Report to:	**SINGLE COMMISSIONING BOARD**
Date:	4 October 2016
Officer of Single Commissioning Board	Clare Watson, Director of Commissioning, Single Commissioning
Subject:	**PRIMARY CARE QUALITY SCHEME REVIEW PAPER**
Report Summary:	To present a review of the first six months of the Primary Care Quality Scheme
Recommendations:	The Single Commissioning Board are requested to approved the following relating to the Primary Care Quality Scheme: 1. That it continues in its current format to the end of 2016/2017 with an active promotion of neighbourhood working, akin to that adopted informally in year one. 2. That the remainder of the year be used to evolve the scheme based on the learning to date from the year one reports, patient feedback and practice feedback, and also to complement the current environment. 3. That changes are also incorporated to further support neighbourhood working, address the Greater Manchester Quality Standards and aligning and running parallel to reducing originating activity across the health economy, while also impacting positively on costs. These changes will also offer greater effectiveness in supporting the financial challenge across the economy.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	This report is a review of the progress made during the first six months of the Primary Care Quality Scheme (PCQS) for which a budget was formally agreed at the start of the financial year. The progress made in 2016-17 will serve to influence the PCQS in 2017-18 for which an indicative budget of £1.5 million was proposed at the Extraordinary Governing Body meeting on 7 September 2016. This value is inclusive of some inherent efficiency. However, it is important that quarterly updates as to the progress made for each practice is received to ensure VfM and particularly as this is a significant component of the CCG Recovery Plan and the wider transformation within neighbourhoods which will be subject to intense scrutiny.
Legal Implications: **(Authorised by the Borough Solicitor)**	As this is a review of the previous year's performance it is difficult to draw any real conclusions around legal implications aside from to highlight the need for the service to ensure at all times going forward it works within the Constitutions of both the NHS and the Council and to ensure value for money is achieved and improved upon. Going forward, how to assess required outcomes to continually improve service and performance which will in turn reduce the potential for successful legal challenge through judicial review, the courts generally or ombudsman complaints could be factored into next year's programme.
How do proposals align with Health & Wellbeing Strategy?	Improved care and outcomes, a focus on early intervention and prevention for all patients are priorities of the Health and Wellbeing Strategy.

How do proposals align with Locality Plan?	To support primary care providers working together at neighbourhood level
How do proposals align with the Commissioning Strategy?	Helping to improve the quality of services delivered in primary care.
Recommendations / views of the Professional Reference Group:	PRG noted the culture shift that has taken place in order to achieve the primary care quality standards and in practices addressing their own performance and taking ownership as part of the GP forward view. PRG would like to see some rigor in developing the process without moving away from this scheme. KR requested that we link in spend with the Care Together vision and that consideration be given to the Commissioning Improvement Scheme as part of the transformational funding. Subsequently, PRG were reminded of the qipp in place on discretionary spend. PRG accepted the three recommendations set out within the report, subject to SCB approval, although highlighted the caveat of their comments made around QIPP.
Public and Patient Implications:	The general practice offer to patients will be improved by the Primary Care Quality Scheme
Quality Implications:	The Primary Care Quality Scheme is designed to improve the quality of care patients received from general practice
How do the proposals help to reduce health inequalities?	The Primary Care Quality Scheme aims to improve the quality of care patients receive from general practice by requiring practises to take a quality improvement approach to the care they deliver.
What are the Equality and Diversity implications?	None.
What are the safeguarding implications?	None, patients are seen by their own practice and therefore with adherence to Primary Medical Services regulations.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	None, patients are seen by their own practice and therefore with adherence to Information Governance responsibilities.
Risk Management:	Risks will be managed through clear process and documentation.
Access to Information :	The background papers relating to this report can be inspected by contacting Chris Martin, Primary Care Development and Quality Manager, by:  Telephone: 0161 304 5300 or 07881 805130  e-mail: christopher.martin4@nhs.net

1. INTRODUCTION

1.1 The Primary Care Quality Scheme (PCQS) was approved in May 2015. The underlying principle of it was to increase and sustain the infrastructure and delivery of primary care services, including parity of investment with other sectors of the health economy, while recognising the trend of moving services out of secondary care into primary care.

1.2 An important part of the brief was to co-design the scheme with GPs, their teams and patients.

1.3 The scheme is the third of five strands in the Primary Care Strategy - Developing Relevant and Meaningful Outcomes for Primary Care.

1.4 Strand three complements strand one of the Primary Care Strategy - Strengthen General Practice Infrastructure and strand two - Developing Models and Pathways of Care that are Meaningful to Patients and Practices.

1.5 The scheme is designed as an alternative to "one size fits all" target driven financial rewards, recognising that each of our 41 practices faces challenges specific to them and their population. This has been achieved by designing a scheme that encourages practices to be aware of and own their practice data, identifying the improvements that are needed and trying out new approaches to encourage a positive and creative culture of improvement from both a patient and a practice perspective.

1.6 An extensive engagement exercise was undertaken during the development phase of the scheme. During the engagement practices pointed out that schemes have been introduced in the past, to be stopped after a short period of time, which it was felt prevented them being as beneficial as they could be.

1.7 Consequently the PCQS was promoted as a potential long term investment in primary care that practices could use to access additional resource, and at the same time implement longer term projects to improve patient and staff outcomes and experience. To emphasise this message, practices were asked to submit two year plans.

1.8 The scheme went live in October 2015 with the initial approval covering a period to the end of March 2017. The investment for 2015/16 was £1 million and is £2 million for 2016/17.

1.9 All 41 practices are participating and submitted plans, which were reviewed by a panel. Practices subsequently submitted a year one report, when the scheme had been running for six months. Year one reports were submitted by all 41 practices and this report discusses the progress of the Primary Care Quality Scheme to date and its position as part of the current primary care position.

2. CONTEXT

2.1 Activity in primary care has increased over a number of years – 90% of contacts with patients are within primary care, while funding, although acknowledged to be lower has reduced to only 9% (RCGP, NAPP 2013) of overall NHS funding. As demand has increased and investment decreased the general practice workforce has become demoralised and burnt out, which is reflected in the difficulties that our practices have faced over recent years (Understanding Pressures in General Practice, Kings Fund May 2016).

2.2 In addition, practices face an increase in the burden of regulation, which is reflected in our underpinning aims of trying to make primary care a better place to work, as well as a better place to access care. This is not always helped by well-intentioned national schemes that fail to fully understand their impact on general practice.

2.3 The combined issues facing general practice run the risk of creating a jaded provider, with the consequent danger that as a group it fails to engage with the CCG, negatively impacting on the CCG's plans.

3. THE BRIEF FOR THE SCHEME, ITS AIMS AND ITS CONTENT

3.1 The Tameside and Glossop Primary Care Strategy had two aims; to make primary care a great place to work and a great place to receive care. It also fulfils a number of other briefs:

- it is the CCGs major recurrent investment in primary care;
- it had to be co-designed.

3.2 It had to achieve its primary purpose of improving the quality of primary care delivered to our population

3.3 To make primary care a great place to work it could not be too administratively onerous on already overstretched practice staff

3.4 The design team recognised that fulfilling all these aims would be challenging and likely to take many years. Success is dependent upon influencing organisational culture across practices and in an every changing NHS environment, we need to provide a culture of continuous improvement where individuals within an organisation have the confidence to try new working to respond to the challenges they face.

3.5 It is a co-designed vehicle created to be different to other investments in primary care, such as the Quality and Outcomes Framework (QOF). This was a deliberate decision to engage and enthuse general practice, while also influencing the culture of general practice.

3.6 QOF undoubtedly serves the purpose it was designed for, but a local quality scheme that merely duplicates QOF is a missed opportunity to affect long term cultural change in general practice within Tameside and Glossop.

3.7 QOF directs practices to look at specific things and to report on those specific things in order to gain points until the maximum number of points, and money, are achieved. There is a danger with such schemes that only the areas specified as attracting investment will be concentrated on, at the expense of areas that are not incentivised, which ultimately does not resolve variations in care.

3.8 Detailed analysis of QOF has also shown that in its first six years, it has failed to make an impact on the mortality of the UK's population (The Lancet, May 2016). It is now widely accepted that a focus on achieving targets in discrete areas has encouraged GPs to lose sight of overall outcomes for patients.

3.9 Unlike QOF, our Primary Care Quality Scheme also had to recognise that not all practices are in the same position. At the time of design general practice in Tameside and Glossop consisted of 41 small businesses facing 41 different sets of problems, dealing with 41 different cohorts of patients, in 41 different premises, with 41 different set of partners and 41 different cultures. Two practices merged in July, which reduces the number of practices to 40.

3.10 The Primary Care Quality Scheme reflects this as it is structured to ask practices to be aware of their position in 40 indicators grouped under the five following domains:

1. Best Practice Care;
2. Patient Safety;

3. Patient Engagement, Patient Satisfaction and Patient Involvement in Service Development;
4. Access;
5. Practice Planning, Primary Care Development and Continuous Improvement.

4. HOW THE SCHEME WORKS AND PRACTICE ENGAGEMENT WITH IT

4.1 The 2015/16 investment equated to £3.91 per weighted patient. There was a split payment of the investment – an initial amount to allow practices to fund additional resources to deliver against their plan and a later payment after evaluating the subsequent report.

4.2 Once practices submitted reports, they were evaluated by a panel, with the panel particularly looking for evidence that practices were aware of their performance and had taken some positive action to address the areas identified as requiring improvement.

4.3 A similar split payment process will be followed for the 2016/17 financial year.

5. YEAR ONE REPORTS

5.1 The year one reports were exciting in the way practices engaged with the scheme, discovered the data relating to their position for each indicator and took ownership of it by making proposals for improving or maintaining their position.

5.2 This is consistent with the direction of integrated neighbourhoods currently being developed; allowing neighbourhoods to develop based on local need similar to the evolving Primary Care at Scale and Multispecialty Community Provider (MCP) proposals.

5.3 An important theme from the year one reports was that of practices engaging with their data and fully understanding their position on each indicator. This entailed the practices engaging with a wide variety of data sources, understanding their position and considering approaches to improving or maintaining that position.

5.4 This is not a top down approach to quality improvement with a one size fits all approach; it leads the practices into understanding what the data says are their particular areas that require improvement and gives them the space and freedom to implement the solution that best fits their circumstances.

5.5 By asking practices to understand their positions in each of the 40 indicators (32 of which were live in 2015/16) we are effectively providing a framework for each practice to own their position and manage the improvement or maintenance of that position in the way that best suits the practice. The scheme also recognises the individuality of each practice and the challenges they may face. It also asks practices to build their own resilience by asking them to plan for the future shape of their business in terms of succession planning.

5.6 This increases the performance of all practices and reduces variation, by incentivizing each practice to focus on improving weaker areas while maintaining stronger areas. This should eventually reduce unwarranted variation in general practice across Tameside and Glossop and reduce health inequalities.

5.7 Equally important is that in the long term, practices will develop - and embed - new behaviours. They will become more interested in their performance and be able to recognise areas requiring improvement and establish their own improvement aims, thereby having more ownership of the work they do.

5.8 It is clear that this approach is not going to be the easiest to measure or evaluate, but it is the best way of accounting for the differences amongst our practices and encouraging them to understand where they need to improve, while providing patients with better quality care. This ultimately feeds into reducing variations of care and health inequalities.

6. ALIGNMENT

6.1 There are a number of areas that the scheme aligns with and supports which can be strengthened in its next iteration.

7. COMMISSIONING IMPROVEMENT SCHEME (CIS)

7.1 This scheme has been implemented for 16/17 and aims to encourage practices to reduce their contribution to costs within other areas of the health economy. It is designed to help the CCG achieve its 16/17 QIPP target.

7.2 A number of areas within the PCQS encourage practices to be aware of the data related to their practice so that they can positively influence that data in a way that best suits each individual practice. This creates a culture where familiarity of data is encouraged, ultimately supporting the CIS, which requires knowledge and ownership of risk stratification data to achieve the aims of the CIS.

8. NEIGHBOURHOOD WORKING

8.1 The strategic direction of the CCG is to move towards working at neighbourhood level, rather than at a practice level. The PCQS was designed at practice level. The Hyde neighbourhood organised itself so that a number of the practices worked together on discrete domains of the scheme. They also hired an external consultant to aid their work on the scheme. This level of learning and co-operation is incredibly helpful in the development of more integrated, neighbourhood working within primary care.

8.2 Risk stratification data is supporting the development of neighbourhood working, and as discussed above the PCQS encourages familiarity and ownership of information and to positively influence it in a way that best fits each individual practice.

8.3 The scheme itself will develop and evolve and the next iteration will include an overt neighbourhood approach to allow us to harness its full potential.

9. GM STANDARDS

9.1 The GM Standards currently consist of 65 indicators in 9 domains. They are due to reviewed by Greater Manchester Health and Social Care Partnership so may not retain their current content. It is an expectation that all Greater Manchester CCGs will introduce the GM Standards, though there is unlikely to be additional resources attached to this.

9.2 While the Greater Manchester Quality Standards are a very different proposition to the Tameside and Glossop PCQS, a mapping exercise has shown that 52% of the GM Standards are replicated by our scheme. This could be increased in the next iteration of the PCQS, in line with the outcome of the GM Standards review.

10. CQC REQUIREMENTS

10.1 As a CCG we have had five practices receive a CQC rating of requires improvement – the majority of these were before the PCQS went live in October 2015. Several of the issues that CQC highlighted as areas requiring improvement – such as training and succession planning – are within the PCQS. The scheme supports the CQC regime and helps to maintain our practices at a standard to ensure a good CQC rating.

11. VULNERABLE PRACTICES

11.1 By attempting to make primary care a better place to work the PCQS recognises that, for various reasons, some of our practices may be vulnerable. Domain 5 – Practice Planning, Primary Care Development and Continuous Improvement – is specifically designed to support practices in developing a level of organisational resilience.

11.2 However, it is also hoped that the scheme will help us to identify those practices that require support, which can then allow the CCG to put the relevant support in place.

12. HEALTH INEQUALITIES

12.1 The PCQS also aims to support the work to reduce health inequalities within Tameside and Glossop through the process of encouraging practices to recognise where they need to improve. As practices start to improve their position for each indicator within the PCQS, addressing the specific needs of their patients, those patients should have greater access to health care with better outcomes with less unwarranted variation across Tameside and Glossop.

13. GENERAL PRACTICE FORWARD VIEW

13.1 The General Practice Forward View provides a framework of support for general practice by providing it with tools to increase resilience through additional investment and focusing on areas of vulnerability. It is believed that this will help in the face of increasing demand.

13.2 The PCQS can be the CCGs vehicle for delivering the General Practice Forward View and is already creating a framework for practices to consider resilience with its Practice Planning, Primary Care Development and Continuous Improvement domain.

14. OUTCOME MEASURES

14.1 The design of the scheme fully recognised the importance of measured outcomes for both patients and practice teams. However, the challenges faced were two-fold:

- Improvements to morbidity or mortality may take many years to be realised; and
- Organisational culture is difficult to measure and currently there are no validated tools to do this in general practice.

14.2 Albert Einstein stated that, *"not everything that can be counted counts and not everything that counts can be counted."* While part of the design of the scheme was to encourage practices to engage with their patient population by better understanding of data it was recognised that there needed to be some measures of success. The following were chosen:

- Evaluating each individual practice's achievement against the indicators by reviewing practices reports at a number of panels;

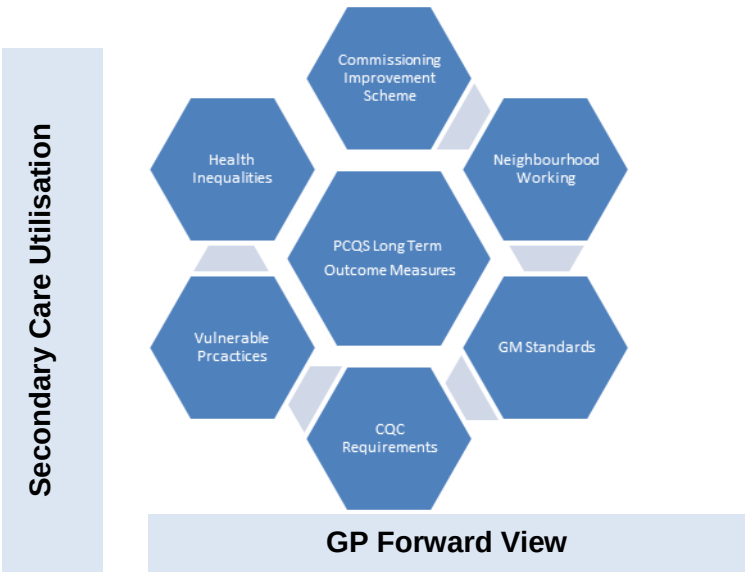
- Externally monitoring 20 indicators over a number of years to see if there is a positive impact on them, recognising that a longer timescale is required to evidence change.

14.3 These long term indicators are as follows:

- Cervical smear take up;
- Flu immunisation vaccination uptake;
- AF prevalence;
- CHD prevalence;
- Asthma prevalence;
- Diabetes prevalence;
- Dementia prevalence;
- Optimum control of blood pressure;
- Hypertension prevalence;
- Patient overall satisfaction;
- Patient satisfaction with access to General Practice;
- How confident patients feel in managing their own health;
- Clinical and Non-clinical staff satisfaction;
- Unfilled GP posts;
- Unfilled Practice Nurse posts;
- Unplanned admission rates;
- Premature mortality (improvements expected over a 5 – 10 year period);
- Healthy life expectancy (improvements expected over a 5 – 10 year period);
- Lower number of deaths in hospital as an indicator of preferred place of death;
- Low proportion of cancers diagnosed on an emergency admissions as an indicator of late diagnosis.

14.4 These indicators are consistent with the commissioning strategy of the Single Commissioning Body and can also help address utilisation of secondary care.

14.5 The diagram below indicates how the outcome measures feed into the areas of alignment, with the GP Forward View providing underpinning support and direction.



14.6 It is always difficult to collect current primary care information, as the national primary medical services contracts do not contain any reporting requirements. In addition there are information governance barriers that may prevent the extraction of data from practice clinical systems. The latter are not insurmountable and the CCG is working to resolve this.

14.7 Consequently, we have to rely upon secondary data sources, such as the Primary Care Web Tool, QOF, Public Health England's Fingertips website, the GP Patient Survey, Friends and Family Test and CQC reports.

14.8 These data sources tend to be updated on an annual basis. As such, the year one PCQS data is being treated as our baseline from which we will measure any future improvements that may occur.

15. LEARNING AND FUTURE DEVELOPMENT OF THE SCHEME

15.1 While general practice has been underfunded for a significant amount of time it is a group of providers that we as a CCG need to rely upon more and more under our integration plans by transferring activity from secondary to primary care.

15.2 It is also a group of providers that the CCG is very focused on to support the delivery of QIPP across the economy and we are working closely with our neighbourhoods to help reduce activity in secondary care.

15.3 Consequently, general practice is under pressure to be at the heart of neighbourhood working while remaining within its existing investment. Without further supportive interventions, including additional investment over and above core contract, general practice will only come under additional pressure, which may be insurmountable for some practices. This pressure on general practice risks subsequent economy wide pressures as unmet demand in primary care will transfer into the wider system.

15.4 Contracts for general practice are negotiated nationally and we have only a low level of influence over them. In addition, contracts in themselves are designed govern the relationship between the provider and the commissioner, rather than the quality aspects of delivering health care. This means limited formal influence over general practice, which is especially critical when general practice is so important to the CCGs proposals for service delivery and financial sustainability.

15.5 We have learnt that it is unwise to solely rely upon a contractual approach to improving quality. This is because it may promote a culture of ticking boxes and act as a disincentive to practices proposing and implementing creative solutions to improving patient care and outcomes. For this very reason our PCQS adopted an approach aimed at promoting a culture of continuous improvement.

15.6 The PCQS is a vehicle that is achieving several things:

- Being the vehicle for achieving the two aims of the Primary Care Strategy;
  - Making primary care a great place to work, and
  - Making primary care a great place to receive care.
- A much needed investment in general practice primary care, that provides the CCG with a level of security that the investment is being focused on patients and practice resilience.
- An initiative to reduce the variations of care across Tameside and Glossop.
- Increasing engagement and interaction with our practices, thus fostering good relations with them at a time when it will be vital to retain these relationships.
- Feeding into CQC requirements and supporting practices in achieving "good" CQC ratings.
- Encouraging practices to engage with their current strengths and weaknesses to allow them to build on the good and reduce the bad.
- Supporting greater resilience in general practice by having a domain that focuses on practice planning, primary care development and continuous improvement.

15.7 The underpinning aim of the PCQS is to change the culture of our practices and to embed quality improvement as a natural product of delivering primary care medical services. This is not a short term proposition and will take longer than two years to do this, therefore it needs to continue if it is to make the desired long term changes especially required to allow the strategic direction of Care Together to be successful.

15.8 Since the scheme was developed over a year ago the CCGs financial position has changed significantly. In addition, the landscape of our local health economy has also changed significantly. As such, the brief for a future iteration of the scheme is different to the original brief, which it fulfils.

15.9 The PCQS is an excellent vehicle for the CCG has to influence practices. While the CCG can influence locally commissioned services, it has little influence over core contracts, which are practices main income streams. This vehicle is imperative in our current financial situation where we need to maintain good relationships with our practices to achieve the financial goals we have set ourselves.

15.10 As the landscape has changed, then so should the Primary Care Quality Scheme. It should be more aligned and run parallel with the CCGs need to reduce spend within primary care and promote neighbourhood working. This does not mean that the scheme should be directly linked to any Commissioning Improvement Scheme. All referrals should always be based upon clinical need and we would wish to avoid the unfortunate national headlines that Bolton CCG suffered, earlier on this year, when the national press stated that GPs were being incentivised not to send patients to hospital.

15.11 The PCQS is a vehicle that will evolve as the landscape in which it exists evolves. Under the recommendations below, which were accepted by PRG, it can be designed to complement and align with the Single Commissioning Board's strategic direction, which will equally change as the environment changes. The recommendations below reflect the changes in the landscape that have occurred during the 18 months of its development and implementation. No doubt there will be more changes whether driven locally by the Single Commissioning Board, regionally by the Greater Manchester Health and Social Care Partnership and nationally by NHS England.

16. RECOMMENDATIONS

16.1 Set out at the front of the report.