NHS
Portsmouth
Clinical Commissioning Group

CCG Headquarters
4th Floor
1 Guildhall Square (Civic Offices)
Portsmouth PO1 2GJ

Primary Care Commissioning Committee

A meeting will be held from 1.00pm – 2.45pm on Wednesday 21 September 2016 in Conference Room B, 2nd Floor, Civic Offices, Portsmouth

AGENDA

	Subject	Lead	Attachment
1.	**Apologies for Absence and Welcome** Apologies received from Michelle Spandley.	Mr T Morton	Verbal
2.	**Declarations of Interest**	Mr T Morton	Verbal
3.	**Minutes of Previous Meeting** a. To agree the minutes of the Primary Care Commissioning Committee meeting held on Wednesday 20 July 2016. b. Matters Arising	Mr T Morton	White
4.	**CQC Inspection of GP Practices**	Ms K Hovenden	Cream
5.	**Alliance Update**	Ms K Hovenden	Pink
6.	**A Quality Improvement Framework for Primary Medical Care**	Mrs T Russell	Blue
7.	**GP Patient Survey Results**	Mrs T Russell	White
8.	**Date and Time of Next Meeting in Public** The next Primary Care Commissioning Committee meeting to be held in public will take place on Wednesday 16 November 2016 at 1.00pm – 2.45pm in Conference Room A, 2nd Floor, Civic Offices, Portsmouth.		
9.	**Meeting Close**		

Distribution:

Voting Members

Dr Linda Collie	- Deputy Clinical Leader/Clinical Executive
Dr Julie Cullen	- Registered Nurse
Ms Katie Hovenden	- Director of Primary Care
Mr Tom Morton	- Lay Member
Ms Jackie Powell	- Lay Member
Mr Innes Richens	- Chief Operating Officer
Ms Tracy Sanders	- Chief Strategic Officer
Mr Andy Silvester	- Lay Member
Mrs Michelle Spandley	- Chief Finance Officer

Dr Tahwinder Upile - Secondary Care Specialist Doctor

Non-Voting Members/In Attendance

Dr Dapo Alalade - Clinical Executive
Mrs Jane Cole - Deputy Chief Finance Officer (for Michelle Spandley)
Mrs Jayne Collis - Business Development Manager
Mr Paul Cox - Practice Manager Representative
Dr Elizabeth Fellows - Chair of Governing Board/Clinical Executive
Mr Patrick Fowler - Healthwatch Representative
Dr Jim Hogan - Clinical Leader and Chief Clinical Officer
Dr Jonathan Lake - Clinical Executive
Ms Suzannah Rosenberg - Director of Quality and Commissioning
Mrs Terri Russell - Head of Primary Care Engagement
Dr Matthew Smith - Consultant in Public Health (on behalf of vacant Director of Public Health, Portsmouth City Council position)
Mr David Williams - Chief Executive, Portsmouth City Council

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PRIMARY CARE COMMISSIONING COMMITTEE

Date of Meeting	21 September 2016	**Agenda Item No**	3
Title	**Minutes of Previous Meeting**		
Purpose of Paper	To agree the minutes of the Primary Care Commissioning Committee meeting held on Wednesday 20 July 2016.		
Recommendations/ Actions requested	Approve		
Potential Conflicts of Interests for Board Members	None		
Author	Jayne Collis		
Sponsoring member	Tom Morton		
Date of Paper	9 September 2016		

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DRAFT

Minutes of the NHS Portsmouth Primary Care Commissioning Committee meeting held on Wednesday 20 July 2016 at 1.00pm – 2.15pm in Conference Room A, 2nd Floor, Civic Offices, Portsmouth

Summary of Actions
Primary Care Commissioning Committee held on Wednesday 20 July 2016

Agenda Item	Action	Who	By
4	**Proposed Closure of the Ramillies Branch Surgery** – Request information from the practice regarding the number of patients who attended the open meeting and provided feedback as part of the engagement work for Andy Silvester.	K Hovenden	Sep 16
4	**Proposed Closure of the Ramillies Branch Surgery** – A programme to be put in place to evaluate the benefits realised as a result of approved mergers for consideration by the Committee on an ongoing basis.	K Hovenden	Sep 16
5	**Proposed Merger of Portsdown Group Practice and Northern Road Surgery; and Proposed Closure of Northern Road as a Branch Surgery** – Ask practices to provide details about the scale of their engagement with patients and stakeholders, including number of respondents, as part of applications to merge or close branches in the future.	K Hovenden	Ongoing
5	**Proposed Merger of Portsdown Group Practice and Northern Road Surgery; and Proposed Closure of Northern Road as a Branch Surgery** – Clarify what is meant by "quasi-trained" nurse.	K Hovenden	Sep 16
7	**Healthwatch Portsmouth Mystery Shopper Report – CCG next steps** – Review the recent announcement regarding the removal of ghost patients and the impact locally.	T Russell	Sep 16
7	**Healthwatch Portsmouth Mystery Shopper Report – CCG next steps** – Discuss how Healthwatch may help in promoting the importance of attending or cancelling GP appointments in order to reduce DNAs and wastage of primary care capacity.	P Cox/ P Fowler	Sep 16

Present:

Dr Linda Collie	- Deputy Clinical Leader/Clinical Executive
Dr Julie Cullen	- Registered Nurse
Ms Katie Hovenden	- Director of Primary Care
Mr Tom Morton	- Lay Member
Ms Jackie Powell	- Lay Member
Mr Innes Richens	- Chief Operating Officer
Ms Tracy Sanders	- Chief Strategic Officer
Mr Andy Silvester	- Lay Member

Mrs Michelle Spandley - Chief Finance Officer

In Attendance

Dr Dapo Alalade	- Clinical Executive
Mrs Jayne Collis	- Business Development Manager
Mr Paul Cox	- Practice Manager Representative
Dr Elizabeth Fellows	- Chair of Governing Board/Clinical Executive
Mr Patrick Fowler	- Healthwatch Representative
Dr Jim Hogan	- Clinical Leader and Chief Clinical Officer
Ms Suzannah Rosenberg	- Director of Quality and Commissioning
Mrs Terri Russell	- Head of Primary Care Engagement
Mr David Williams	- Chief Executive, Portsmouth City Council

Apologies

Dr Jonathan Lake	- Clinical Executive
Dr Matthew Smith	- Consultant in Public Health (on behalf of vacant Director of Public Health, Portsmouth City Council position)
Dr Tahwinder Upile	- Secondary Care Specialist Doctor

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1. Apologies and Welcome

Apologies received from Dr Jonathan Lake, Dr Matthew Smith and Dr Tahwinder Upile.

Tom Morton welcomed everyone to the meeting and noted that Terri Russell was in attendance in order to present Items 6 and 7. He reminded those present that although the meeting was being held in public it was not a public meeting and therefore no participation from members of the audience is allowed during the formal business of the Committee.

The CCG undertakes primary care co-commissioning under delegated powers from NHS England. As a GP membership organisation we are open and transparent in how we handle perceived or potential conflicts of interest in all aspects of our business. In line with our policies the chairing of the Committee is a lay member representative. In addition there is only one voting representative from member practices, the Clinical Executive lead for primary care. All other Clinical Executives and the practice manager representative are in attendance at the committee which means they will normally be able to participate in discussions where there is no perceived conflict of interest but will not participate in decision making. Where members (voting or in attendance) are felt to have a direct potential conflict of interest they will be excluded from our discussions as well as decision making. However in order to retain the voice of local primary care the Clinical Executive lead for primary care, Dr Linda Collie, will be allowed to participate in discussions for such items unless they are directly about their practice.

2. Declarations of Interest

Dr Linda Collie, Dr Dapo Alalade, Dr Elizabeth Fellows, Dr Jim Hogan and Paul Cox declared possible conflicts of interest relating to agenda items 4 and 5. It was agreed they would withdraw from both discussion and decision making but Dr Collie may remain to provide the local primary care perspective.

3. Minutes of Previous Meeting

The minutes of the Primary Care Commissioning Committee meeting held on Wednesday 18 May 2016 were approved as an accurate record.

An update on actions from the previous meeting was provided as follows:

Agenda Item	Action	Who	By	Progress
3	**Minutes of Previous Meeting** – Rewording of 3rd paragraph on Page 5.	J Collis	July 2016	Complete.
4	**Primary Care Commissioning Committee Work Programme 2016/17** – review our arrangements with HEE (Wessex)	L Collie/ J Maxwell	July 2016	Dr Linda Collie agreed to discuss this with Dr Matthew Smith in light of Dr Maxwell's departure.
5	**Delegated Primary Care Commissioning Annual report 2015/16** – Use GP survey results and any other available information to track year on year changes in satisfaction by patient since we have taken on delegated commissioning.	K Hovenden	Ongoing	This will be incorporated into future monitoring and reporting.
6	**2016/17 GMS Contract Changes** – Work with Healthwatch on information from patients about their experience of online booking with a view to identifying best practice for the future. Update to be provided at next meeting.	K Hovenden /P Fowler	July 2016	On agenda.
7	**Heyward Road Premises Development** – Details of plans for patient engagement from the practice regarding the development would be requested and shared with Healthwatch.	K Hovenden /P Fowler	July 2016	Katie Hovenden has spoken to the practice about sharing information with healthwatch re patient engagement. The practice will continue to engage with patients as the work progresses.
8	**Acute Visiting Service Review and Recommendations** – Consider in future how we might analyse the types of patients being seen by the AVS and whether other measures would have helped.	K Hovenden /M Compton	Ongoing	This is part of an ongoing evaluation.

Dr Dapo Alalade, Dr Elizabeth Fellows, Dr Jim Hogan and Paul Cox declared possible conflicts of interest relating to the following agenda items and therefore excluded themselves from the meeting. Dr Linda Collie remained, as the items did not directly relate to her, in order to provide the voice of primary care.

4. Proposed Closure of the Ramillies Branch Surgery

Katie Hovenden presented a paper which detailed an application to close the Ramillies surgery. The application was discussed at the Primary Care Operational Group meeting held on 18 April 2016 and following a request for some clarification a revised application was reviewed and recommended for approval on 13 June 2016. Trafalgar Medical Group Practice is the new name for the practice following the merger of Osborne Road and

Ramillies on 1 April 2016 and Ramillies is the branch surgery with the Osborne site being the main surgery.

A number of engagement activities have been undertaken including stakeholder meetings and the paper outlines the practice assessment on the impact on patients. Ramillies operate out of an old converted residential property with very limited development opportunities. The practice did apply for a small premise improvement grant last year but following the merger and subsequent proposed closure they decided not to take it forward.

When the application was presented to the Primary Care Operational Group assurance was sought regarding capacity and space for patients, GP and nursing capacity and patients concerns regarding parking.

If approved the CCG would work with the practice on the close down of the site.

Andy Silvester asked about feedback from patients and how many gave feedback and attended the meeting. Katie Hovenden said that she did not know but that she would ask the practice for the information.

Action: K Hovenden

Jackie Powell asked that if patients wanted to move to the Osborne Practice would there be sufficient capacity. Katie Hovenden said that it is possible this may create some pressure on the practice however the CCG would work with the practice to ensure the best use of space. She noted there was potential to create additional NHS clinical space in the Osborne Practice building. Jackie Powell asked if it had been made clear to patients that there was more space at Eastney Health Centre. Katie Hovenden explained that it was more about capacity to see patients rather than space and an action could be put in place to monitor where patients are asking to be seen and if the practice are meeting their requests.

Dr Julie Cullen asked if the proposed date for closure of 1 August 2016 as detailed on page 8 was correct. Katie Hovenden apologised that the date was incorrect and the proposed date for closure is 30 September 2016.

Patrick Fowler asked how the benefits and advantages of practice mergers would be reviewed and would there be learning from these for the future. Katie Hovenden said that a programme could be put in place to evaluate the benefits realised as a result of approved mergers for consideration by the Committee on an ongoing basis.

Action: K Hovenden

Dr Linda Collie commented that it would be useful in future if mergers and then closure such as this proposed could be dealt with as one item. Katie Hovenden said that now that the CCG has taken more operational responsibility for such applications she had put in place revised arrangements to address this as seen in the following agenda item.

The Primary Care Commissioning Committee approved the closure of Ramillies Surgery from 30 September 2016

5. Proposed Merger of Portsdown Group Practice and Northern Road Surgery; and Proposed Closure of Northern Road as a Branch Surgery

Katie Hovenden presented a paper which detailed a proposed merger of Portsdown Group Practice and Northern Road Surgery and subsequent closure of Northern Road Surgery. She explained that this is the first merger/closure that has been taken through the new process that the CCG had established and she would be interested to receive comments.

Northern Road Practice has been exploring opportunities for mergers for some time but for various reasons a merger had not materialised until now. The proposal requests the formal contractual and therefore patient record database merger of Portsdown Group Practice and Northern Road Surgery under one single contract. In order to facilitate progression to a full contractual merger the 2 practices joined each other's contracts on 1 April 2016. Since then Dr Klemenz has unexpectedly decided to hand in his notice and left the practice on 30 June 2016, leaving the Northern Road contract to continue under the names of the 2 Portsdown GPs that were added to the contract in April. They have therefore effectively become responsible for the service provision at Northern Road.

The benefits to patients of the merger and closure are clearly outlined in the proposal. There has been considerable engagement with patients regarding the case for merger prior to Portsdown Group Practice involvement and an open meeting with patients and staff has been held.

Jackie Powell commented that process seems more clear cut.

Tracy Sanders commented that this proposal was in a far more helpful format however the size and scale of engagement with patients and stakeholders, including number of respondents, as part of applications to merger or close branches in future would be useful.

Action: K Hovenden

Tracy Sanders asked for confirmation that there were no plans to alter services at Paulsgrove or Cosham Park House. Katie Hovenden confirmed that there were no plans that the CCG were aware of that will impact on access in Paulsgrove and Cosham.

Tom Morton asked what was meant by a "quasi-trained nurse" as mentioned on page 3 of the application for merger document. Katie Hovenden agreed to look into this and update members at the next meeting.

Action: K Hovenden

Dr Linda Collie noted that she supported the proposal.

The Primary Care Commissioning Committee approved the merger of Portsdown Group Practice and Northern Road Surgery and the simultaneous branch closure of the Northern Road site.

6. General Practice Forward View – Local Implementation

Katie Hovenden introduced a paper which provided a summary of the General Practice Forward View which was published in April 2016.

Terri Russell provided a summary of the key elements in particular the existing and planned initiatives that have been developed locally in response to the national strategy.

Tom Morton asked about next steps and if there was a timeline for the action plan referred to in the paper. Terri Russell explained that the team are putting the action plan together at the moment and they hope to have something ready in the autumn in order to discuss this with member practices and other relevant stakeholders.

Innes Richens commented that it was encouraging to see reference to the bigger picture as outlined in our blueprint. He asked about the collective community nursing workforce and where the thinking is on this. Katie Hovenden explained that we did recognise that the Solent Community Teams had been through some challenging times and it is important to get stability in the workforce before introducing new dynamics however we have identified some areas where they may be opportunities to use the workforce differently as early priorities. Suzannah Rosenberg said that she agreed that there is an improved position

with Community Nursing and they have done a tremendous job. It has been quite an uphill journey and they currently see themselves as a discrete service and therefore there was work to be done to progress aspirations for sharing the workforce differently.

Dr Julie Cullen commented that it is encouraging to hear however there is a workforce of registered nurses in training with placements in primary care who work across all areas and this could be a tremendous advantage. There could be a lot of added value promoting placements for undergraduate nurses.

Michelle Spandley thanked Terri Russell for putting together the paper and for including the local initiatives, when bidding for pots of money we just need to be clear of the process and that it is usually non-recurring.

Dr Jim Hogan commented that all training places in primary care in Wessex are filled. There is a desire that, for the 120 nurses who start in the new school of nursing at Portsmouth University, training will be integrated. The issue is when we plan in silo we have silo rationing and we are starting to feel this in primary care. We are starting to see this with the rationing of district nursing and we need to think about the impact on services.

Paul Cox thanked Terri Russell and her team for producing the paper and commented that the burden that practice managers are feeling is not recognised in the paper. There is nothing in the paper to help practice managers to plan for the future and he said he feels this is an important part of the jigsaw.

The Primary Care Commissioning Committee noted the paper.

7. Healthwatch Portsmouth Mystery Shopper Report – CCG Next Steps

Katie Hovenden introduced a paper which detailed the next steps for the CCG following a mystery shopper exercise undertaken by Healthwatch. She thanked Patrick Fowler for the report for providing the report on behalf of Healthwatch.

Terri Russell highlighted the main areas of the report which has been shared with practices and the CCG:

- Appointment system – Practices were encouraged to promote on-line bookings.

- Out of hours phone messages – Majority of practices had comprehensive and clear message however most did not explain that callers could not leave a message. Practices were contacted and an appropriate message was put in place.

- Website out of hours advice – Practices were contacted to ensure information was up to date and the CCG will review the information regularly and provide feedback.

- Current waiting times – There was a great deal of variation between practices and one case had an excessive wait (up to 35 days). The CCG is working with practices to understand appointment availability.

- Surgery opening hours – CCG will regularly review practice website information and encourage practices to articulate the range of services they offer and if possible include dates and times etc.

- Registration information – There is no requirement for patients to provide ID in order to register with a practice and the CCG has shared the updated guidance with practices.

Patrick Fowler said that it was good to receive the report and see that it has had a positive impact and he hopes that it is developing relationships with practices.

Tom Morton commented that working in partnership is extremely important and the CCG is grateful to Healthwatch for undertaking the exercise.

Dr Elizabeth Fellows commented that the report was really useful and showed the need to balance same day appointments and routine. At the CCG event in Guildhall Square last year, when asked, members of the public suggested that 3-5 days were thought to be a reasonable time to wait for a routine GP appointment. We need to encourage practices and remind them there are other ways of delivering services and scheduling clinics which may better meet the expectations of their patients.

Dr Dapo Alalade asked about registration information and the recent announcement regarding the removal of ghost patients and the impact locally. Terri Russell agreed to look at the guidance and report back to the next meeting.

Action: T Russell

Dr Dapo Alalade asked about wastage and what Healthwatch were doing in terms of advising patients. Patrick Fowler explained that in terms of information to patients Healthwatch would welcome feedback from practices on what would help and if there are particular messages they would like to promote. Paul Cox said that we need to encourage patients to tell practices as soon as they know they cannot attend an appointment. It was agreed that how Healthwatch may help in promoting the importance of attending or cancelling GP appointments would be discussed further.

Action: P Cox/P Fowler

8. Date of Next Meeting in Public

The next Primary Care Commissioning Committee meeting to be held in public will take place on Wednesday 21 September 2016 at 1.00pm – 2.30pm in the Conference Room B, 2nd Floor, Civic Offices. Tom Morton thanked everyone for attending the meeting and reminded members of the public that feedback and comments would be welcomed.

Jayne Collis
28 July 2016

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PRIMARY CARE COMMISSIONING COMMITTEE

Date of Meeting	21 September 2016	**Agenda Item No**	4
Title	**CQC Inspection of GP Practices**		
Purpose of Paper	To provide an update to the committee on the CQC inspection of GP practices in Portsmouth and the support being provided.		
Recommendations/ Actions requested	To note the update on CQC ratings of GP practices in Portsmouth.		
Potential Conflicts of Interests for Board Members	None		
Author	Katie Hovenden – Director of Primary Care		
Sponsoring member	Suzannah Rosenberg – Director of Quality and Commissioning		
Date of Paper	1 September 2016		

CQC Inspection of GP practices

1. Background

The Care Quality Commission are responsible for regulating, inspecting and rating NHS GP practices as well as GP out of hours services.

As the regulator, the CQC will hold GP practices to account for the delivery of any enforcement action or improvement action plan resulting from the inspection but the CCG has a local monitoring and supporting role, particularly as from 1 April 2015, the CCG has delegated commissioning responsibilities for GP primary care services.

Inspections of GP practice are scheduled throughout the remainder of this year and Practices will receive two weeks' notice of their inspection. CQC have indicated that all GP first rating inspections will be completed by 20 January 2017 provided the locations were registered on or before 1 October 2014. Currently reports are being published up to 3 months after the inspection visit but the CQC are seeking to shorten this timescale.

2. Practice Inspections and ratings

The CQC operating model is underpinned by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which include the fundamental standards introduced in April 2015.

Inspectors assess services against five key questions:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

As well as focusing on the five key questions, CQC also look at how services are provided to people in specific population groups. For every NHS GP practice they look at the quality of care for the following six population groups:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia).

To direct the focus of their inspection, inspection teams use a standard set of key lines of enquiry (KLOEs) that directly relate to the five key questions – are services safe, effective, caring, responsive and well-led? These KLOEs are set out in the NHS GP practices and GP Out of Hours Services Provider Handbook.

3. Intelligent Monitoring Data

CQCs operating model includes ongoing Intelligent Monitoring of the risks that individual GP practices are not providing either safe or high-quality care.

The Intelligent Monitoring tool is built on a set of indicators that relate to the five key questions asked of all and analyses a range of information, including patient experience, staff feedback and patient outcomes.

The current sources of information are set out in the table below. This information is intended to give inspectors some background and context about the areas of care that may need to be followed up along with local insight and other factors.

Indicator sources Outcome measures and safety events	**Information from people who use services and the public**	**Information from and about staff**
• Prescribing indicators – safe prescribing/effective prescribing indicators. • Safeguarding referrals and alerts. • Selected QOF indicators. • Secondary care activity: e.g. emergency admission rates for long-term conditions, A&E attendance rates, referral rates to secondary care. • Vaccination rates. • Screening uptake – e.g. breast, cervical cancers. • Patient safety incidents.	• Responses from General Practice Patient Survey. • People's experiences shared with CQC. • Feedback left on NHS Choices, and other feedback sites (e.g. www.Iwantgreatcare.org). Complaints. • Feedback from local Healthwatch.	• Concerns raised by staff to CQC. • Fitness to practise referrals and cases.

4. GP Practice Ratings

CQC ratings of GPs practices are based on a combination of what they find at inspection, what people tell them, Intelligent Monitoring data and information from the provider and other local organisations. Practices will be awarded one of the following ratings: outstanding, good, requires improvement or inadequate.

5. Actions following publication of CQC Report

Practices are first sent a draft copy of their CQC report and have an opportunity to correct factual inaccuracies. Depending on the initial rating, the CCG Director of Quality is also sent a draft copy of the report.

CQC advise the CCG of all new inspection reports published on a weekly basis and CCG Quality Team reviews the published report and in all cases the CCG Accountable Officer then writes to the practice to outline next steps depending on the CQC rating.

6. Special Measures

If a service is rated as inadequate overall it will be placed straight in special measures.

If a GP practice is rated as inadequate for one of the five key questions or one of the six population groups it will usually have six months to improve. Should a practice be rated as "Inadequate" overall the practice will be placed directly into "special measures"

The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example to cancel their registration.

Practices placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, a key question or overall, CQC will take action in line with their enforcement procedures to begin the process of preventing the provider from operating the service.

7. Support to Practice Placed in special measures

At the start of special measures the practice will draw up an action plan, which will be submitted to CQC. The CCG Primary Care Quality and Primary Care teams will work with the NHS England Area Team to provide specific support to the practice, to identify solutions and sources of support and to monitor progress will the delivery of the action plan. The CCG will also need to consider whether any contractual actions are appropriate.

Practices placed in Special Measure have the opportunity to access bespoke support from the Royal College of General Practitioners (RCGP). This programme supports practices that need to make significant changes to improve their services. It provides a package of expert professional advice, support and peer mentoring from senior GPs, practice managers and nurse practitioners with specialist expertise in quality improvement, coordinated by the RCGP.

The RCGP supports the practice in drawing up their improvement plan, which is tailored to the specific needs identified by CQC and any other issues identified by the advisors. The focus of this programme is to:

- help GPs understand the problems identified by CQC
- support the practice to develop an improvement plan to address issues underlying the problems identified by CQC and any additional issues identified by the RCGP (including those highlighted by local contacts)
- help prioritisation of actions required by the improvement plan
- provide direct advice and mentoring to GPs, practice managers and other staff as they work on the improvements agreed in the improvement plan;
- liaise with key stakeholders where appropriate and draw on insight and support from other local practices and professional leaders, including LMCs and CCGs.

The CCG will provide matched funding of £5k so this creates a budget of £10k as a co-funded service. The service is flexible as the practice may not need £10k worth of support from the RCGP.

8. **Summary of GP Practice CQC Reports published to date**

Over the last quarter CQC have carried out and published three more inspections in Portsmouth. Overall ratings for these three were good, requires improvement and inadequate. The quality and primary care teams are working with the practice that has been placed in special measures; this practice has also requested a rating review.

The poorest performing area by far is the safe domain. When drilling down we can identify some areas for improvement but within those areas there are no common themes.

Of note, CQC identified and made comment on a further area of outstanding practice this quarter in relation to leading through learning & improvement.

See Appendix 1 for summary of Portsmouth CCG GP Practice CQC Ratings - January 15 to July 16

Katie Hovenden

Director of Primary Care
September 1st 2016

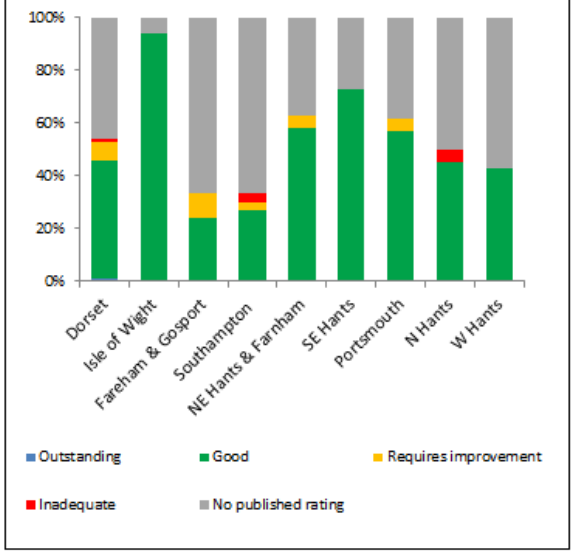
Appendix 1

Summary of Portsmouth CCG GP Practice CQC Ratings - January 15 to July 16

Overall ratings

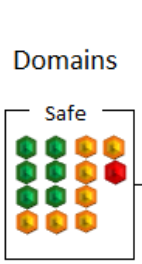
14 practices inspected
12, Good, 1 requires improvement, 1 inadequate

Wessex: CQC Ratings as a proportion of all practices at 25 July 2016



Domains

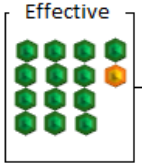
= must do
= should do



Safe

19 must do actions, 14 should do actions

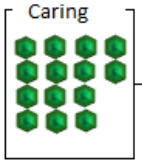
S2 Learning & improvement from safety incidents
S3 Reliable safety systems & processes incl. safeguarding
S3 Medicines management
S3 Cleanliness and infection control
S4 Staffing and recruitment
S5 Monitoring safety and responding to risk
S5 Arrangements for emergencies and major incidents



Effective

1 must do, 4 should do actions

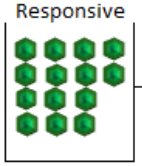
E1 Effective needs assessment
E2 Management, monitoring and improving outcomes
E3 Effective staffing



Caring

3 should do actions

C3 Patient & carers support to cope emotionally with care and treatment

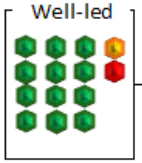


Responsive

4 should do actions, 2 outstanding practice[1]

R3 Access to the service
R4 Listening and learning from concerns and complaints

[1] Open access to the practice for patients who were resident at a local care home.
The practice had a duty GP each day who answered the phones and was joined by two further GPs between 9am & 9.30am. The GPs triaged the calls dealing over the phone, giving general advice, booking urgent appointments or directing patients to the nurse practitioner.



Well-led

2 must do, 1 should do actions, 1 outstanding practice[2]

W2 Governance arrangements
W5 Management lead through learning & improvement

[2] The practice promoted continual development of staff and retained these staff members as employees at the practice. For example, the practice encouraged a staff member to progress on to medical school training and further training as a GP. They have also encouraged a member of the nursing team to train as an advanced nurse practitioner.

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PRIMARY CARE COMMISSIONING COMMITTEE

Date of Meeting	21 September 2016	**Agenda Item No**	5
Title	**Alliance Update**		
Purpose of Paper	The purpose of this paper is to provide an update to the Primary Care Commissioning Committee on the services, projects, and work streams currently being delivered and undertaken by the Portsmouth Primary Care Alliance. This paper also details the funding arrangements between NHS Portsmouth Clinical Commissioning Group and the Alliance to provide these services.		
Recommendations/ Actions requested	This paper is for information purposes. The Committee is asked to note the ongoing developments.		
Potential Conflicts of Interests for Board Members	N/A		
Author	Mark Compton, Head of Primary Care Transformation		
Sponsoring member	Katie Hovenden, Director of Primary Care		
Date of Paper	6 September 2016		

NHS
Portsmouth
Clinical Commissioning Group

Portsmouth Primary Care Alliance Projects and Workstreams

Introduction

The purpose of this paper is to provide an update to the Primary Care Commissioning Committee (PCCC) on the services, projects, and workstreams currently being delivered and undertaken by the Portsmouth Primary Care Alliance (PPCA). This paper also details the funding arrangements between NHS Portsmouth Clinical Commissioning Group (CCG) and the PPCA to provide these services. This paper is for information purposes and the PCCC is asked to note ongoing developments.

Background

The PPCA is a GP federation whose membership is made up of all GP practices in the city, with the exception of the Guildhall Walk Healthcare Centre practice. The PPCA has been established as a limited company whereby GP members are shareholders of the organisation. Similar to other areas across the country, the setup and establishment of a local GP federation has been viewed as an effective enabler to: capitalise on opportunities to deliver primary medical care services at scale; support improved sustainability of primary care; and provide more effective and efficient models of care through transformational change programmes.

Portsmouth CCG has, over the previous 18 months, supported the establishment of the PPCA and funded the Alliance to deliver services, support transformational change, and to facilitate more collaborative working amongst GP practices in the City.

Service Delivery

Currently the PPCA is providing one service delivery contract with the CCG as detailed below:

Acute Visiting Service

Against a backdrop of mounting pressure seen in primary care (through workforce shortages and increased demand), and increased scrutiny of Portsmouth Hospitals Trust (PHT) performance (4 hour wait targets being missed, bed shortages, and increasing delayed transfers of care), the CCG engaged with key stakeholders to devise a means of addressing these challenges. The proposal for an Acute Visiting Service (AVS), whereby GPs provide home visits on behalf of practices to registered patients requiring an urgent visit in a patient's own home or nursing / residential home, was widely supported by local GPs.

The development and establishment of the AVS has been seen as a crucial success element of the Alliance to date, both from the point of view of member GP practices and patients. Responding to home visit requests for frail elderly patients has seen a reduction in the number of patients aged >65 being admitted to hospital during the pilot phase. The service has been funded as a proof of concept through the Better Care Fund and now enters its second year of development, with an extension to in-hours service provision and new delivery models continuing to be tested. The changes in the second year of the pilot include the provision of an afternoon service, and increasing the capacity of the service in the mornings through additional GPs and paramedic practitioners. The service has been operational since September 2015 and current funding is in place until August 2017. During this period the CCG will continue to monitor and review the effectiveness of the service and a

decision will be made regarding on-going funding and main-streaming of the service beyond the testing phase. The total cost of investment in this service in 2016/17 is £449,933.

Development and Infrastructure Support

The CCG continues to fund PPCA for a second year to support primary care involvement in the development and delivery of the Portsmouth Blueprint. This second year of funding builds on work undertaken in 2015/16 through the Clinical Director and Business Support Officer roles within each cluster, as well as funding to support bi-monthly engagement of member practices at cluster meetings.

The CCG has requested that the PPCA and Solent NHS Trust work in partnership to develop a proposal and business case on a new out-of-hospital care model specification, which will include subsequent phased implementation programmes as part of the overall delivery to achieve the vision articulated in the Portsmouth Blueprint.

The funding provided to PPCA for 2016/17 is to enable the development and delivery of this proposal in line with agreed expectations and timeframes. The investment is made in recognition of the need for ongoing infrastructure support and to enable the PPCA to actively lead this work in conjunction with Solent NHS Trust. Specifically this funding will enable PPCA to effectively engage with member practices, Solent NHS Trust, and other key stakeholders in order to develop and subsequently deliver a joint proposal for a new out-of-hospital model of care in line with the strategic objectives outlined in the partnership framework between the three organisations.

A Memorandum of Agreement (MOA) has been accepted between the PPCA and the CCG, outlining the objectives to be achieved with quarterly monitoring to provide assurance these are met. The total cost of investment for development and infrastructure support in 2016/17 is £232,344; the projects and workstreams being implemented as a result of this investment are detailed below.

Projects and Workstreams

The following projects and workstreams are being developed and delivered in support of the MOA.

Clinical Triage within Primary Care Hubs

PPCA are working on developing a model of primary care hub and spoke sites within the city; this includes the provision of an urgent primary care triage model to be delivered at scale on behalf of practices across the city as part of the Portsmouth Blueprint work programme. The ability to effectively manage same-day, urgent care demand, whereby face-to-face appointments are driven primarily by clinical need and patients are effectively signposted to the correct service for their presenting condition (determined through clinical triage), will result in additional capacity within primary care; this additional capacity can be utilised to decrease waiting times for routine primary care appointments, and to provide more proactive, planned care for patients with complex needs. The workstream includes the expansion of an urgent primary care triage hub pilot already being delivered within the city, currently covering circa 55,000 patients.

Detailed below is a list of associated projects which feed into the primary care hub work.

- **Musculoskeletal (MSK) Integration**
  The PPCA are currently working with Solent NHS Trust to devise models of care which result in more effective and efficient management of MSK demand. The organisations are testing the integration of physiotherapists within GP practices so that patients can be advised and managed by a physiotherapist without needing to present to their GP first. The potential reduction in demand on associated MSK services in the community and in secondary care is currently being evaluated before further rollout.

- **Mental Health Integration**
  Similar to the MSK integration, the PPCA and Solent NHS Trust are testing the integration of mental health practitioners within GP practices so that patients can be advised and managed appropriately for their mental health needs without having to present to their GP first. The potential reduction in demand on associated mental health services in the community is currently being evaluated before further rollout.

- **System Demand and Capacity Analysis**
  The PPCA, Solent NHS Trust, and the CCG are currently identifying and scrutinising demand for primary care services across the whole local health system, including: GP practices; Out of Hours (OOHs); Walk-in Centre attendances; A&E attendances (minors); and 111 activity. This information is being linked with workforce analysis to devise new models of care to meet system-wide demand through efficient use of staffing and resources.

- **111 Integration**
  The PPCA and Solent NHS Trust are working with South Central Ambulance Service (SCAS) on how the primary care hub model could better integrate with the local 111 service and manage patient demand more effectively. Currently work is being conducted on the possibility of opening up further service options within a local Hub on the Directory of Services (DOS) by exploring local clinical triage options for specific 111 calls where appropriate.

- **Extended Hours & Out of Hours Delivery**
  The PPCA and Solent NHS Trust are also investigating the potential to expand the provision of traditional core working hours within primary care. The aim is to create a 7 day a week primary care service which has a seamless interface between the traditional in-hours and OOHs care provision. This will be achieved through the establishment of primary care hubs delivering extended hours care delivery which will also integrate with OOH service delivery.

- **Workforce Development**
  PPCA are working with appropriate partners, such as Health Education England (HEE), to investigate further opportunities to co-ordinate, train, and integrate a future workforce of primary, community, and social care staff. This will be achieved through the diversification of the current workforce and enabling new career and training opportunities for existing and new staff. The Alliance is also working with GP trainers in the city to help make Portsmouth an attractive place to recruit the next generation of GPs.

- **Estates**
  As part of the development of primary care hubs within the city, the PPCA are working with practices to understand current freehold and leasehold arrangements with individual GP sites. This information is being used to assess the potential utilisation of specific primary care sites as a base for primary care hubs in the city.

Workforce Bank

In addition to the workforce development project, the PPCA are also working on creating a bank workforce of GPs, Nurses, and Allied Health Professionals which can be called upon by local practices. This will reduce the need to rely on locum agencies who charge a premium rate for their services.

Establishing Multi-Disciplinary Team (MDT) Virtual Ward Meetings

The PPCA and Solent NHS Trust are working with local health partners to develop and refine virtual ward meetings for patients who would benefit from an MDT approach to care management. These MDT meetings include: GPs; Geriatricians; Community Matrons; Social Care; and representatives from the voluntary sector. The Alliance has been working to refine the process in the Central Cluster, and recently rolled out the model to the North and South Clusters.

Cluster Meetings

As detailed earlier in this paper, the PPCA are co-ordinating and managing cluster level meetings between member GP practices in order to facilitate improved collaborative working and develop opportunities for primary care delivery at scale. These meetings are a critical engagement vehicle to develop and promote the transformational work programme being undertaken by the Alliance.

Community Dermatology

The PPCA are working in collaboration with the CCG and PHT to devise a new pathway for dermatology services to be delivered out of hospital in community settings. A business case is currently being constructed and will be considered by the CCG before implementation. The pathway being devised utilises the efficiencies of tele-dermatology to gain the advice and guidance of consultant dermatologists, and also shifts the cutting of skin lesions out to community settings, creating a more cost-effective service closer to patients' homes.

Primary Care Outreach Nursing

The PPCA are working with several practices in the city to assist in the evaluation of outreach nursing pilots currently funded through non-recurrent monies by the CCG. The Alliance are assessing the feasibility and impact of providing a city-wide coordinated service delivered at locality levels. The evaluation and any subsequent business case for recurrent funding will be presented to the CCG and help inform future commissioning intentions.

Organisational Development

Being a newly formed organisation the PPCA are still in the process of aligning their strategy, people, and processes to become a more effective and efficient organisation. The funding received from the CCG assists in their organisational development and ongoing ability for partnership working. It also helps to develop and establish new working arrangements with member practices, as well as respond to any opportunities presented from CCG tendered services.

Investment in 2016/17

Acute Visiting Service	April 16 – August 16 (original model)	£134,062
	Sept 16 – March 17 (new model)	£315,871
	Total	£449,933*
Clinical and Business Infrastructure		£232,344
Total Investment		**£682,277**

*This investment was agreed on an 'invest to save' premise. The estimated savings through reduced non-elective emergency admissions in 2016/17 is £799k, resulting in a net saving of £349k.

Recommendations

The PCCC is asked to note the report and projects in place to secure primary care transformation in Portsmouth City via the work undertaken by PPCA.

Mark Compton, Head of Primary Care Transformation

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PRIMARY CARE COMMISSIONING COMMITTEE

Date of Meeting	21 September 2016	**Agenda Item No**	6
Title	**A Quality Improvement Framework for Primary Medical Care**		
Purpose of Paper	This paper provides an overview of the proposed development of a Quality Improvement framework for General Practice.		
Recommendations/ Actions requested	The Primary Care Commissioning Committee is requested to receive the information included in the paper.		
Potential Conflicts of Interests for Board Members	None		
Author	Terri Russell, head of Primary Care Engagement		
Sponsoring member	Katie Hovenden, Director of Primary Care		
Date of Paper	5 September 2016		

NHS
Portsmouth
Clinical Commissioning Group

A Quality Improvement Framework for Primary Medical Care

Introduction

The introduction of the General Practice Forward View in April 2016 has been generally well received, with the acknowledgement that… "If general practice fails the NHS fails". The report itself sets out a plan aligned with increased investment to stabilise and transform Primary Care and attempts to articulate specific, practical and funded steps that can be taken to grow and develop workforce, drive efficiencies in workload and relieve demand, modernise infrastructure and technology and to support practices to redesign the way primary care is delivered to patients. However one of the most significant challenges will be how we maintain a focus on securing continuous quality improvement in general practice whilst this transformation takes place.

There is no single standard definition for what we mean by "quality" in the NHS. Quality means different things to different people; quality for a patient may mean good access or continuity of care but to a GP may focus on good clinical outcomes.

However in November the Governing board endorsed the CCGs Quality Strategic Framework which outlines NHS Portsmouth's approach to quality and safety ensuring that quality and safety are at the heart of all the health care Portsmouth CCGs commissions, including primary care.

What as a CCG do we mean by Quality

The CCGs Quality Strategic Framework reiterates the high level national outcomes that the CCG needs to improve, namely:

1. Preventing people from dying prematurely
2. Enhancing quality of life for people living with long term conditions
3. Helping people to recover from episodes of ill health following injury
4. Ensuring that people have a positive experience of care
5. Treating and caring for people in a safe environment and protecting them from avoidable harm

These are linked to 3 main areas of the national and local quality agenda i.e. Patient Safety, clinical effectiveness and patient experience

CCG's have, since their inception, had a statutory responsibility to support continuous quality improvement in Primary Care. However with Portsmouth CCG's delegated responsibility for commissioning Primary Medical Services and for the first time a national 'must do' requirement to develop a plan to support the sustainability and quality of general practice, we need to ensure we have a coherent and practical action plan in place for Portsmouth practices.

This document sets out the CCG's intention to develop a Quality Improvement framework for Primary Medical Care that includes the process of developing the framework, sets out the culture of quality improvement that we intend to adopt and outlines the improvement goals we are aiming to achieve as a result.

What is quality improvement?

The NHS has been through a prolonged period of hyperactive policy making and competing beliefs on how to improve quality of care, largely in response to reviews of services that were deemed to have failed patients or consistently delivered poor care and/or poor outcomes. The current paradigm is a focus on increased regulation and inspection, coupled with faith in the role that patient choice, market forces and 'naming and shaming' can play in improving quality.[i]

Within its Quality Strategic Framework , the CCG has adopted the following guiding principles in its approach to quality:

- We will **listen** to our patients, their families and friends and **hear** what they are telling us
- We will **act** quickly when we know that something is not right
- We will be **honest** if things go wrong
- We will strive for **continuous improvement & learning**
- We will not rely on **tick boxes** to assure ourselves of quality

Quality improvement in healthcare should not just based on quality assurance and measurement. It must also encompass principles of staff engagement, small scale trials, teamwork and cooperation with robust clinical leadership. In terms of primary care CCG considered the following of upmost importance: the furtherance of a culture of continual learning and improvement in patient care, providing challenge and support to practices without prejudice and listening to what patients tell us about what is important to them. The CCG is also committed to lessening the administrative burden placed on practices, to reducing stresses and improving the working lives of practice staff which will in turn have a positive impact on patient experience.

Improvement goals

Whilst this paper is not pre-empting any agreed standards and metrics that will form part of the final Primary Care Quality Improvement Framework there are a number of overarching improvement goals that, as a CCG, we will be working on with our member practices. The CCG will preserve a culture of transparency and sharing, whilst maintaining discretion and confidentiality when required.

1. Patient experience
    - Reviewing complaints, FFT feedback and the national GP Patient survey
    - Challenging expectations, utilising technology, empowering patients to self-care
    - Working with Healthwatch and other local stakeholders
2. Patient safety
    - National standards, clinical audit and CQC
    - Local support through the CCG quality team
    - Incident analysis and learning
3. Clinical effectiveness and indicators of variation
    - QOF, Primary Care Web Tool, addressing unwarranted variation
    - Primary Care CQUIN including prescribing workstreams and LCS's
    - Reducing health inequalities, morbidity and mortality
4. Staff Experience

- Reviewing and monitoring workforce indicators
- Developing local programmes to increase recruitment and retention
- Addressing workload issues and developing new roles in general practice

5. Value for money
    - Benefits realisation of primary care at scale
    - Supporting practices to create efficiencies and improve productivity
    - Investment package for general practice linked to clear outcome measures

Developing the Primary Medical Care Quality Improvement Framework

The Primary Care Team will establish a steering group to guide the development of the Quality Improvement Framework and it is imperative that the framework is co-designed with our member practices and other significant stakeholders. This will ensure that the process is accepted and understood within general practice in the city and seen as a supportive tool rather than an additional burden.

Again without anticipating the content of the framework the three core areas that form the tool will be made up of[ii]:

1. Quality Assessment
    - Development of qualitative and quantitative measures in order to assess primary medical services *where possible the assessment tool will utilise existing measures and metrics
2. Quality Improvement
    - A framework of activities to support quality improvement in general practice utilising quality improvement methodologies with support from the Primary Care team, e.g. self-reflection, corrective measures and audit and sharing best practice
3. Quality Assurance
    - Assessment against an agreed set of standards with relevant evidence by an external body (the CCG). This element may include practice visits and/or reports but with minimal burden on practices and is not intended to replicate nor replace existing regulatory requirements (e.g. CQC)

Timescales

The Primary Care Team, in conjunction with the Quality Team and practice representatives will look to developing a draft scheme to share in the autumn 2016. We would look to test the framework with a group of practices initially and then make any necessary changes early in 2017 with a final framework in place for the 1st April 2017.

Terri Russell
Head of Primary Care Engagement
July 2016

[i] Improving Quality in the English NHS – A strategy for action, Nuffield Trust, 2016
[ii] Improving the Quality of Care in General Practices, Kings Fund, 2011

PRIMARY CARE COMMISSIONING COMMITTEE

Date of Meeting	21 September 2016	**Agenda Item No**	7
Title	**GP PATIENT SURVEY RESULTS**		
Purpose of Paper	To inform the Committee of the latest results of the national GP Patient Survey and of the actions the CCG is taking in response to this.		
Recommendations/ Actions requested	The Primary Care Commissioning Committee is requested to receive the information included in the paper.		
Potential Conflicts of Interests for Board Members	None.		
Author	Steve McInnes, Primary Care Relationship Manager		
Sponsoring member	Terri Russell, Head of Primary Care		
Date of Paper	10 September 2016		

GP Patient Survey

The GP Patient Survey (GPPS) is an England-wide survey, administered by Ipsos MORI, which provides CCG and practice-level data about patients' experiences of their GP practices. This covers a range of topics including:

- Making appointments
- Waiting times
- Perceptions of care at appointments
- Practice opening hours

This report presents some of the key results for NHS Portsmouth CCG for the July 2016 publication, which combines two waves of fieldwork, from July to September 2015 and January to March 2016. 6,398 questionnaires were sent out, and 2,337 were returned completed, representing a response rate of 37%.

Results

General observations

It is evident that there is a downward trend locally in the vast majority of measures over the last 3 years and this is in common with the national picture. In many of the indicators a significant variation across practices is noted. Some examples are given below:

- Ease of getting through on the telephone – Range 42% to 97% (rating 'Easy').
- Overall experience of making an appointment – Range 55% to 90% (rating 'Good').

Whilst comparisons are indicative only - due to some concern regarding small numbers and statistical significance - there appear to be areas where it would be worth exploring why the variation exists beyond the potential demographic reasons.

Comparisons against other local CCGs provide a mixed picture and this is summarised within the charts enclosed with this report.

Overall experience of GP surgery

It is pleasing to note that in one of the main overarching measures the CCG average is quite high and just above the national figure (87% vs 85%) indicating that a high proportion of patients rate their GP practice as very good or fairly good.

Making appointments

The CCG's Quality Premium for 2016-17 includes performance relating to one of the key questions in the GPPS: 'Experience of making an appointment'. There is a requirement to attain 85% as a CCG by July 2017 or improve by 3 percentage points between July 2016 and July 2017 publications. The overall CCG result for July 2016 was 73% (in line with the national average) and the aim is to improve on this as much as possible, and attain at least 76% by next year.

Some of the other GPPS measures tie in with the experience of making an appointment and access in general. Areas where the Portsmouth average is *higher or in line* with the national average:

- Ease of getting through to the practice on the phone - 74% reported a good experience (vs 70% national average).
- Helpfulness of receptionists – 87% reported that receptionists were helpful (in line with national average).
- Success in getting an appointment – 85% (in line with national average)

Areas where the Portsmouth average is *lower* than the national average:

- Awareness of online appointment system – 28% (vs 31% national figure).
- Convenience of appointment – 91% had a convenient appointment (vs 92% national).
- Length of time to be seen – 56% stated they *didn't* have to wait too long (vs 58% national)
- Satisfaction with opening hours – 75% (vs 76%)

Confidence and trust in the clinician

Positive results were seen for both GP and Nurse appointments:

- 94% had trust in their GP (94% national)
- 98% had trust in their Nurse (97% national)

What the CCG and practices are doing

The CCG has shared a summary as well as the detailed results from the last two publications, including practice by practice comparisons (with the necessary caveat). The Primary Care Relationship Manager has discussed some of the key results with Practice Managers at the local Practice Manager forum, particularly where the CCG average is lower than other local CCGs and/or the national average. Some small group work was also undertaken to review variations and share experiences and any examples of good practice.

The next step is to make contact with individual practices where they are a clear outlier, and this will be done at both ends of the spectrum, to consider further:

- What practice may be doing well/differently from others to achieve good results
- What actions the CCG/practice may need to take forward to try and improve results

It should be noted that the GPPS results are just one measure of how a practice is perceived by patients and the CCG will be looking to triangulate with other sources of information to develop a fuller picture of patient journeys. This will be part of the CCG's Quality Improvement Framework which is currently being developed by the Primary Care Team.

The CCG is already working with practices on reviewing and improving access, including through one of the key requirements of the Primary Care CQUIN for 2016-17. Within this practices are required to undertake an access audit within their practice in order to help understand capacity and demand and to help inform the development of an improved access plan. Some of the measures for this requirement include improving results from GPPS results that tie in with access.

Some of the detailed slides from the July 2016 results are enclosed for reference, which summarise results of: the CCG Average; national average; the range across Portsmouth practices; and the range across local CCGs.

The next GPPS publication is due January 2017 and this will be reviewed to track progress, particularly around the key measures identified where there appears to be room for improvement.

Steve McInnes
Primary Care Relationship Manager
NHS Portsmouth CCG

10 September 2016

GP PATIENT SURVEY

NHS PORTSMOUTH CCG

Latest survey results

July 2016 publication

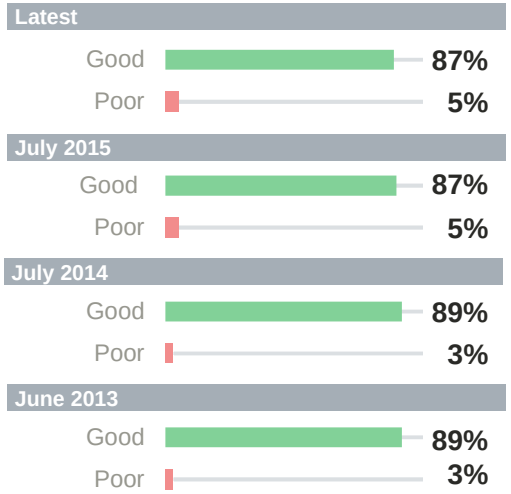
Version 1| Public

Ipsos MORI
Social Research Institute

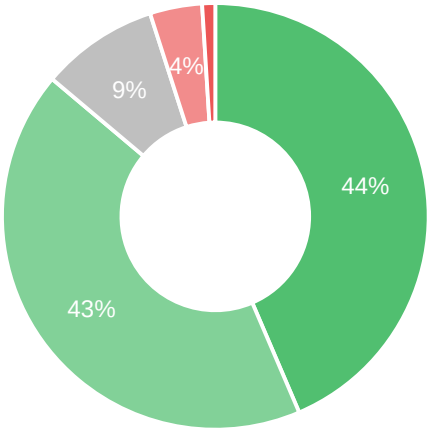
Overall experience of GP surgery

Q28. Overall, how would you describe your experience of your GP surgery?

CCG's results over time



CCG's results

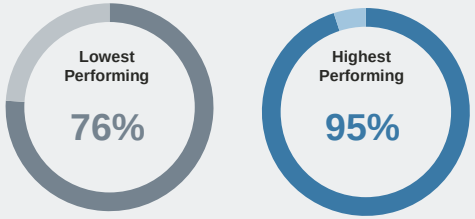


National results

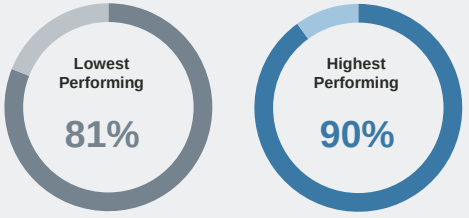
85%
Good

5%
Poor

Practice range in CCG – % **Good**



Local CCG range – % **Good**



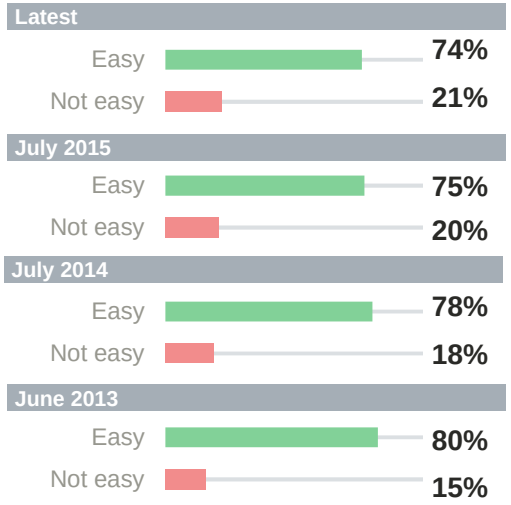
Base: All those completing a questionnaire: National (819,140); CCG 2016 (2,282); CCG 2015 (2,565); CCG 2014 (2,759); CCG 2013 (3,026); Practice bases range from 23 to 122; CCG bases range from 1,950 to 11,303

%Good = %Very good + %Fairly good
%Poor = %Very poor + %Fairly poor

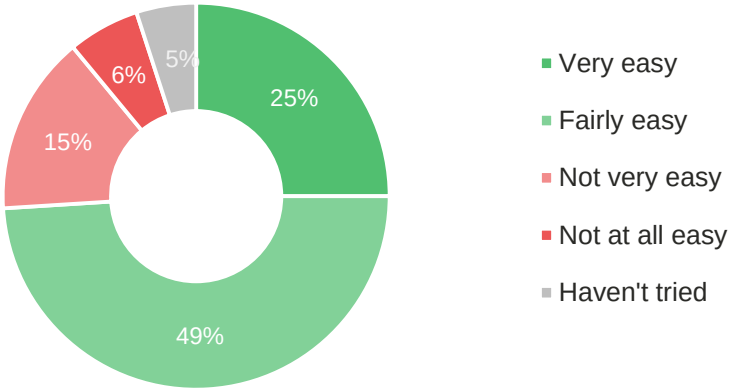
Ease of getting through to GP surgery on the phone

Q3. Generally, how easy is it to get through to someone at your GP surgery on the phone?

CCG's results over time



CCG's results

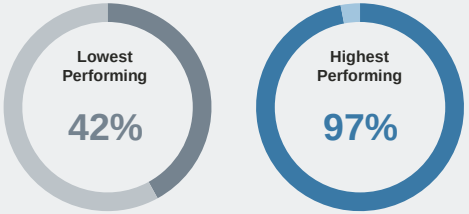


National results

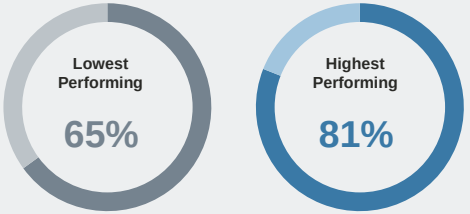
70%
Easy

26%
Not easy

Practice range in CCG - % **Easy**



Local CCG range - % **Easy**



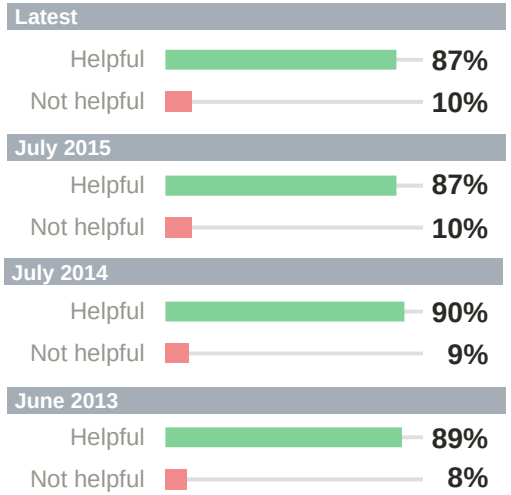
Base: All those completing a questionnaire: National (832,192); CCG 2016 (2,322); CCG 2015 (2,595); CCG 2014 (2,830); CCG 2013 (3,082); Practice bases range from 23 to 126; CCG bases range from 1,972 to 11,543

%Easy = %Very easy + %Fairly easy
%Not easy = %Not very easy + %Not at all easy

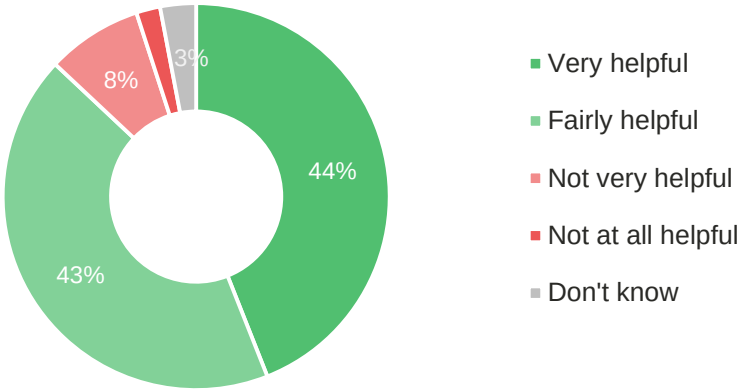
Helpfulness of receptionists at GP surgery

Q4. How helpful do you find the receptionists at your GP surgery?

CCG's results over time



CCG's results

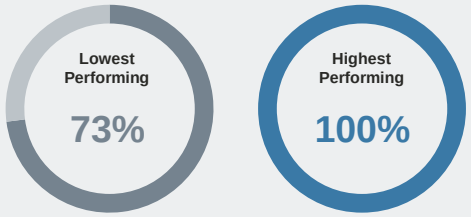


National results

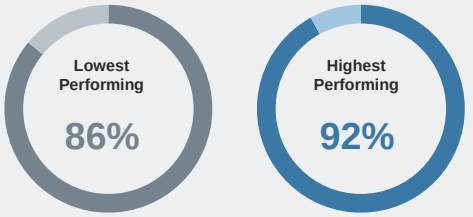
87%
Helpful

11%
Not helpful

Practice range in CCG - % **Helpful**



Local CCG range - % **Helpful**

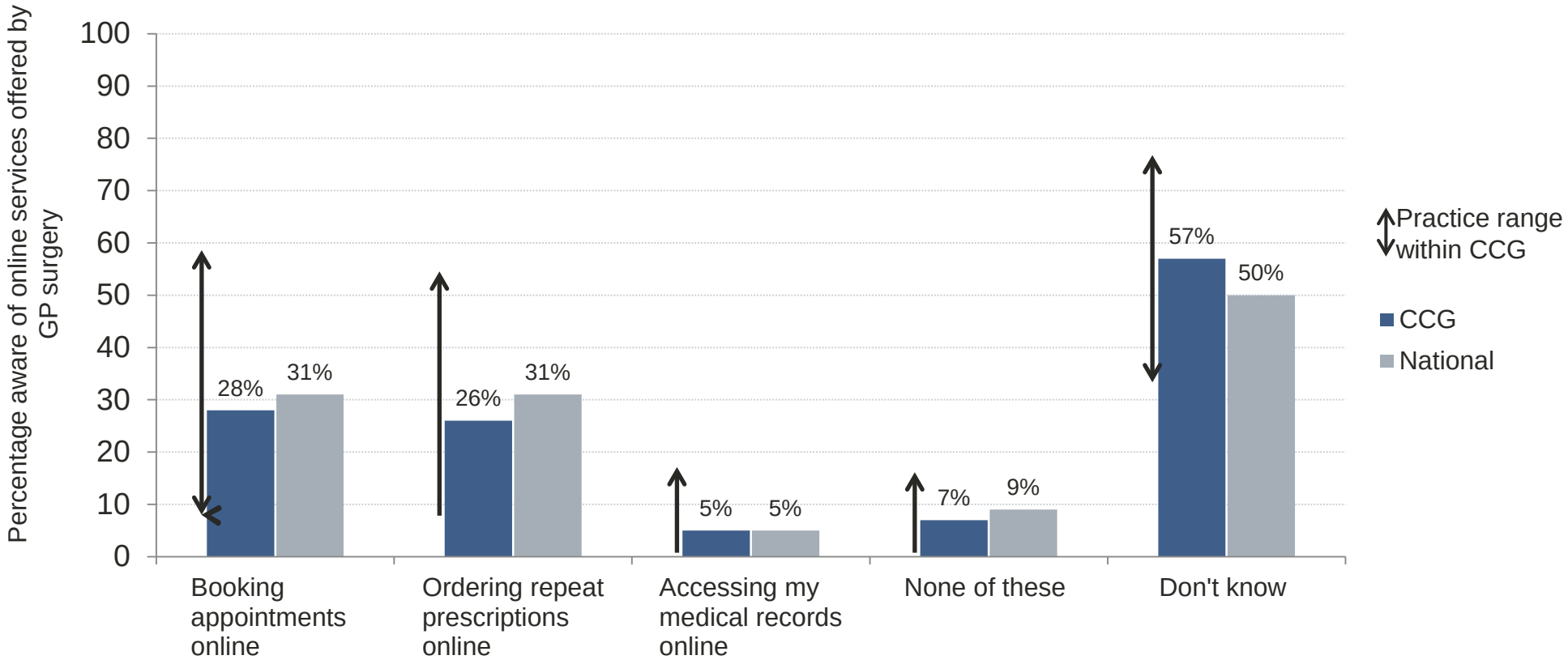


Base: All those completing a questionnaire: National (831,620); CCG 2016 (2,324); CCG 2015 (2,596); CCG 2014 (2,828); CCG 2013 (3,080);
Practice bases range from 23 to 125; CCG bases range from 1,971 to 11,529

%Helpful = %Very helpful + %Fairly helpful
%Not helpful = %Not very helpful + %Not at all helpful

Awareness of online services

Q6. As far as you know, which of the following online services does your GP surgery offer?

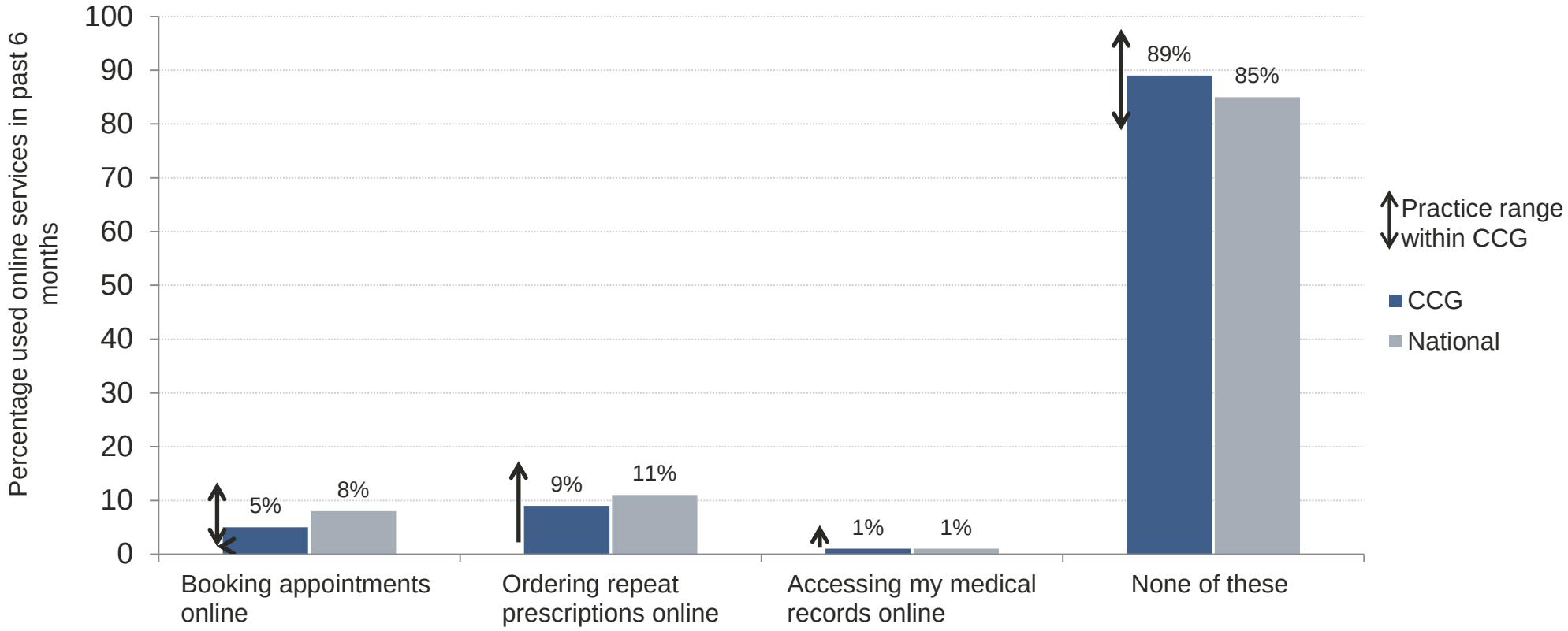


Comparisons are indicative only: differences may not be statistically significant

Base: All those completing a questionnaire: National (808,746); CCG (2,264); Practice bases range from 23 to 123

Online service use

Q7. And in the past 6 months, which of the following online services have you used at your GP surgery?



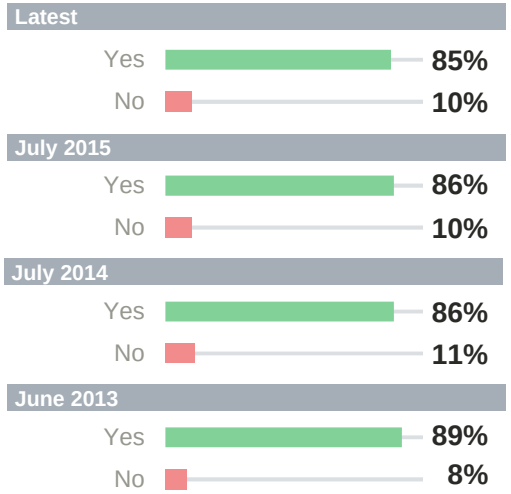
Comparisons are indicative only: differences may not be statistically significant

Base: All those completing a questionnaire: National (810,322); CCG (2,257); Practice bases range from 23 to 124

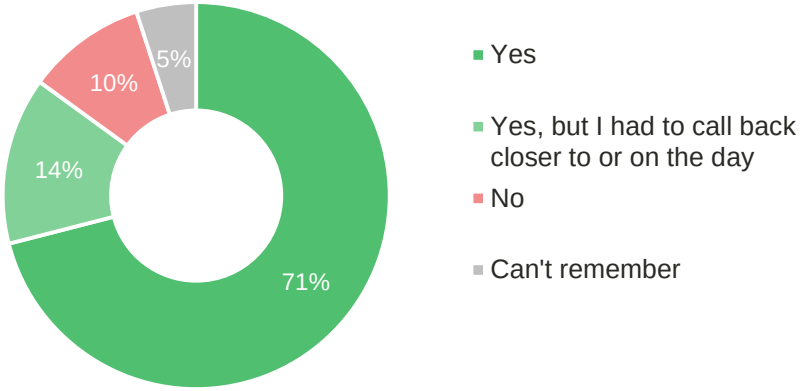
Success in getting an appointment

Q12. Last time you wanted to see or speak to a GP or nurse from your GP surgery, were you able to get an appointment to see or speak to someone?

CCG's results over time



CCG's results

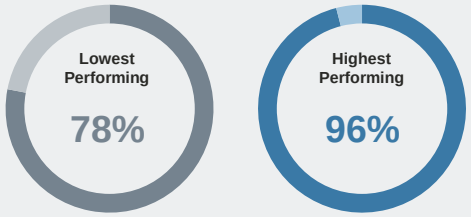


National results

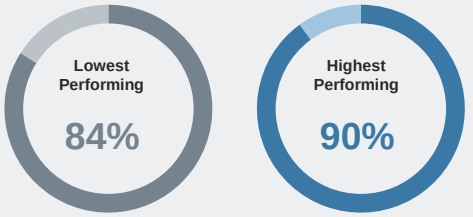
85%
Yes

11%
No

Practice range in CCG - % **Yes**



Local CCG range - % **Yes**



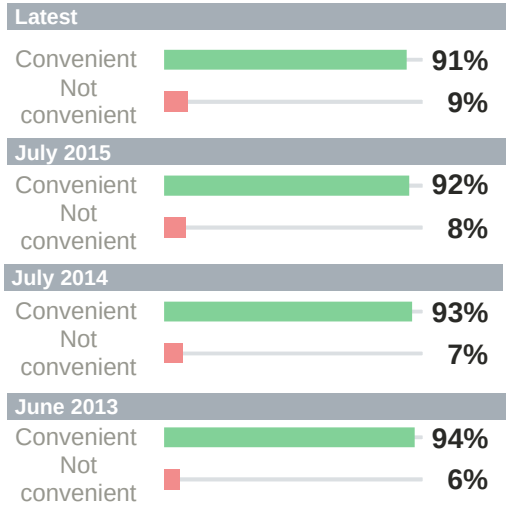
Base: All those completing a questionnaire: National (798,498); CCG 2016 (2,224); CCG 2015 (2,508); CCG 2014 (2,719); CCG 2013 (2,996); Practice bases range from 22 to 120; CCG bases range from 1,889 to 11,150

%Yes = %Yes + %Yes, but I had to call back closer to or on the day

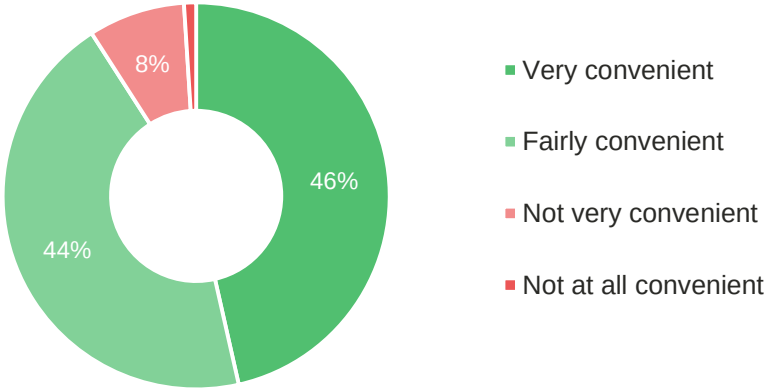
Convenience of appointment

Q15. How convenient was the appointment you were able to get?

CCG's results over time



CCG's results

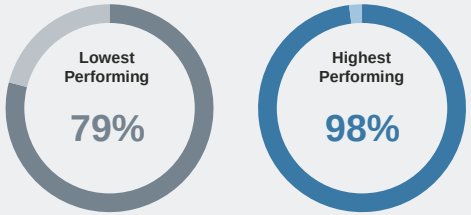


National results

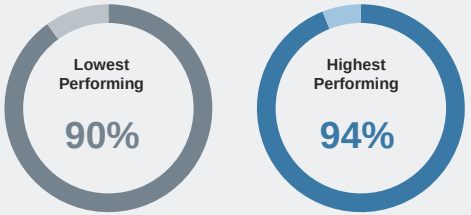
92%
Convenient

8%
Not convenient

Practice range in CCG - % **Convenient**



Local CCG range - % **Convenient**

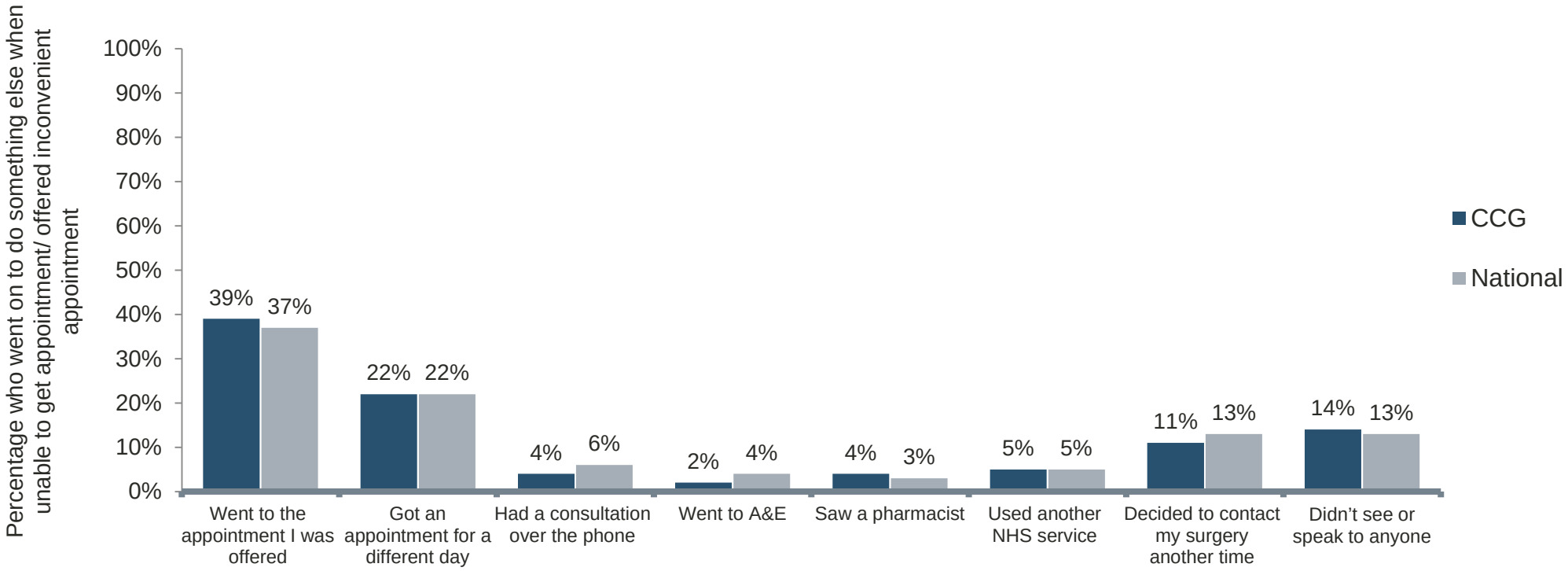


Base: All those able to get an appointment: National (685,063); CCG 2016 (1,918); CCG 2015 (2,209); CCG 2014 (2,379); CCG 2013 (2,667); Practice bases range from 20 to 108; CCG bases range from 1,693 to 10,142

%Convenient = %Very convenient + %Fairly convenient
%Not convenient = %Not very convenient + Not at all convenient

What patients do when they are unable to get appointment / are offered an inconvenient appointment

Q17. What did you do on that occasion?



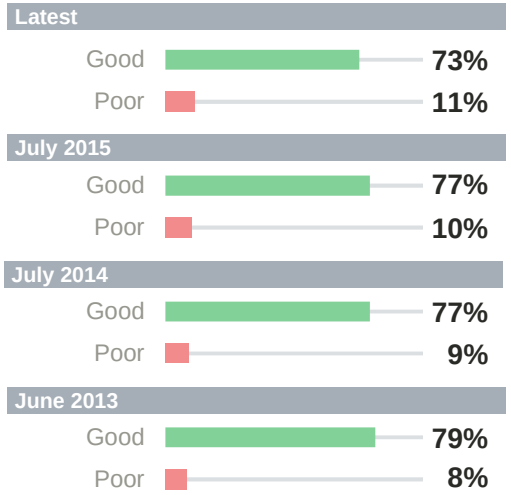
Comparisons are indicative only: differences may not be statistically significant

Base: All those who were not able to get an appointment or were offered an inconvenient appointment: National (113,406); CCG (309)

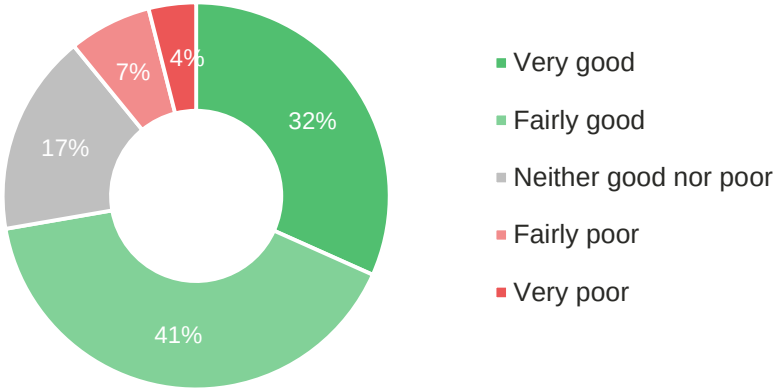
Overall experience of making an appointment

Q18. Overall, how would you describe your experience of making an appointment?

CCG's results over time



CCG's results

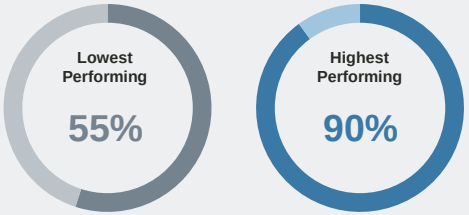


National results

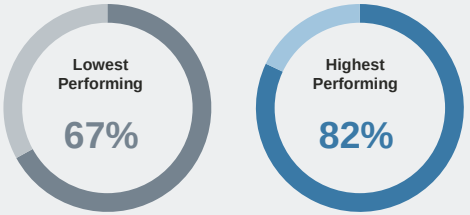
73%
Good

12%
Poor

Practice range in CCG - % **Good**



Local CCG range - % **Good**



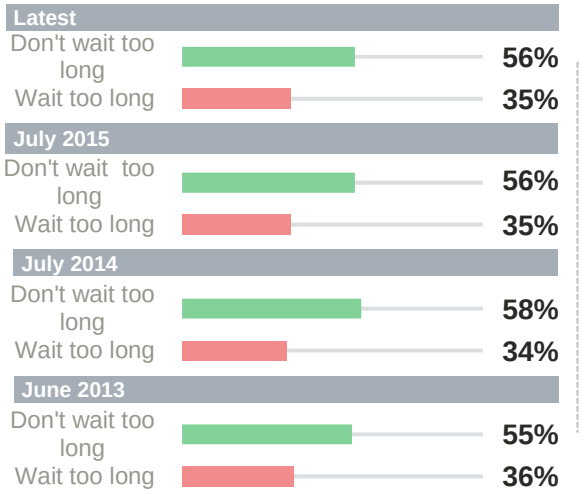
Base: All those completing a questionnaire: National (795,484); CCG 2016 (2,213); CCG 2015 (2,501); CCG 2014 (2,704); CCG 2013 (2,968); Practice bases range from 22 to 120; CCG bases range from 1,872 to 11,073

%Good = %Very good + %Fairly good
%Poor = %Fairly poor + %Very poor

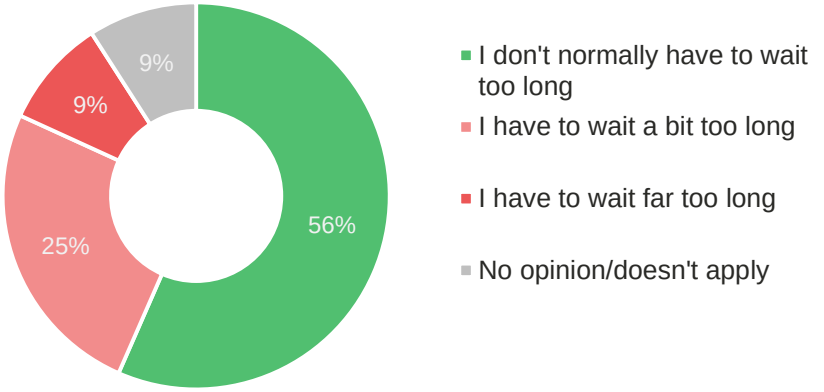
Waiting times at the GP surgery

Q20. How do you feel about how long you normally have to wait to be seen?

CCG's results over time



CCG's results



National results

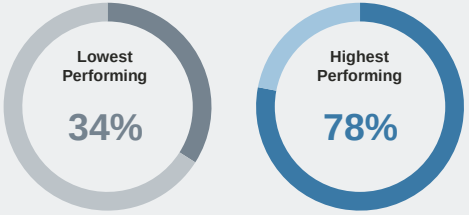
58%

Don't wait too long

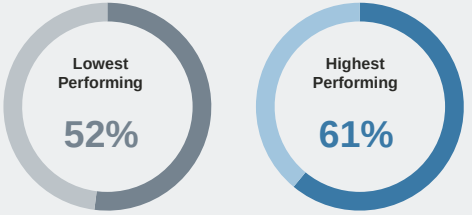
34%

Wait too long

Practice range in CCG – % **Don't wait too long**



Local CCG range – % **Don't wait too long**



Base: All those completing a questionnaire: National (799,241); CCG 2016 (2,232); CCG 2015 (2,499); CCG 2014 (2,716); CCG 2013 (2,985); Practice bases range from 22 to 120; CCG bases range from 1,870 to 11,124

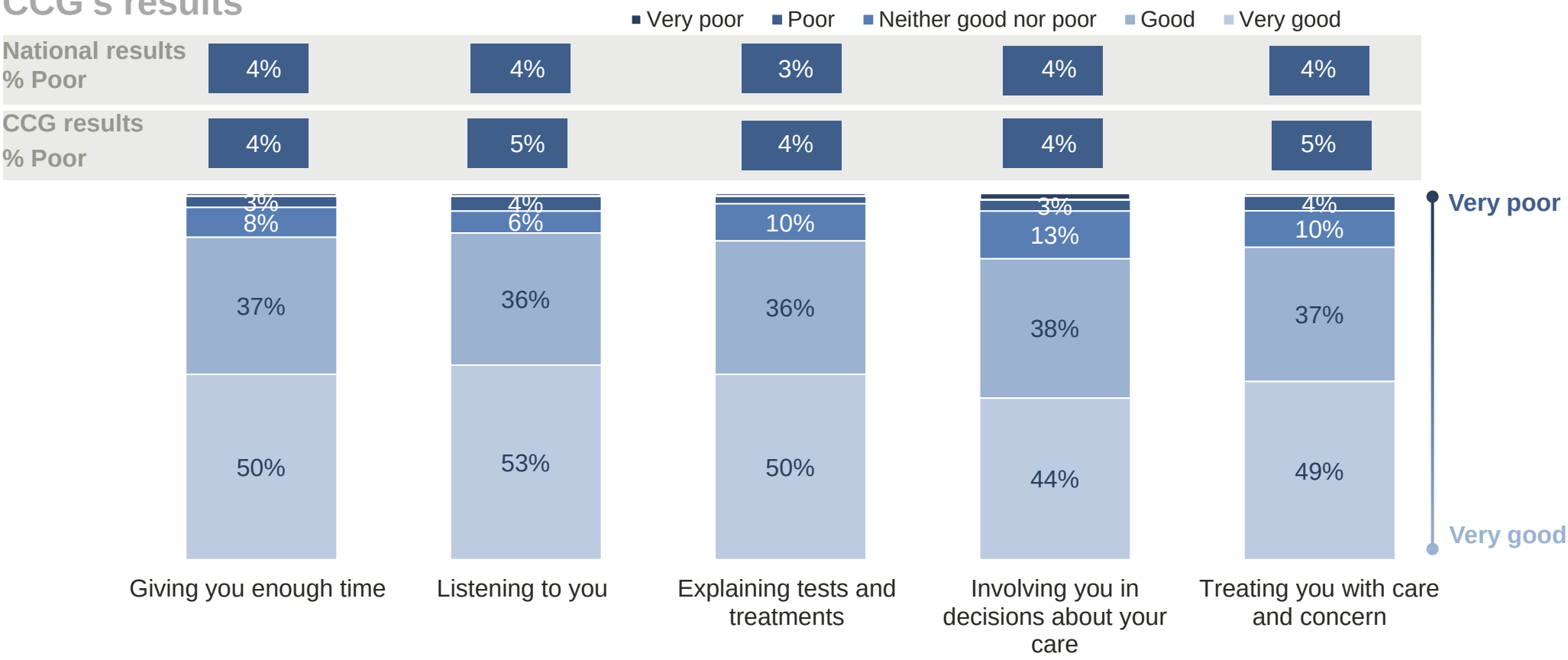
%Wait too long= %Wait a bit too long + %Wait far too long

Perceptions of care at last GP appointment

Q21. Last time you saw or spoke to a GP from your GP surgery, how good was that GP at each of the following?*

*Those who say 'Doesn't apply' have been excluded from these results.

CCG's results



Base: All those completing a questionnaire excluding 'doesn't apply': CCG (2,223; 2,225; 2,116; 2,030; 2,186); National (794,990; 793,029; 763,302; 733,291; 780,925)

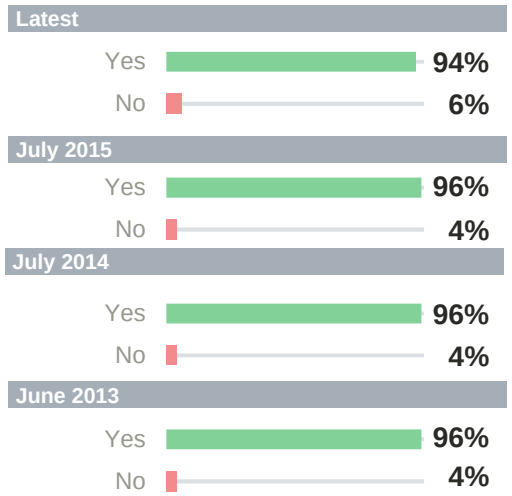
%Poor = %Very poor + %Poor

Confidence and trust in the GP

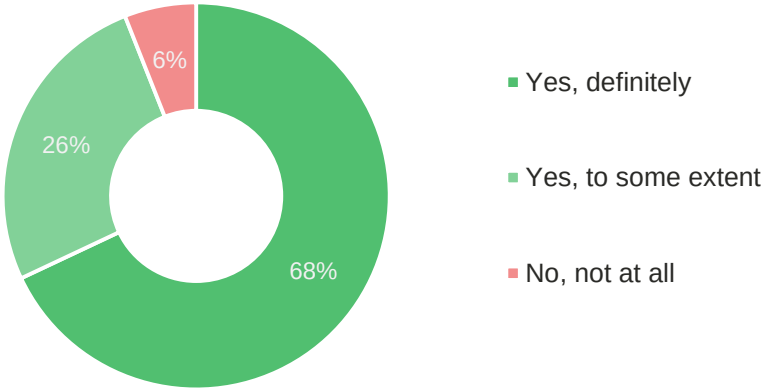
Q22. Did you have confidence and trust in the GP you saw or spoke to?*

*Those who say 'Don't know/can't say' have been excluded from these results.

CCG's results over time



CCG's results

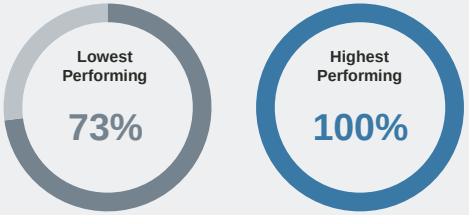


National results

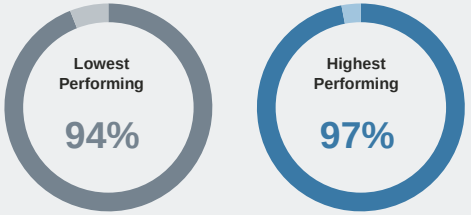
95%
Yes

5%
No

Practice range in CCG - % **Yes**



Local CCG range - % **Yes**



Base: All those completing a questionnaire excluding 'don't know/ can't say': National (781,398); CCG 2016 (2,193); CCG 2015 (2,472); CCG 2014 (2,684); CCG 2013 (2,949); Practice bases range from 20 to 120; CCG bases range from 1,860 to 10,964

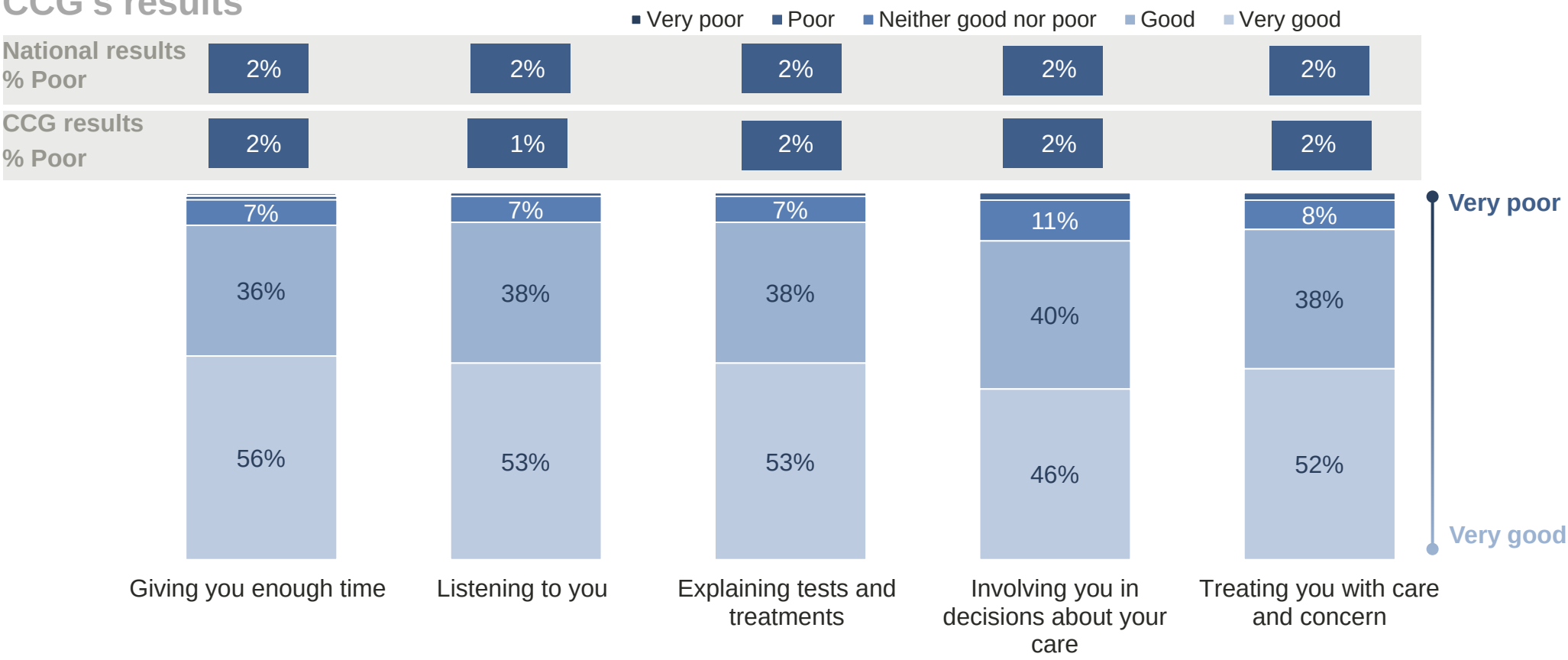
%Yes = %Yes, definitely + %Yes, to some extent

Perceptions of care at last nurse appointment

Q23. Last time you saw or spoke to a nurse from your GP surgery, how good was that nurse at each of the following?*

*Those who say 'Doesn't apply' have been excluded from these results.

CCG's results



Base: All those completing a questionnaire excluding 'doesn't apply': CCG (2,001; 1,975; 1,901; 1,707; 1,945); National (712,463; 705,297; 686,913; 625,477; 695,184)

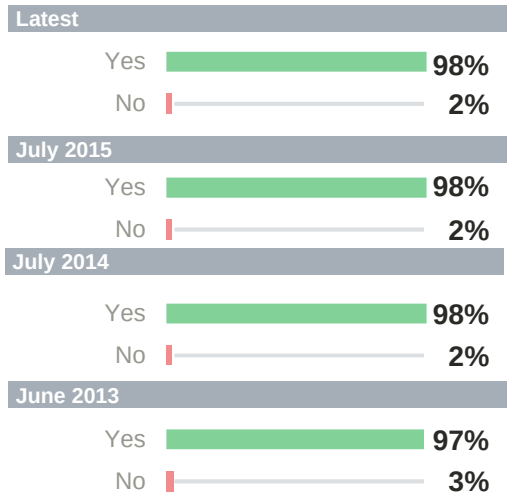
%Poor = %Very poor + %Poor

Confidence and trust in the nurse

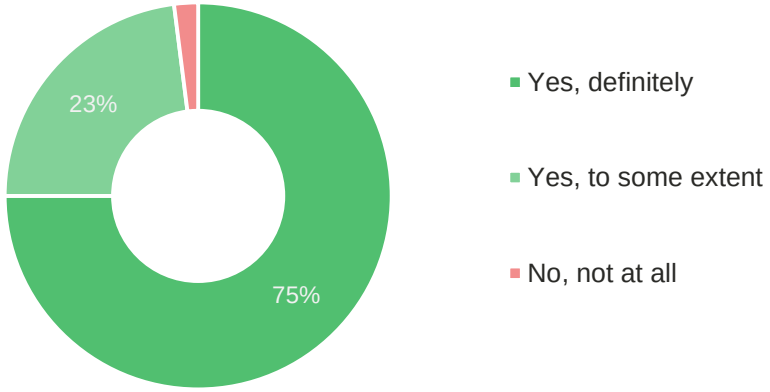
Q24. Did you have confidence and trust in the nurse you saw or spoke to?*

*Those who say 'Don't know/can't say' have been excluded from these results.

CCG's results over time



CCG's results

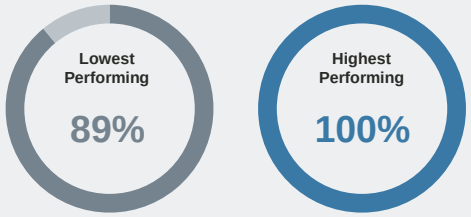


National results

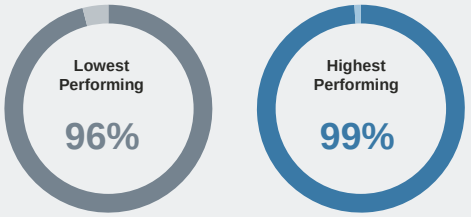
97%
Yes

3%
No

Practice range in CCG - % **Yes**



Local CCG range - % **Yes**



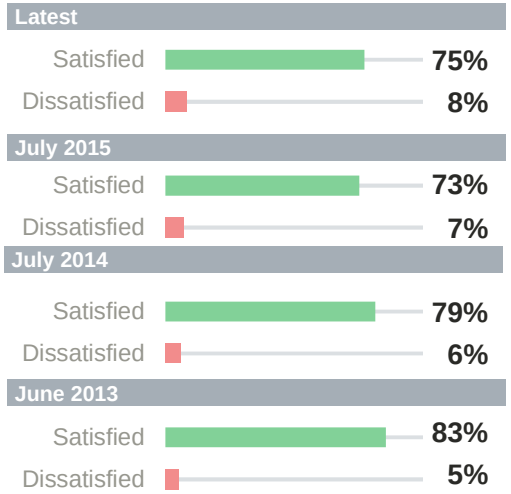
Base: All those completing a questionnaire excluding 'don't know/ can't say': National (703,184); CCG 2016 (1,968); CCG 2015 (2,233); CCG 2014 (2,447); CCG 2013 (2,694); Practice bases range from 18 to 110; CCG bases range from 1,712 to 9,843

%Yes = %Yes, definitely + %Yes, to some extent

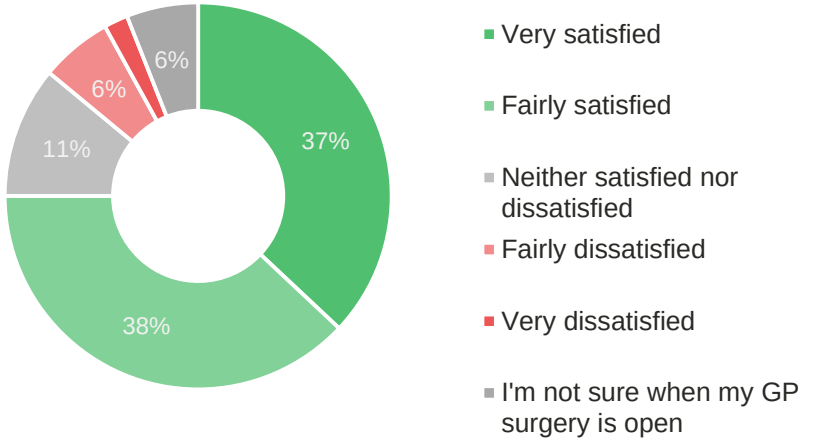
Satisfaction with opening hours

Q25. How satisfied are you with the hours that your GP surgery is open?

CCG's results over time



CCG's results

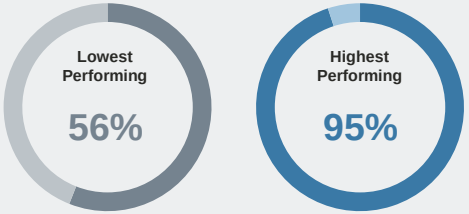


National results

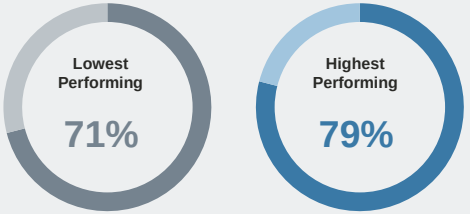
76%
Satisfied

9%
Dissatisfied

Practice range in CCG - % **Satisfied**



Local CCG range - % **Satisfied**



Base: All those completing a questionnaire: National (820,097); CCG 2016 (2,299); CCG 2015 (2,567); CCG 2014 (2,765); CCG 2013 (3,032); Practice bases range from 23 to 124; CCG bases range from 1,951 to 11,319

%Satisfied = %Very satisfied + %Fairly satisfied
%Dissatisfied = %Very dissatisfied + %Fairly dissatisfied