key issues and priorities for local carers (Bolton Council, 2013). The latest Census data suggests that there are 30,649 unpaid carers in Bolton (Office for National Statistics (ONS), 2011).

Delivery

Practices will be expected to:

1. Identify a Carers Lead within the Practice
2. Have a Carers Register which is maintained and updated
3. Ensure that all staff, including receptionists, are ‘carer aware’, and have a basic understanding of support available
4. Offer carers an annual health check
5. Have an electronic referral form on the Practice system to refer carers to Bolton Carers Support and other support networks
6. Display information in the waiting room, to help carers identify themselves, and to highlight available support and information
Standard 17. Carers

CCG Support

The Primary Care Development Team will:

1. Provide a Carers Health Link Worker who will make regular contact with the Practice Carers Lead
2. Provide data and information on Practice achievement of this standard
3. Work with the Data Quality Manager to develop an electronic Carer’s Health Check Template for the Practice system
4. Develop an electronic form for the Practice system, for referrals to Bolton Carers Support and other support networks
5. Distribute a bi-monthly bulletin with local and national carer updates and information
6. Provide a Practice Toolkit, which will include guidance and information

Key Performance Indicators

Improve carers’ registers
- Achieve 2% of list size

Annual health check for carers
- Achieve 80%

References

Bolton Council, (2013) Joint Strategic Needs Assessment for Carers Available at: www.boltonhealthmatters.org/content/carers-jsna
Royal College of General Practitioners, (2014) Supporting Carers: An action guide for general practitioners and their teams Available at: www.rcgp.org.uk/clinical-and-research/clinical-resources/~/media/ CB33FA45E03741A08E64F92A5F74DB07ashx

CCG Contact – Georgette Kay
georgettekay@nhs.net
## Standard 18. Transfer of Care

### Rationale

In Bolton, there has been an increase in requests from secondary care to Primary Care, to undertake work traditionally carried out in consultant-led units. Unfortunately, this can lead to friction between the Acute Trust and Primary Care, about where responsibility lies.

Incidents of this nature have been documented locally. For example, Secondary Care wants to instigate a drug treatment of their choice. However, before this treatment can be initiated, the patient requires a Dexascan. Secondary Care issues a request for Primary Care to organise the scan. Learning from incidents, such as this example, has shown that when care of a patient inadvertently falls between 2 services there is a risk that recommended treatment will not be delivered. Bolton Clinical Commissioning Group (CCG) aims to minimise such incidents, wherever possible.

The CCG also recognises there may be some opportunity for treatment and care to be safely transferred to Primary Care. For example, GPs could undertake prescribing and monitoring, attributable to specialist or Secondary Care follow ups, and have the added benefit of reducing costs.

Discussion on the appropriate transfer of care, will take place at the Clinical Standards Board (CSB). The CSB will be asked to take a view on areas where responsibilities are unclear. The final decision on such issues will be made by the CSB.

### Delivery

**Practices will be expected to:**

1. Accept transfer of care at the appropriate point, to ensure the best patient experience, in the most appropriate clinical setting

2. Ensure that recommendations of the CSB and the Greater Manchester Medicines Management Group (GMMMG) are followed and implemented

3. Cascade information about transfer of care to the wider Practice Team at regular team meetings

### CCG Support

**The Primary Care Development Team will:**

1. Work with the CSB on the development of their document – Principles of Managing Patients. This document will explain the rationale for decision making on appropriate transfer of care

2. Ensure there is a formal process in place to review the transfer of work. This will be done on an on-going basis through the CSB

3. Provide the Practice with updates on this area of work through normal communication channels

4. Provide Practices with support, detail and information relating to any decisions taken by the CSB

### Key Performance Indicators

**Accept transfer of care as agreed by CSB**

**Ensure that information relating to transfer of care is shared widely within the Practice**

### References


### CCG Contact – Lynda Helsby

lynda.helsby@nhs.net
### Standard 19. Patient Experience

#### Rationale

When patients are ignored, they are most at risk. This was one of the main conclusions of the Francis Report (2013). In the same year, Don Berwick presented his report on patient safety at The King’s Fund. He suggested the NHS should be engaging, empowering and hearing the views of patients, and their carers, all the time. The Government Care Act (2014) strongly advocates that patients are involved in decisions about their care, and services that may affect them.

It is well documented that feedback from patients is vital in order to transform NHS services and support patient choice. The learning from patient surveys, or patient forums, can be used to stimulate local improvement. It can also empower NHS staff to carry out the sorts of changes that make a real difference to patients and their care (NHS England, 2014).

The Friends and Family Test (FFT) was introduced in England, in April 2013. This was established in all NHS inpatient and A&E departments. In December 2014, it was rolled out across Primary Care organisations. The FFT is an important feedback tool that supports the principle that, people who use NHS services should have the opportunity to provide feedback on their experience. For example, it asks people if they would recommend the NHS services they have used. The FFT provides a mechanism to highlight both good and poor patient experience (NHS England, 2014). Patient participation in Primary Care can be a powerful partnership between patients, GPs and their Practice staff. The first Patient Forums were established around 1972 by GPs in England and Wales (National Association for Patient Participation (NAPP), 2014).

Establishing a patient forum, in a GP Practice, can result in improved patient satisfaction levels, and lead to high quality and responsive care. The benefits of patient forums include:

- Helping patients to take more responsibility for their health
- Contributing to continuous improvement of services and quality of care
- Fostering improved communication between Practice staff and patients
- Providing practical support to help implement change

Evidence shows that successful Practices, and effective Patient Forums, go hand in hand (NAPP, 2014).

#### Delivery

**Practices will be expected to:**

1. Encourage patients to take part in the FFT
2. Organise and host a Patient Forum. This must be held at least quarterly. The format can be either face to face, or via email
3. Improve on patient survey measures

#### CCG Support

**The Primary Care Development Team will:**

1. Provide Practices with national updates on the FFT, as and when they are produced
2. Keep Practices up to date on CCG priorities
3. Monitor patient survey results, and feedback to Practices on progress and peer comparisons
4. Develop a template to enable feedback to the CCG
## Standard 19: Patient Experience

### Key Performance Indicators

<table>
<thead>
<tr>
<th>Patient forums – quarterly</th>
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</thead>
<tbody>
<tr>
<td>• Feedback learning to the CCG</td>
</tr>
</tbody>
</table>

### Friends and Family Test

#### Improve Patient Survey measures:

- Exceed peer average by at least 1%
- Or match peer cluster average
- Or improve by 10%

### References

- National Association for Patient Participation (NAPP), (2014) Available at: [www.napp.org.uk/overview.html](www.napp.org.uk/overview.html)

### CCG Contact – Nicola Onley

nicola.onley@nhs.net
SECTION 5: CCG EVENTS
5.1 CCG events

5.1.1 NHS Bolton Clinical Commissioning Group (CCG) will provide a programme of events to support delivery of the Standards, and other CCG priorities.

5.1.2 The CCG will develop a calendar of events (CCG Calendar.) This will include the dates and topics for all CCG events throughout the year. 1 copy of the CCG Calendar will be provided to each Practice.

5.2 General principles for CCG events

5.2.1 The CCG will organise all the events described within each Standard.

5.2.2 The CCG will also organise additional events, which Practices will be expected to attend e.g. Safeguarding, Health Improvement, Contract Update, Training for Cancer Leads and End of Life Leads.

5.2.3 The CCG will organise 12 Clinical Leads meetings per year.

5.2.4 Representatives will be expected to feedback at Practice team meetings.

5.2.5 There will be some flexibility within the event programme to deliver ‘hot topics’ as they arise.

5.3 Attendance at CCG events

5.3.1 Practices are expected to send 2 representatives to CCG events. Representation should include at least 1 GP.

5.3.2 Practices are expected to send a GP to at least 10 out of 12 Clinical Leads meetings.
<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>22nd April</td>
<td>Safeguarding</td>
<td>24th February</td>
<td>Feedback</td>
</tr>
<tr>
<td>27th May</td>
<td>Topic - TBC</td>
<td>13th &amp; 20th</td>
<td>July</td>
</tr>
<tr>
<td>24th June</td>
<td>CCG Event - TBC</td>
<td>10th &amp; 17th</td>
<td>June</td>
</tr>
<tr>
<td>22nd July</td>
<td>CCG Event - TBC</td>
<td>8th &amp; 15th</td>
<td>July</td>
</tr>
<tr>
<td>23rd September</td>
<td>Health Improvement</td>
<td>9th &amp; 16th</td>
<td>September</td>
</tr>
<tr>
<td>25th November</td>
<td>Update Bolton Quality Contract</td>
<td>9th &amp; 16th</td>
<td>November</td>
</tr>
<tr>
<td>28th October</td>
<td>Topic - TBC</td>
<td>27th January</td>
<td>Feedback</td>
</tr>
<tr>
<td>24th February</td>
<td>Topic - TBC</td>
<td>23rd March</td>
<td>March</td>
</tr>
<tr>
<td>28th November</td>
<td>Update Bolton Quality Contract</td>
<td>23rd March</td>
<td>March</td>
</tr>
</tbody>
</table>
SECTION 6: EDUCATION & TRAINING
6.1 Education and training programmes

6.1.1 NHS Bolton Clinical Commissioning Group (CCG) will provide a programme of education and other training sessions to support delivery of the Standards, and a selection of educational needs identified by local Primary Care staff.

6.1.2 Dedicated programmes will be developed for GPs, Practice Nurses (PN), Practice Managers (PM), Health Care Assistants (HCA), Health Trainers (HT) and Receptionists.

6.1.3 The CCG will develop a calendar of education and training (CCG Calendar). This will include the dates and topics for all education and training sessions to be covered throughout the year. 1 copy of the CCG Calendar will be provided for each Practice.

6.2 General principles for education and training

6.2.1 There will be some flexibility within the education and training programmes to deliver ‘hot topics’ as they arise.

6.2.2 Education sessions will usually take place at The Bridge Conference Centre, Bradford Street, Bolton, BL2 1JX.

6.2.3 Training sessions may be delivered by the CCG at other local venues.

6.2.4 Flyers for each session will be developed by the Primary Care Development Team. These will be emailed out via the Practice News Bulletin, Practice Manager and GP distribution lists.

6.2.5 An agenda for each session will be developed collaboratively between the Primary Care Development Team and the CCG Education and Training Leads.

6.2.6 Certificates of attendance, where appropriate, will be emailed to Practice Managers for dissemination within their Practice.

6.2.7 There may be extenuating circumstances when education sessions may need to be cancelled at short notice. The CCG will endeavour to let Practices know well in advance, but circumstances may dictate otherwise.

6.3 GP education

6.3.1 The diary allows for 11 x 3 hour sessions per year.

6.3.2 GP education will usually be delivered on the 1st Wednesday of each month.

6.3.3 Sessions can also be arranged to take place at individual Practices, for those who cannot attend the dedicated sessions. However, these can only be arranged in the event of extenuating circumstances, and by prior agreement with the CCG. Requests for individual Practice education sessions should be addressed to lesley.hardman@nhs.net.

6.3.4 Some education topics may need to be addressed in further detail through the Clinical Governance and Clinical Leads meetings.

6.4 Practice Nurse education

6.4.1 The diary allows for 15 sessions per year. These sessions may be half or full days dependent on the topic.

6.4.2 PN education will usually be delivered on the 3rd Wednesday of each month.

6.4.3 Practices will be expected to encourage PNs to attend dedicated education sessions.
6.5 **Health Care Assistant & Health Trainer education**

6.5.1 HCA and HT education will be delivered as a joint session.

6.5.2 The diary allows for 2 sessions per year. These sessions may be half or full days dependent on the topic.

6.5.3 HCA and HT education sessions will usually be delivered in April and October.

6.5.4 It is expected that Practices will send at least 1 HCA, to both sessions, each year.

6.5.5 It is expected that all HTs will attend both sessions each year.

6.5.6 Additional staff groups who work in a Primary Care setting may be invited to these sessions. This will be dependent on the content of the session, and their involvement in the wider Primary Care Work Programme e.g. Pharmacy Health Trainer Champions, Staying Well Advisers and various staff from local Wellbeing Services.

6.6 **Practice Manager discussion forum**

6.6.1 The diary allows for 6 x CCG led sessions per year. Practice Managers may also choose to attend peer led sessions. These are organised by the Practice Manager Lead.

6.6.2 The PM discussion forum and peer led sessions will usually be delivered alternately, on a monthly basis.

6.6.3 In the event that a PM cannot attend a session, it is expected that Practices will send a deputy, who will provide feedback to the PM.

6.6.4 It is the responsibility of individual PMs or deputies to take notes at the meeting, to enable feedback at Practice Team meetings.

6.6.5 Following the meeting, the CCG will send out contact details of any speakers, in case further information is needed by individual Practices.

6.7 **Receptionist training**

6.7.1 The diary allows for 4 x 2 hour sessions per year.

6.7.2 Receptionist training will usually be delivered in May.

6.7.3 2 sessions will be delivered on 2 separate days. This will allow for the diverse working patterns of Receptionists across Primary Care. These sessions will usually be delivered on a Tuesday and a Thursday.

6.7.4 It is expected that Practices will allow every Receptionist the opportunity to attend 1 session every year.

6.8 **Prescribing education**

6.8.1 The diary allows for 3 prescribing events per year.

6.8.2 Practices should ensure that a minimum of 1 GP attends each event.

6.8.3 Prescribing events will require pre-work. This will need to be submitted to the CCG prior to the event. The work will be peer reviewed at the event.
### Education and Training Programme 2015-16

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Date</th>
<th>Event</th>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st April</td>
<td>Respiratory</td>
<td>29th April</td>
<td>COPD</td>
<td>21st April</td>
<td>Bolton Quality Contract</td>
</tr>
<tr>
<td>6th May</td>
<td>Mental Health including Dementia</td>
<td>20th May</td>
<td>Mental Health including Dementia</td>
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<tr>
<td>3rd June</td>
<td>MSK Part 2</td>
<td>17th June</td>
<td>Travel Health (full day)</td>
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<tr>
<td>1st July</td>
<td>Neurology</td>
<td>15th July</td>
<td>Paediatric Asthma</td>
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<tr>
<td>5th August</td>
<td>Dermatology</td>
<td>19th August</td>
<td>Imms and Vacs (full day)</td>
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<tr>
<td>2nd September</td>
<td>Cancer</td>
<td>16th September</td>
<td>Sexual Health and Cytology (full day)</td>
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<tr>
<td>7th October</td>
<td>End of Life</td>
<td>21st October</td>
<td>Diabetes</td>
<td>20th October</td>
<td>Lifestyle Updates (full day)</td>
</tr>
<tr>
<td>4th November</td>
<td>Difficult arenas in consultation skills</td>
<td>18th November</td>
<td>Consultation skills, clinical governance including CPD, PGDs, significant events, confidentiality, CPR, manual handling</td>
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<tr>
<td>2nd December</td>
<td>CKD and AF</td>
<td>16th December</td>
<td>CVD including CKD and AF</td>
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<td></td>
<td></td>
<td>20th January</td>
<td>Safeguarding Update</td>
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<tr>
<td>3rd February</td>
<td>Laboratory Medicine</td>
<td>17th February</td>
<td>Laboratory Medicine/ Infection Control</td>
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<tr>
<td>2nd March</td>
<td>Women’s Health</td>
<td>16th March</td>
<td>Cancer and End of Life</td>
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</tbody>
</table>
SECTION 7: PRACTICE PLANS
## Implementing the new GP Quality Contract – Baseline Staff Audit

<table>
<thead>
<tr>
<th>Practice Name:</th>
<th>Practice Population:</th>
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<table>
<thead>
<tr>
<th>Practice Number:</th>
<th>Weighted List Size:</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>How many wte GPs do you have?</th>
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<tbody>
<tr>
<td>(assuming 8 sessions per week for a wte GP)</td>
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</table>

<table>
<thead>
<tr>
<th>Do you have any Nurse Practitioners working in the Practice?</th>
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<tbody>
<tr>
<td>If yes, how many sessions per week?</td>
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</table>

<table>
<thead>
<tr>
<th>How many Practice Manager hours does the Practice have per week?</th>
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<tbody>
<tr>
<td>(Include PM hours, and any additional hours provided by the Deputy PM)</td>
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<thead>
<tr>
<th>How many Practice Nurse hours does the Practice have per week?</th>
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<tr>
<th>Do you have a Health Care Assistant?</th>
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<tbody>
<tr>
<td>If yes, how many hours per week do they work?</td>
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<thead>
<tr>
<th>Excluding Practice Manager hours, how many administrative / reception hours does the Practice have per week?</th>
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<tr>
<th>Do you have any other staff not included in the categories above?</th>
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</table>


## Implementing the new GP Quality Contract – Project Management

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>Will there be a project steering group?</td>
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<td>Who will be on it?</td>
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<td>How often will it meet?</td>
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<tr>
<td>Who will be responsible for making it meet?</td>
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<tr>
<td>How will you ensure that your workforce is focused on the right areas to deliver the new contract? e.g. do any job descriptions need to be reviewed? And by whom?</td>
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<tr>
<td>Is there any additional training / equipment required?</td>
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<tr>
<td>What are the specific needs of your Practice population?</td>
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<tr>
<td>What are you providing now?</td>
<td></td>
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<tr>
<td>What are you ready to provide?</td>
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</tbody>
</table>
## Implementing the new GP Quality Contract – Practice Action Plan

How will you ensure that the Practice is ready to implement the new GP specification?

<table>
<thead>
<tr>
<th>Standard</th>
<th>What is your baseline data telling you?</th>
<th>What do you need to do to achieve your KPI?</th>
<th>What resources will be needed to support this? Will you need additional workforce?</th>
<th>Who will lead this standard?</th>
<th>What external support might be needed?</th>
<th>Date completed</th>
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</thead>
<tbody>
<tr>
<td>1. Access</td>
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<td>2. Prescribing</td>
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<td>3. Demand Management</td>
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<td>4. Health Improvement</td>
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<td>5. Screening</td>
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<tr>
<td>6. Health Protection</td>
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</table>
### Implementing the new GP Quality Contract – Practice Action Plan

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<tr>
<th>Standard</th>
<th>What is your baseline data telling you?</th>
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<th>Who will lead this standard?</th>
<th>What external support might be needed?</th>
<th>Date completed</th>
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<tr>
<td>7. Sexual Health</td>
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<td>8. Cancer Referral</td>
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<td>9. Best Care / LTC</td>
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<td>10. Exception Reporting</td>
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<tr>
<td>11. End of Life</td>
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<tr>
<td>12. Emergency Planning</td>
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</table>
### Implementing the new GP Quality Contract – Practice Action Plan

How will you ensure that the Practice is ready to implement the new GP specification?

<table>
<thead>
<tr>
<th>Standard</th>
<th>What is your baseline data telling you?</th>
<th>What do you need to do to achieve your KPI?</th>
<th>What resources will be needed to support this? Will you need additional workforce?</th>
<th>Who will lead this standard?</th>
<th>What external support might be needed?</th>
<th>Date completed</th>
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<tbody>
<tr>
<td>13. Patient Safety</td>
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<tr>
<td>14. Membership Engagement</td>
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<tr>
<td>15. Mental Health, Learning Disability and Military Veterans</td>
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<tr>
<td>16. Phlebotomy</td>
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<tr>
<td>17. Carers</td>
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<tr>
<td>18. Transfer of Care</td>
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<tr>
<td>19. Patient Experience</td>
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</tbody>
</table>
# Implementing the new GP Quality Contract – Investment Plan

<table>
<thead>
<tr>
<th>Staff</th>
<th>Role</th>
<th>Time</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>GP Sessions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Practice Nurse</td>
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<td></td>
<td>Practice Manager</td>
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<tr>
<td></td>
<td>Reception</td>
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<td></td>
<td>Total</td>
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### 8.1 Glossary

<table>
<thead>
<tr>
<th>Acronyms</th>
<th>Description</th>
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<tbody>
<tr>
<td>A &amp; E</td>
<td>Accident &amp; Emergency</td>
</tr>
<tr>
<td>AAA</td>
<td>Abdominal Aortic Aneurysm</td>
</tr>
<tr>
<td>AF</td>
<td>Atrial Fibrillation</td>
</tr>
<tr>
<td>APMS</td>
<td>Alternative Provider Medical Services</td>
</tr>
<tr>
<td>ASTRO PU</td>
<td>Age, Sex and Temporary Resident Originated Prescribing Unit</td>
</tr>
<tr>
<td>BCSP</td>
<td>Bowel Cancer Screening Programme</td>
</tr>
<tr>
<td>BIDAS</td>
<td>Bolton Integrated Drug &amp; Alcohol Service</td>
</tr>
<tr>
<td>BMI</td>
<td>Body Mass Index</td>
</tr>
<tr>
<td>BP</td>
<td>Blood Pressure</td>
</tr>
<tr>
<td>BQC</td>
<td>Bolton Quality Contract</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CHD</td>
<td>Coronary Heart Disease</td>
</tr>
<tr>
<td>CKD</td>
<td>Chronic Kidney Disease</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>CSB</td>
<td>Clinical Standards Board</td>
</tr>
<tr>
<td>CVD</td>
<td>Cardiovascular Disease</td>
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<tr>
<td>DES</td>
<td>Directed Enhanced Services</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DMARDS</td>
<td>Disease Modifying Anti-Rheumatic Drugs</td>
</tr>
<tr>
<td>DNA</td>
<td>Did Not Attend</td>
</tr>
<tr>
<td>DNACPR</td>
<td>Do Not Attempt Cardiopulmonary Resuscitation</td>
</tr>
<tr>
<td>EOL</td>
<td>End of Life</td>
</tr>
<tr>
<td>EUR</td>
<td>Effective Use of Resources</td>
</tr>
<tr>
<td>FFT</td>
<td>Friends and Family Test</td>
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<tr>
<td>GM</td>
<td>Greater Manchester</td>
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<tr>
<td>GMC</td>
<td>General Medical Council</td>
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<tr>
<td>GMMMG</td>
<td>Greater Manchester Medicines Management Group</td>
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<tr>
<td>GMS</td>
<td>General Medical Services</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<td>GSF</td>
<td>Gold Standards Framework</td>
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<tr>
<td>GSR</td>
<td>Global Sum Rate</td>
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<tr>
<td>HBA1C</td>
<td>Haemoglobin A1c (Glycated Haemoglobin)</td>
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<tr>
<td>HF</td>
<td>Heart Failure</td>
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<tr>
<td>HSCIC</td>
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<tr>
<td>KPIs</td>
<td>Key Performance Indicators</td>
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<td>LDSAF</td>
<td>Learning Disability Self Assessment Framework</td>
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<td>Acronyms</td>
<td>Description</td>
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<td>LES</td>
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<tr>
<td>LFTs</td>
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<td>Long Term Conditions</td>
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<td>LVD</td>
<td>Left Ventricular Dysfunction</td>
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<td>MH</td>
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<td>MI</td>
<td>Myocardial Infarction</td>
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<td>MPIG</td>
<td>Minimum Practice Income Guarantee</td>
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<tr>
<td>NAPP</td>
<td>National Association For Patient Participation</td>
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<td>NCSP</td>
<td>National Chlamydia Screening Programme</td>
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<td>Non Elective</td>
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<tr>
<td>NHSCSP</td>
<td>NHS Cancer Screening Programme</td>
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<td>NHSNW</td>
<td>NHS North West</td>
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<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
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<td>OGTT</td>
<td>Oral Glucose Tolerance Tests</td>
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<td>ONS</td>
<td>Office for National Statistics</td>
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<td>OOH</td>
<td>Out of Hours</td>
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<tr>
<td>PHE</td>
<td>Public Health England</td>
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<td>Procedures of Limited Clinical Value</td>
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<td>QBIT</td>
<td>Quality Business Intelligence Tool</td>
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<td>QIPP</td>
<td>Quality, Innovation, Productivity &amp; Prevention</td>
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<td>QOF</td>
<td>Quality and Outcomes Framework</td>
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<tr>
<td>QP</td>
<td>Quality and Productivity</td>
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<td>Royal College of General Practitioners</td>
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<td>Royal College of Paediatrics &amp; Child Health</td>
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<td>STI</td>
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<td>SUS</td>
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