PUBLIC

Agenda item 8

DERBYSHIRE HEALTH AND WELLBEING BOARD

5 October 2017

Report of Dr Alan Dow

Primary Care Reform Update

1. Purpose of the report

To provide the Health and Wellbeing Board with an update on the details of the Greater Manchester Primary Care Reform Programme.

2. Information and analysis

This paper is the agreement which sets out the terms and conditions upon which funding from the Greater Manchester transformation fund has been awarded to Tameside and Glossop CCG for distribution within the Locality area. The aim of the additional investment is to take forward a number of elements of the Primary Care Strategy, specifically strengthening resilience within general practice and improving access, quality and outcomes for patients.

There are a number of specifically funded elements within this investment agreement:

- Provision of 7 day access
- Training care navigators and medical assistants
- Development of a GM Resilience Programme
- Provision of a Clinical Pharmacy Programme
- Provision of online consultation software

The NHS Contract, Operational and Planning Guidance sets out national requirements for primary care. The GM Primary Care Reform Programme is clear that the funding within this investment agreement must enable system wide transformation by ensuring sustainable general practice. The investment agreement (attached) outlines the national requirements relating to primary care and the Tameside and Glossop response to delivery of the requirements.

GMHSCP, CCG, LMC and Orbit (GP Federation) are all signatories to the agreement to demonstrate joint working and resilience.

To support the delivery of the Programme the GM Chief Officer has agreed to allocate £3.588m of Transformation Funding to the Locality.

The document is the completed submission to GMHSCP which sets out our Locality response to the requirements, which includes areas where we are already delivering and areas where progress is required.

3. Links to the Health and Wellbeing Strategy

The key priorities are aligned to the GP Forward View and clearly set out the objective of improving access to primary care, including through the expansion of primary care workforce for capacity and skills and the further usage of technology for the provision of services.

RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1. Note the submission and contents of the Investment Agreement made to GMHSCP, including the requirements.

2. Receive future progress updates as appropriate

Alan Dow
CCG Chair
Tameside and Glossop CCG

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

GREATER MANCHESTER HEALTH AND SOCIAL CARE TRANSFORMATION
TAMESIDE AND GLOSSOP CCG INVESTMENT AGREEMENT
GM PRIMARY CARE REFORM PROGRAMME

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PARTIES

This is an agreement between:

(1) NHS England, 3 Piccadilly Place, London Road, Manchester, M1 3BN

(2) NHS Tameside and Glossop CCG Clinical Commissioning Group, Dukinfield Town Hall, King Street, Dukinfield, SK16 4LA

(3) Orbit Healthcare Ltd, GP Federation, Haughton Thornley Medical Centre, Thornley Street, Hyde, SK14 1JY

(4) West Pennine Local Medical Committee, c/o Barley Clough Medical Centre, Nuggett Street, Oldham, OL4 1BN

each a **Party** and together, the **Parties.**

BACKGROUND

(A) Pursuant to the GM devolution agreement between Government and GM local authorities and the MoU developed between GM local authorities, GM CCGs and NHS England (which created a framework for the delegation and ultimate devolution of health and social care responsibilities to GM), from April 2016, the NHS bodies and local authorities in GM have taken control of £6bn of public money to run health and social care throughout the region.

(B) The Greater Manchester Health and Social Care Devolution Memorandum of Understanding ('MOU') sets out the ambition for full devolution of funding and decision making for health and social care in GM. It describes the principles for how partners will work together, including a commitment to collaborate and make decisions in the best interests of patients and the people of GM.

(C) The NHS bodies and local authorities in GM have developed a comprehensive GM Strategic Plan ('Taking Charge') to address the key challenges facing health and social care. The GM Strategic Plan sets out how, in pursuing five transformation themes, the NHS bodies and local authorities in GM will achieve clinical and financial sustainability.

(D) NHS England agreed in December 2015 that £450m would be made available over a five year period for the establishment of a 'Transformation Fund' on the basis that the GM HSCPB would oversee the deployment of this fund within GM to deliver the major change programme set out in the GM Strategic Plan, whilst securing locally the

outcomes to which NHS England is committed as a consequence of the November 2015 Comprehensive Spending Review.

(E) The objectives of the Transformation Fund are to support solutions which deliver clinical and financial sustainability across GM and at locality level and improve the health and social outcomes included in the GM Strategic Plan.

(F) The specific purpose of the Transformation Fund is: investment in new systems, processes and infrastructure; and/or additional costs involved in developing and implementing new services while existing services are decommissioned.

(G) In order to access the Transformation Fund a Locality must have in place a robust Locality Plan agreed by all key parties in the Locality Area, which is wholly aligned to the broader vision for health and social care transformation in GM and the specific schemes identified in the GM Strategic Plan.

(H) Access Criteria for the Transformation Fund have been developed and agreed by the GM HSCPB.

(I) These criteria have been adopted by the GM Chief Officer on behalf of NHS England.

(J) The overall governance and accountability of the Transformation Fund is the responsibility of the GM Chief Officer and Head of Paid Service, GMCA, both supported by the GM HSCPBE.

(K) The Transformation Fund will be subject to the GM Accountability Framework, which will specify a full range of outcomes across health and social care to be delivered by the Transformation Fund.

(L) NHS England has delegated responsibility internally to the GM Chief Officer for allocating the awards from the Transformation Fund. The GM HSCPBE has considered the Transformation Fund proposal outlining the GM Primary Care Reform Programme and made a recommendation to the GM Chief Officer for actioning. The GM Chief Officer having considered the application accepted this recommendation on [DATE].

(M) This Agreement sets out the terms and conditions upon which funding from the Transformation Fund has been awarded to the CCG for distribution within the Locality Area.

(N) This Agreement should be read in association with other key documents:

(i) GM Primary Care Reform programme (Schedule 1)
(ii) GM Primary Care Strategy (Schedule 1A)
(iii) Locality mobilisation plan – Primary Care Reform (Schedule 2)
(iii) Locality based initiatives for primary care reform (Schedule 3)

1. Definition and Interpretation of terms

1.1 The definitions and rules of interpretation in this clause apply in this Agreement

Access Criteria: criteria agreed on in March 2016 by the GM HSCPB[1] and adopted by NHS England that must be satisfied in order for a Locality to be granted Transformation Funding:

- Deliver the GM vision
- Enable transformational change
- Consolidate resources
- Secure value for money
- Facilitate learning for others

Agreement: this agreement between the Parties comprising these terms and conditions together with all schedules attached to it

CCG: the Clinical Commissioning Group specified as a Party to this Agreement and which is receiving Transformation Funding in accordance with this Agreement

Commencement Date: [date]

Expiry Date: At the end of [date]

Five Year Forward View: the document published in October 2015 by NHS Improvement, the Care Quality Commission, Public Health England and Health Education England setting out a new shared vision for the future of the NHS based around new models of care[2]

GP Forward View: the document published in April 2016 acknowledges the pressures faced in General Practice and sets out a programme of

[1] https://www.greatermanchester-ca.gov.uk/download/meetings/id/753/04a_transformation_fund_criteria

[2] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

support to General Practice in respect of investment, workforce, workload, infrastructure and care design.

GM: the Greater Manchester region comprising 10 local authority areas: Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford, and Wigan

GM Accountability Framework: A GM Accountability Framework to set the approach to be undertaken internal to GM describing thresholds and levels of intervention and how the GM system can have oversight of its own performance to inform any national requirements." Timescale for completion of the Framework is August 2016[3]

GM Chief Officer: means the NHS England officer appointed to lead the GM health and social care devolution programme

GMCA: Greater Manchester Combined Authority

GM HSCPB: the Greater Manchester Health and Social Care Partnership Board governed by the terms of reference set out in Schedule 5, which is responsible for setting the overarching strategic vision for the GM health and social care economy

GM HSCPBE: the Greater Manchester Health and Social Care Partnership Board Executive a group comprised of members of the GM HSCPB which was established to provide support to the GM HSCPB

GM Primary Care Strategy: the GM Primary Care Strategy 'Delivering Integrated Care across Greater Manchester – The Primary Care Contribution' sets out the direction of travel for primary care transformation going forward and is aligned to the 10 Greater Manchester Locality Plans.

GM Strategic Plan: the GM Strategic Sustainability Plan – Taking Charge[4] and the implementation plan set out within, aligned to the Five Year Forward View, which sets out how GM will achieve clinical and

[3] https://www.greatermanchester-ca.gov.uk/download/meetings/id/1166/07_taking_charge_-_implementation_plan

[4] https://www.greatermanchester-ca.gov.uk/homepage/73/taking_charge_of_our_health_and_social_care_in_greater_manchester

financial sustainability during a five year period underpinned by a number of principles agreed in the MoU signed in February 2015[5]

Health and Wellbeing Board: the forum established by the Health and Social Care Act 2012 where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities and, in the context of this Agreement, refers to the relevant Health and Wellbeing Board for the Locality Area.

Inter Authority Transfer: An Inter Authority Transfer (IAT), is the mechanism used by CCGs, NHS England and NHS England local area teams to transfer resource known as allocations. It cannot be used with other organisations such as NHS providers or LAs

A sending and receiving organisation is required (like a budget transfer between budget holders in a standard organisation)

Key Milestones: has the meaning set out in Clause 5.2

Local Authority: the local authority specified as a Party to this Agreement

Local Authority Transformation Funding: the proportion of the Transformation Funding payable to a Local Authority to enable it to deliver the Locality Plan

Locality: the GM Local Authority, the CCG and the Providers who are Parties to this Agreement

Locality Area: The geographical area covered by the Local Authority

Locality Cost Benefit Analysis: the detailed financial analysis and evaluation of the costs and benefits associated with the Locality Plan [and which is attached at Schedule 8 to this Agreement]

Locality Plan: a 5 year plan for health and social care and wider public service reform, which has been developed and agreed between the commissioners and providers within the Locality Area [and which is attached at Schedule 1[A] to this Agreement]

[5] https://www.greatermanchester-ca.gov.uk/downloads/download/40/greater_manchester_health_and_social_care_devolution_memorandum_of_understanding

Locality Plan Implementation Plan: the plan describing the implementation of the Locality Plan, which was endorsed by the GM HSCPB [and which is attached at Schedule 1B to this Agreement]

MoU: the Greater Manchester Health and Social Care Devolution Memorandum of Understanding, an agreement between the GM local authorities, the GM CCGs and NHS England which was signed in February 2015 and which creates a framework for the delegation and ultimate devolution of health and social care responsibilities to GM

NHS Act: National Health Service Act 2006

NHS England: the National Health Service Commissioning Board established by section 1H of the NHS Act and known as NHS England

NHS Improvement: the operational name for the organisation bringing together Monitor, the NHS Trust Development Authority and certain patient safety and service change teams

NHS Improvement Agreement: any agreement entered into between NHS Improvement (or one of its constituent legal entities) and a provider in the Locality Area relating to an allocation from the Sustainability and Transformation Fund

Programme: the GM Primary Care Reform Programme, a programme of reform (set out in Schedule 2) created in accordance with the Locality Plan or transformation theme, for which Transformation Funding has been awarded

Provider Transformation Funding: the proportion of the Transformation Funding payable to a NHS Trust/Foundation Trust to enable it to deliver the Locality Plan

Recipients: those Parties who have been identified in the Locality Plan Implementation Plan as proposed recipients of the Transformation Funding

Senior Leader: the person appointed by the Locality responsible for delivering the Programme and for delivering value for money from the funds awarded to the Locality.

Stronger Together: the GM strategy published in 2013 by GMCA and the Local Enterprise Partnership (LEP) around the twin themes of Growth and Reform that sets out a series of priorities that will drive sustainable economic growth and reform the way that public services are delivered

Sustainability and Transformation Fund: the national transformation fund established to support delivery of the Five Year Forward View

Taking Charge: the GM Strategic Plan

Transformation Fund: the £450m fund that NHS England has agreed to allocate to GM to deliver the major change programme set out in the GM Strategic Plan, whilst securing locally the outcomes to which NHS England is committed as a consequence of the November 2015 Comprehensive Spending Review, and which represents GM's share of the available transformation budget over the period 2016 to 2021

Transformation Funding: the sum of funding allocated by NHS England from the Transformation Fund to the CCG to distribute to the Recipients

Transformation Fund Proposal: the proposal documentation that was submitted by the Locality to secure access to Transformation Funding [and which is attached at Schedule 8 to this Agreement]

1.2 Clause, Schedule and paragraph headings shall not affect the interpretation of this Agreement.

1.3 The Schedules form part of this Agreement and shall have effect as if set out in full in the body of this Agreement. Any reference to this Agreement includes the Schedules.

1.4 A reference to a statute or statutory provision is a reference to it as it is in force for the time being, taking account of any amendment, extension or re-enactment and includes any subordinate legislation for the time being in force made under it.

1.5 A reference to a document is a reference to that document as varied (other than in breach of the provisions of this Agreement) at any time.

1.6 References to clauses and Schedules are to the clauses and Schedules of this Agreement. References to paragraphs are to paragraphs of the relevant Schedule.

2. Term

2.1 This Agreement shall take effect on the Commencement Date and shall continue until the Expiry Date, unless extended in accordance with clause 2.2 or terminated sooner in accordance with the provisions of this Agreement.

2.2 The Parties may extend this Agreement by such period as they agree.

3. Objectives of the Agreement

3.1 By entering into this Agreement the Parties re-affirm their commitment to:

(i) deliver the transformation of health and social care services in GM and the wider reform of public services in GM as set out in the GM Strategic Plan.
(ii) deliver the commitments of the GM Primary Care Reform Programme
(iii) collaborate and cooperate with each other, in line with the principles set out in the MOU, and work within the agreed GM Health and Social Care partnership governance arrangements.

3.2 Each Party confirms that implementation of its obligations under this Agreement is consistent with its statutory obligations, and that it has complied with any relevant requirements imposed upon it by legislation or regulatory authority, and will continue to do so.

3.3 The aim of the additional investment is to take forward a number of elements of the Primary Care Strategy, specifically strengthening resilience within General Practice and improving access, quality and outcomes for our 2.8M residents.

3.4 There are a number of specifically funded elements within this investment agreement:

- Provision of 7 Day access
- Training Care Navigators and Medical Assistants
- Development of a GM Resilience Programme
- Provision of a Clinical Pharmacy Programme
- Provision of on-line consultation software

These are described in more detailed in the papers attached at Schedule 1A and 1B, and the detailed metrics and milestones set out in Schedule 2. These describe how the specific schemes will be delivered in the context of a wider programme of reform of primary care.

The NHS Contract, Operational and Planning Guidance sets out national requirements for primary care. The GM Primary Care Reform Programme is clear that the funding within this investment agreement must enable system wide transformation by ensuring sustainable

general practice. Schedule 4 outlines those national requirements relating to primary care in order for the locality to indicate its plans.

It is acknowledged that to address some of the resilience challenges, GMHSCP, CCGs, LMCs and GP Federations will need to work together. For this reason, they are all signatories to the Investment Agreement, although will have different responsibilities under the agreement.

The GMHSCP GP Resilience Programme, known as 'GP Excellence' will also have the remit to support GP practices to improve quality and outcomes for their patients. To support this, GMHSCP are developing a primary care dashboard which all GP practices will have access to and uses data which is in the public domain. The dashboard will mature over time and the indicators will change to reflect the priorities of GMHSCP, CCG commissioners and the GP community. The GP Excellence Team will also hold quarterly meetings with locality GP provider clinical quality and commissioning leads with an aim to review the position across Greater Manchester and to also share good practice.

To support the GP Excellence Programme, partners across the system need to commit to working together to understand current quality (using the dashboard and other local data) and address issues. The mechanism for this will be further developed, and may include a Quality Primary Care 'Congress' to pull together learning across GM. Each CCG will have a quality lead and providers are expected to nominate a lead for clinical quality who will work in collaboration with the CCG quality lead and their local practices to review the data and support changes where these are indicated.

4. Confirmation of support for the Programme by the Health and Wellbeing Board

4.1 The Locality confirms that details of the Primary Care Reform Programme have been discussed at the Health and Wellbeing Board; and the Health and Wellbeing Board is supportive of the objectives and approach of the Programme. The Primary Care Reform Programme plan was approved by the Health and Wellbeing Boards as early principles in January 2017 and will go back to those Boards with full detail of this Investment Agreement on 21st September for Tameside and 5th October for Derbyshire.

5. Agreed milestones

5.1 The Parties have agreed key milestones which are outlined in schedule 2 (Key Milestones).

6. Transformation funding

6.1 To support the delivery of the Programme the GM Chief Officer has agreed to allocate £3.588m of Transformation Funding to the Locality. (See Clause 9.1 for funding flow).

6.2 The profile of this funding is:

Quarter	Funding
~~Q1 2017/18~~	~~[£X]~~
Q2 2017/18	£0
Q3 2017/18	£107,804
Q4 2017/18	£107,804
2018/19	£1,307,014
2019/20	£1,106,028
2020/21	£959,661

Note: The duration of the period of fixed funding and the profile of fixed funding will be determined by the GM Chief Officer (with the support and advice of the GM HSCPBE), in the light of the specific Locality Plan under consideration, and the proposed Key Milestones to meet under that Locality Plan.

Please note that in order to receive the totality of the access funding of £6ph, localities will need to fulfil all requirements for improving access ensuring that the reasonable needs of patients are met during core hours, as outlined in schedule2, (pg 19). Any transitional funding to support localities in meeting the improved access requirements should be factored into quarterly milestone payments and outlined in local trajectories.

6.3 The Transformation Funding awarded may only be used for the purpose for which it is intended, as set in the Transformation Fund Proposal – Primary Care Reform.

6.4 Recipients of Transformation Funding are required to adhere to their own Standing Financial Instructions. However, with the exception of reports prepared by advisors for regulatory purposes, expenditure incurred on external consultancy contracts in excess of £50,000 (advisory or management capacity) will be subject to the approval of the GM Chief Officer.

7. Flow of funding

7.1 Table 1 below outlines the funding flows of the Transformation Funding for each of the elements of the Primary Care Reform Programme:

Table 1 – funding flows

Element	Receiving organisation	Funding flow
Provision of 7 day access	CCG	Inter Authority Transfer
Training Care Navigators and Medical Assistants	CCG	Inter Authority Transfer
Development of a GM Resilience Programme	GM HSCP	Budget transfer
Provision of a Clinical Pharmacy Programme	APMS Contract Holder*	Invoice
Provision of online consultation software	CCG	Inter Authority Transfer

7.2 The CCG shall distribute the Transformation Funding to the Recipients as required to deliver the Programme as defined in Schedules 1 and 2 with the exception of the Clinical Pharmacy Programme where the funding will be paid to the APMS contract holder.

8. Senior leader responsible for delivery

8.1 The Locality has appointed Clare Watson, Director of Commissioning, as the Senior Leader responsible for delivering the Programme and for delivering value for money from the funds awarded to the Locality as set out in in Clause 8 of this Agreement.

9. Reporting and evaluation

9.1 The Senior Leader will provide regular updates and assurance to the GM HSCPB and GM HSCPBE (in a form and at a frequency to be determined by the GM HSCPB and GM HSCPBE) and to the Health and Wellbeing Board on the Locality's progress towards achieving the Key Milestones.

9.2 The Senior Leader will provide all such information, documents, records and other items and assistance as the GM Chief Officer may reasonably require in connection with the performance of any Party's obligations under this Agreement.

9.3 The Locality will participate in any evaluation of the Programme in a form to be agreed with the GM HSCPB as part of the ongoing operation of the GM Accountability Framework.

9.4 The Locality will ensure the Locality Plan and the Programme associated with this Agreement is monitored through its governance and programme management arrangements, as set out in Schedule 6. The GM Chief Officer and / or their representatives will have the right to attend Locality meetings that relate to the distribution or use of the Transformation Funding and/or the delivery of the Programme.

10. Performance

10.1 The GM HSCPB and the Locality agree to work together for the successful implementation of the Programme and to work collaboratively to address any issues that arise or are foreseen. The investment should deliver improvements in access and quality and high level outcomes will be developed and agreed across GMHSCP, CCGs and stakeholders. These will be monitored via a rolling programme.

10.2 If the Locality:

(i) fails to deliver any Key Milestone;
(ii) delivers the Key Milestones out with the timescales for delivery specified in Schedule 2; or
(iii) commits a material breach of this Agreement and either such breach is in the reasonable opinion of the GM Chief Officer not capable of remedy or such breach is in the reasonable opinion of the GM Chief Officer capable of remedy and is not remedied to his reasonable satisfaction within such time period as he shall stipulate, acting reasonably,

then the GM Chief Officer (with advice and support from the GM HSCPB and/or the GM HSCPBE) may:

a) specify additional or amended requirements on the Locality and make the allocation of further Transformation Funding contingent on performance of those additional requirements;
b) re-profile, pause, reduce or cease payment of some or all of further Transformation Funding;

c) seek the recovery of some or all of the Transformation Funding; and/or
d) terminate this Agreement by giving written notice to the Parties.

Before exercising any right under clause 10.2(a)-(d) inclusive, the GM Chief Officer shall have, at the least:

(iv) considered whether any alternative options are available that would address the outstanding performance issue(s);
(v) taken reasonable steps to meet with the Locality to discuss the performance issue(s) and seek alternative options to address them; and
(vi) discussed the matter with the GM HSCPB.

10.3 The CCG would only be required to repay to NHS England:

(i) any uncommitted Transformation Funding that it has not yet distributed to the Recipient; any Transformation Funding that the CCG has in turn been repaid by the Recipients.

11. Variations

11.1 This Agreement may be varied by the Parties at any time by agreement in writing in accordance with the Parties' internal decision-making processes.

12. Confidentiality

12.1 The Parties agree to keep confidential all documents relating to or received from another Party under this Agreement that are labelled as confidential.

12.2 Clause 12.1 shall not apply to disclosure of information:

(i) required by any applicable law;
(ii) where a Party can demonstrate that such information is already generally available and in the public domain otherwise than as a result of a breach of Clause 12.1
(iii) which is already lawfully in the possession of the receiving party, prior to its disclosure by the disclosing party.

12.3 Where a Party receives a request to disclose information that another Party has designated as confidential, the receiving Party shall consult

with the other Parties before deciding whether the information is subject to disclosure.

13. Dispute Resolution

13.1 Subject to Clause 13.2, if any dispute arises out of or in connection with this Agreement, the Parties must first attempt to settle the dispute in accordance with the procedures set out in Schedule 6.

13.2 A Party may seek an injunction in connection with any breach by another Party of its obligations under Clause 12.

14. General

14.1 Subject to clause 14.2, this Agreement is personal to the Parties and no Party shall, without the prior written consent of the other Parties, assign, transfer or vest, except by the operation of any statutory provision, the benefit of the Agreement to any other person.

14.2 The benefit and/or burden of this Agreement may be assigned or transferred by any Party to any successor of all or part of its functions, property, rights and liabilities.

14.3 The Parties agree that this Agreement shall not be interpreted as constituting a partnership between the Parties nor as constituting any agency between the Parties and the Parties agree that they shall not do cause or permit anything to be done which might lead any person to believe otherwise.

14.4 Any termination of this Agreement shall be without prejudice to any rights or remedies of the Parties in respect of any antecedent breach of this Agreement.

14.5 The termination of this Agreement shall not affect the coming into force or the continuation in force of any provision of this Agreement which is expressly or by implication intended to come into or continue in force on or after such termination or expiry.

14.6 Unless otherwise stated all sums stated in this Agreement are inclusive of all applicable tax, including any VAT.

14.7 The construction, validity and performance of this Agreement shall be governed by the laws of England.

14.8 This Agreement may be entered into in any number of counterparts and by the parties to it on separate counterparts, each of which, when so executed and delivered shall be an original.

15. Signatures to Agreement

15.1 The CCG will be responsible and accountable for the delivery of the requirements as set out within this Agreement. However, Local Medical Committees and GP Provider/Federations are also requested to sign the Agreement to demonstrate their support in delivery.

Signatures

NHS England

Signed on behalf of NHS England

Name: Jon Rouse

Role: GM Chief Officer

Signature:

_____

The Greater Manchester Health and Social Care Partnership Board

Signed on behalf of the Greater Manchester Health and Social Care Partnership Board

Name: Lord Peter Smith

Role: Chair

Signature: _____

Date:

The Locality

Signed on behalf of the CCG

Name:

Role:

Signature: _____

Date:

Signed on behalf of the Local Medical Committee

Name:

Role:

Signature: _____

Date:

Signed on behalf of the GP Federation

Name:

Role:

Signature: _____

Date:

Schedule 1 – Primary Care Reform Programme

SBP paper - Primary Care Reform 24-02-1

Schedule 1A – GM Primary Care Strategy

GM Partnership - Primary Care Strategy

Schedule 2 - The metrics and milestones for measuring performance

Improving Access

There should be appropriate access to meet the reasonable needs of the population during core hours and therefore all patients should have access to both routine and urgent primary care services during the hours 8am – 6.30pm, Monday to Friday. Reasonable needs[6] are considered as:

- Attend a pre-bookable appointment
- Book / cancel appointments
- Collect a prescription
- Access urgent appointments / advice
- Ring for telephone advice
- Access to diagnostics
- Access to medical records
- Any alternative arrangements are discussed with the PPG

Localities will need to provide assurance as to how they will ensure that the reasonable needs of the population are met in line with above.

2. The locality is clear as to how it is going to embed the primary care reform programme into the development of their LCO and neighbourhood model over the duration of the agreement in line with the ambitions set out in the Primary Care Reform Programme (schedule 1). This includes optimising this additional capacity in order target vulnerable and complex patients such as supporting nursing and care homes to provide more proactive care, targeted appointments for carers, linking in to integrated neighbourhood teams and the voluntary sector.

[6] House of Commons Committee of Public Accounts. Access to General Practice: progress review Sixty-first Report of Session 2016-17 https://www.parliament.uk/business/committees/committees-a-z/commons-select/public-accounts-committee/inquiries/parliament-2015/access-general-practice-16-17/

Requirements	Locality Response	Trajectory – key milestones
Outline Service Model		
Delivery of 7 day access FOR a neighbourhood, hub based model serving populations of circa 30k – 50k	Current model in place delivering 30 mins/1000 population with delivery across three hubs within Ashton, Hyde and Glossop with flexible appointment booking accessed at patient registered practice or centrally via the out of hours service. At present utilisation data does not support expanding this to further hubs however this service is part of the review of primary care provision outside core hours. This is with the intention of streamlining services through those periods where there are duplications of services in place at the same time so as to make these easier for patients to navigate and/or be signposted to. This will involve public consultation.	In place August to December
Provision of 30mins per 1000 population rising to 45mins/1000* population by 20/21 *It is envisaged this will incorporate a wider primary care team as part of neighbourhood delivery model	30 mins/1000 population is in place at present with the planning for the increase to 45 mins/1000 population in place however this is reliant on receiving the transformation funding related to Extended Access provision. A potential model of delivery has been drafted to ensure that this is feasible, including a provider partnership delivery model. The final delivery will be incorporated into the overall model of primary care provision outside of core primary medical services access; this is subject to public consultation.	2018/19 delivery
The service operates for a minimum 1.5 hours (after 6.30pm)	The current model of delivery operates from 3 hubs each offering 1.5 hours Monday to Friday, and 3 hours Saturday	In place

Requirements	Locality Response	Trajectory – key milestones
Monday to Friday and at least 4 hours on Saturday and at least 4 hours on Sunday. (Early morning appointments can also be provided via the Extended Access DES either on a hub arrangement or at an individual practice level.)	and Sunday. This equates to 4.5hours each weekday and 9 hours each weekend day. The delivery model noted above will increase the hours of access across the hubs which will enable the alignment of extended access with wider out of hours services to offer both booked and unscheduled access across the locality. The Extended Access DES has been signed up to by 19 of our 39 practice for 2017/18 with a further 6 responses (as at 2/8/17) outstanding – delivery of the DES is, at present, all on an individual practice basis.	Consultation autumn 2017 Model in place by autumn 2018 In place
Provision of routine diagnostics (as per commitment already agreed as part of Healthier Together),	The extended access hubs all provide blood testing, and cervical screening is also available through dedicated nurse clinics.	In place
Measurement		
All practices will consent to and download a nationally automated tool to measure appointment activity both in-hours and during the additional hours to enable improvements in matching capacity to times of high demand.	We will work with our practices via both neighbourhood meetings and Practice Managers Learning Forum (PMLF) and in conjunction with our LMC to secure sign up to this tool once available. We will explain the rationale behind this tool to support management of demand across the economy and support the commissioning of services to meet demand.	Initial discussion through September PMLF and further communication once the tool is available.
To provide information as part of a GM minimum data set to illustrate	We will continue to provide information to GM as requested on all areas of primary care provision, however with specific	Ongoing

Requirements	Locality Response	Trajectory – key milestones
the impact, outcomes and learning as a result of this additional funding.	reference to demonstrating use of resources, both existing allocations and additional resources. A baseline will be established for both routine and on the day demand, aligned to the data sets of the online tool. We will establish this for individual general practices and the extended access hubs. Further outcomes to be measured through practice surveys to include patient feedback. Potential outcomes measured may include ease of telephone access to primary care services. The local Primary Care Quality Scheme has been designed to enable practices to identify three quality improvement projects; a number of our practices have identified access to general practice as one of their areas of focus. The impact of their internal changes will also be measured in addition to the impact of the transformation funding. This is a two year scheme with interim reporting.	Initial baseline survey to establish current capacity September 2017. Interim reports due March 2018.
Raising patient and public awareness		
Ensure the service is advertised to patients so that it is clear to patients how they can access these appointments.	Increased focus on marketing of the extended access service is part of the in year worksteams of the Provider. Initially, as the project was a pilot, extensive advertising was deliberately kept to a minimum so as to be able to manage patient and practice expectation. Now the delivery model is established, advertising is being revisited, use of social media, printed media with clear communication re the access points and also the development of a website for the service with a view to include availability of appointments. This will improve utilisation rates.	Autumn 2017 Ongoing

Requirements	Locality Response	Trajectory – key milestones
	Where a practice population is required to access care in a different location/through a different route is in place patients are clearly signposted to this through practice information. This relates to practice mergers with multiple sites, extended access appointments at hub locations and sub-contracting arrangements.	
There is a link to the service on every GP practice website and the CCG website.	Practice websites will be updated as part of the marketing workstream noted above.	Spring 2018
There is a mechanism for patients to book an appointment in-hours and out of hours	Patients can book an extended access appointment via their practice during practice core hours (8am-6.30pm, Monday to Friday). Outside of practice core hours, the OOH provider can book appointments were appropriate so as to maximise utilisation of the service and manage patients and service provision out of hours effectively. Further provision for booking via A&E or the Primary Care Streaming service will be implemented following mobilisation. E-booking of appointments to general practice is available in all Tameside and Glossop practices.	In place Q3 17/18
All practice receptionists are able to direct patients to the service and offer appointments to the additional hour's service on the	Practices access appointments through a shared appointment book for direct booking whether in hours or in extended access hub depending on appointment availability and patient choice.	In place

Requirements	Locality Response	Trajectory – key milestones
same basis as appointments in core hours.		
Patients should be offered a choice of evening or weekend appointments on an equal footing to core hours appointments.		
To have a single number which patients can book appointments	Patients can book an extended access appointment via their practice during practice core hours (8am-6.30pm, Monday to Friday). Outside of core hours, the OOH provider can book appointments. This ensures consistency for patients, choice of evening or weekend appointments on an equal footing to core hours appointments and care navigator roles utilised to best effect.	In place
Digital		
Patients will be able to access alternative modes of consultation both in hours and through the additional hours service which includes; • Telephone consultations • Online consultations • Web-ex consultations (where available)	Practices currently offer a range of modes of consultation with many practices already offering telephone consultations. Route of access will be part of a wider mapping of practices and the variation in delivery models in 2017/18. Roll out of online consultation systems is on the agenda for consideration by practices in hours and for implementation within extended access hubs, with appropriate governance in place, however is linked to availability of the transformation funding resource. A small number of practices already	In place In year In year but linked to availability of resource.

Requirements	Locality Response	Trajectory – key milestones
	exploring skype consultations and the use of clinical asynchronous digital exchange systems. The extended access provider is exploring the potential roll out of an app providing access to further methods of consultation option including self-care videos, links to expert patient group meetings via skype or alternative technology and also social media groups set up around health issues for forum discussion around issues and management of those issues. All are subject to appropriate IG protocols.	2018/19
Addressing inequalities		
There is a plan to address the issues of inequalities in patients' experience of accessing general practice identified by local evidence and actions	Patient experience is reviewed both through external data collections and publications, such as the GP patient survey (GPPS), Friends and Family Test and also through local feedback and complaints. GPPS results is one data source in our primary care dashboard with current and prior year's achievements reviewed. Patient feedback is one strand of our Primary Care Quality Scheme for the two years 2017-2019; where a practice is an outlier in this area they may choose this as one of their practice QI projects for the scheme. Baseline and outcomes for accessing services through the use of surveys and data to contribute to this workstream, as set out above (ref:measurement)	Ongoing ongoing

Requirements	Locality Response	Trajectory – key milestones
Effective access to wider whole system services		
There is active connection to other system services enabling patients to receive the right care from the right professional, including access to and from other primary care and general practice services such as urgent care services	We currently have a range of subcontracted periods; including 8 practices with a half day closure however also practices with shoulder time and/or lunchtime closures. In hours access has been discussed by our Primary Care Committee and an approach to achieve improvements to periods of subcontracting to ensure reasonable needs is being taken forward. Practices are asked to complete and provide assurance on how they will meet reasonable needs by the end of Sept 2017.	End Sept 2017
	Initial discussions have also taken place with gtd (the provider in periods of subcontracting) as to how, and the timescales by which, the subcontracted offer can be be expanded to meet the agreed definition. The implementation of this increased offer will be as quickly as possible, with recognition the elements of this will be quicker to implement than others.	From August 2017
	The development of our Integrated Neighbourhoods broadens the range of professionals available to patients and the inclusion of the care navigator in this model will ensure signposting to the right professional/service can be facilitated where self care is not an option. A care navigation model is already in place in two of our neighbourhoods and is being expanded across the other three through quarters 2 and 3 of the current year.	Q3 2017/18

Requirements	Locality Response	Trajectory – key milestones
	A detailed review of urgent primary care provision and usage has been carried out with the intention of aligning provision for a simpler mode of access for patients, through removal of duplication. Subject to consultation.	Review completed July 2017. Consultation outcome due December 2017.
Local Care Organisation		
The locality will incorporate the service as part of the development of LCO.	Primary Care is a key part of our integrated neighbourhood model, with implementation of this workstream is being led by our Integrated Care FT. Our vision for successfully incorporating primary care is to have in place a shared MOU across the locality economy, Single Commission, the ICFT, Orbit (GP Federation) and gtd (Out of Hours provider). A provider tri-partite arrangement is also being established across the three provider organisations for the partnership delivery of urgent primary care services.	Ongoing April 2018 December 2017
The service model is discussed and signed off by the Health and Wellbeing Board	A paper on primary care reform was presented to our Health and Wellbeing Boards in January with further update, reflecting this Investment Agreement being taken to the Tameside meeting on 21st September 2017 and the Derbyshire meeting on 5th October 2017.	Sept/ Oct 2017

Training for reception and clerical staff

As part of the General Practice Forward View, a new five year £45 million fund has been created to contribute towards the costs for practices of training reception and clerical staff to undertake enhanced roles in active signposting and manage

ment of clinical correspondence. For GM, this equates to £2.3m over four years to fund both care navigation and/or workflow optimisation. It will be for localities to determine how this is best deployed locally. Further information around these roles is appended to the agreement (appendices one and two).

Requirements	Locality Response	Trajectory – key milestones
The role of the care navigator is part of a multidisciplinary team	The care navigator is a key role of our future model of service delivery and in the development of our Integrated Neighbourhood. As such this is one of our workstreams of Care Together and is being led by our ICFT. In previous years each Practice within the Hyde Neighbourhood secured monies to employ Care Navigators within each Practice. The Care Navigator worked with the Practice population, actively supporting patients to identify any health and social care needs and support them to make any improvements (this pilot targeted the over 75s population). Learning from the Pilot will feed into any future transformational plans within the ICFT. All four Tameside Neighbourhoods secured non recurrent transformational funding to commission Care Navigation training from West Wakefield Health and	In place Launch event 21st September 2017 including overview and initial training with further e-learning through Q3 of 2017/18.

Requirements	Locality Response	Trajectory – key milestones
	Wellbeing, this would help to establish the Care Navigator Infrastructure. All frontline staff will be trained to care navigate patients empowering patients to choose well, consider self care options and release GP capacity. Care navigators will sign post patients to elements within the MDT making use of existing and appropriate resources for patient need. Glossop Practices are already actively signposting to https://the-bureau.org.uk/ who currently deliver the Care Navigator function to Glossop residents. As 'The Bureau' is already established and has been delivering a 'Care Navigator' model for some time, a meeting has been set up to gauge learning from them about the systems they have established to capture/record activity/performance as well as how they update patient records once an alternative/appropriate service has been identified.	The initial model will signpost to three services, MECS, Be Well and minor ailments. The wider development of this role will be as part of the ICFT workstream within the delivery of Integrated Neighbourhoods. Use of the bureau is already in place in Glossop.
The role is connected to a practice/group of practices and is part of the practice team	As above, the establishment of care navigators is a key element of our integrated neighbourhood model and as such will be connected to practices on a	ongoing

Requirements	Locality Response	Trajectory – key milestones
	neighbourhood footprint. This will provide resilience within this team whilst recognising the variation between neighbourhoods and the need of those populations. Each Care Navigator in Tameside is a current non clinical member of the practice team who will have increased knowledge of available services. Care Navigation is provided outside of the practice team in Glossop, delivered by 'The Bureau' via an established model as above.	
The role(s) meets the competencies as set out in HEE Competency Framework for Care Navigators - see https://hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf • Essential - Signposting to local service; inputting data to directory and databases; supervised, e.g. GP receptionist • Enhanced - Greater level independent working, enhanced communication skills, i.e. health coaching, e.g. care navigator • Expert - Developing services; dealing with more complex cases; advanced	Using the West Wakefield Health & Wellbeing care navigation model we are implement in phase one of the HEE Care Navigation competency framework at the essential level of care navigation. As the pilot areas are established we will use the GPFV resources to move care navigators up to enhanced levels by offering training on an annual basis at minimum. This will include super user groups where champions of care navigation in each practice will be brought together to share good practice and address issues. They can then user peer to peer support at future training events sharing good practice to move up to expert level over the next four years.	Current implementation phase. From Q4 of 2017/18 and into 2018/19

Requirements	Locality Response	Trajectory – key milestones
communication skills;, mentoring other staff e.g. Navigator team leader	Over the next few years there will be additional roles within an extended primary care team, which may include the following in General Practice: • Pharmacist • Physiotherapy • Mental health workers • Physician associates These will complement a greater neighbourhood offer by Licensed Practitioners, e.g. Podiatry, OT etc. Care navigation infrastructure including templates and communication strategies will be used in future to support the care navigating away from GP appointments in to the extended primary care team.	Clinical pharmacists in 2017/18; other roles through 2018/19 and beyond.

Supporting GP workload – training of clerical staff to manage medical correspondence / Medical Assistants

A member of clerical staff within the practice is provided with training and relevant protocols to support the GP in clinical administration tasks. These may include tasks such as READ coding, action incoming clinical correspondence in accordance with agreed protocols, ordering tests, chasing results and outpatient referrals, liaising with other providers and explaining care processes to patients.

Requirements	Locality Response	Trajectory – key milestones
Ensure the practice has developed its own internal systems (which have been assured) including safe and appropriate protocols to guide staff; that there is a system of supervision and regular audits of safety and effectiveness. This should include the opportunity to learn from other practice examples	This workstream, although a clear part of our future workforce vision, is an area we will progress through 2017/18. We will utilise our established Practice Manager Leaning Forum, in conjunction with our LMC, as a network though which we will design and implement this GPFV workstream. Our PM Liaison Manager will lead on this workstream and coordinate our design in conjunction with the learning from other areas.	2017/18 to establish to route to implement this recognising the current system of individual businesses for the majority of our practices but with sight of neighbourhood working for resilience and shared learning. 2018/19 for the incorporating of these roles within practices.
To ensure there is a system for practice managers, GPs and staff to hear from others who are already working in this way		

GM Excellence Programme

- Provide Locality input (provider and CCG Quality Lead) into the design and delivery of the operating model
- Continue to provide statutory duties to support General Practice
- Join up local intelligence in order to offer a pro-active approach to supporting General Practice
- Promote the GM Resilience Programme within the locality
- Facilitate neighbourhood resilience as part of new models of care

Requirements	Locality Response	Trajectory – key milestones
Promote the GM Excellence Programme locally	Tameside and Glossop is supportive of the GM Excellence programme and the delivery of this on a GM footprint and has been proactive through two of our Clinical Leads, Dr Joanna Bircher and Dr Alison Lea, in the establishment of the programme. We are also represented on the GM Excellence programme working group. We have shared launch communication received and as the programme is further established, though the single point of access and the recruitment to the central team we will continue to update our member practices and link local support offered to the provision available through the Excellence programme.	In place ongoing
In conjunction with the GM Co-ordination and Support Team, identify local delivery teams within respective localities, this could include: • CQC outstanding practices	Our Primary Care Delivery and Improvement Group has coordinated support locally to practice identified as needing support, whether by practice request or identified through our primary care dashboard and	In place

Requirements	Locality Response	Trajectory – key milestones
• GP Federations • CCG Quality Improvement Leads • LMC support	local knowledge. This will continue as our local response alongside the GM team. We have a Primary Care Team in place with specific practice manager and practice nurse liaison posts plus, but not limited to, the following: Governing Body Lead for Primary Care Clinical Lead for Quality Improvement Orbit Healthcare – GP Federation LMC Nursing and Quality Directorate colleagues, particularly in relation to safeguarding issues/support. Enhanced Training Practice There is an established network for shared learning across practices through the PM Learning Forum and through neighbourhood commissioning meetings.	In place
Ensure Locality representation on the GM Excellence Working Group who will oversee the GM programme	In addition to the involvement of Drs Bircher and Lea, Christopher Martin is locality rep on the working group with cover provided in his absence as required.	In place
Establish a formal link between any local systems of support and the GM Support and Development hub to ensure the two systems complement rather than duplicate.	Our Primary Care Delivery and Improvement Group has coordinated support locally to practice identified as needing support, whether by practice request or identified through our primary care dashboard and local knowledge. This will continue as our local response alongside the GM team and as the GM hub	On establishment of the GM hub

Requirements	Locality Response	Trajectory – key milestones
	is established the link between the two systems will be established with a clear communication link and named first contact for the locality.	
Identify provider and commissioner lead to meet quarterly with the GP Excellence Team to discuss the primary care dashboard for the locality / neighbourhood and identify areas for quality improvement and support.	Dr Joanna Bircher – Clinical Lead for Quality Improvement and Christopher Martin - Primary Care Development and Quality Manager	In place
Demonstrate how the locality will build resilience into new models of care at a neighbourhood / LCO over the duration of the programme	Our vision for new models of care is a neighbourhood approach and therefore a resilience model can be established. This includes a plan, through 2017/18 setting out the scope, in partnership with the innovative Primary Care Co (gtd and Orbit) and ICFT, of a salaried model for delivery of primary medical services contracts.	2017/18

Online Consultations
Recent years have seen rapid development of a number of online consultation systems for patients to connect with their general practice. Using a mobile app or online portal, patients can contact the GP. This may be a follow-up or a new consultation. The e-consultation system may be largely passive, providing a means to pass on unstructured input from the patient, or include specific prompts in response to symptoms described. It may offer advice about self-care and signposting to other sources of help, as well as the option to send information to the GP for a response.

In early adopter practices, these systems are proving to be popular with patients of all ages. They free time for GPs, allowing them to spend more time managing complex needs. Some issues are resolved by the patient themselves, or by another member of the practice team. Others are managed by the GP entirely remotely, in about a third of the time of a traditional face to face consultation. Others still require a face to face consultation, and these are enhanced by the GP already knowing about the patient's issue.

Requirements	Locality Response	Trajectory – key milestones
Please outline project description which should include but not limited to: Scope and content Objective and benefits Location and distribution (where appropriate) Wider stakeholders, their interest and plan for engagement *If online consultation systems are currently deployed in practices, please list them here.*	Online consultations, both synchronous and asychronous will be developed alongside face to face and telephone consultations. GPs and practice staff will be consulted and a programme of engagement for wider stakeholders will be undertaken. Patient engagement will be undertaken via Patient Participation Groups initially and a campaign to promote such online consultations will be incorporated into the wider CCG digital strategy. Benefits to patients include sparing patients unnecessary travel and the convenience of being able to consult with their GP Practice from a variety of locations suitable to the patient. Benefits to General	

	Practice include a reduction in the consultation time (as reported by early pilot sites) and the opportunity to utilise the technology to support a range of service delivery models.	
Please describe how the plans for deploying online consultations are aligned with other relevant STP, commissioning, clinical and digital technology strategies	Online consultations will be available to patients booking into extended hours appointments which will increase the flexibility of response of extended hours. The promotion of Patient Online services will incorporate such online consultations. Virtual clinics (i.e. mental health, counselling, behavioural therapy) will be considered alongside existing services. General Practice providing services for other local practices will utilise online consultations alongside EMIS Remote Consultations. EMIS Remote Consultations facilitates access to the patient's record at the registered practice and allows the consulting practice to write directly to that record. In addition to this, Group consultations are being implemented within Tameside and Glossop.	
Please describe the procurement strategy, who will be leading, and timetable for completion, to include:	Clarity regarding lead responsibility for the procurement is required. The details of the procurement process will follow.	October 2017

• Market assessment and plan for market engagement • Procuring organisation • Procurement Advisers (CSU, Health Informatics Service, NHS England Procurement Hub) where applicable • Procurement route, (eg. Direct award, competition, framework, EU procurement procedure) • Procurement plan – timetable • Key commercials considerations (e.g. term and expiry, service levels and standards, quality and assurance, business continuity etc.)		
Provision of training in clinical skills to ensure safety and productiveness of alternative consultations	The CCG has a GP IM&T training programme in place which provides training for practice staff in the use of clinical applications. This training programme will expand to incorporate training and awareness sessions for online consultations. Promotion and communications will also be managed through our Practice Managers Learning Forum and in conjunction with the LMC.	
Promote the use of the practice website as the first point of contact for patients	Practice websites vary however all provide a wealth of information regarding the routes for accessing healthcare in and out of hours. In addition, many use social media to provide communication and information to patients.	In place Qs3 and 4 of 2017/18

	Information for self care etc is available via many at present however we will work with practices, as part of the implementation of care navigators, to increase this. Patient choice, and access to the internet must be recognised however increasing the contact with practices via the website will reduce the efficiency within reception teams and improvements in this area will be looked at as part of the IT workstreams of primary care development. Increased use of the practice website aligns to also increasing the population accessing their record online.	
To co-operate with the development of an app that will enable patients to access the local service and book appointments on line (it is anticipated that there will be a national app available 18/19)	Where local support/information is required in the development of this national app we will provide this in a timely manner. One of our practices, in conjunction with gtd, is looking at the development of an app providing access to further methods of consultation option including self care videos. We can facilitate links between this and GM teams to ensure learning can be shared.	

Clinical Pharmacists in General Practice

Requirements	Locality Response	Trajectory – key milestones
Expansion of the Clinical Pharmacist Programme This will be subject to an APMS contract between GM HSCP and the provider organisation for the duration of the 3 year funding.		
There is a clear implementation plan in place for the recruitment and placement of the Clinical Pharmacists.	As the employing organisation will be the ICFT this will be a new arrangement for the majority of the pharmacists most of whom are sessional self-employed/ agency and reflect the difference from the CPGP scheme to current arrangements. There will also be scope for pharmacists currently fulfilling roles within the local secondary care setting to apply for the CPGP posts. This would be done in conjunction with the ICFT to avoid disruption of the secondary care workforce. Again this will allow us to draw on an already experienced workforce to fill the new roles. Finally there are some community pharmacists in the area who are interested in developing themselves by applying for positions such as those that would be available here. A few, though not many, have some experience of working in primary care and the necessary clinical skill set, all will have good patient counselling skills and the proposed educational programme, both within and external to the programme will help to develop any such individuals.	Advert published with expectation for first posts to be filled for October 2017 start date. Further recruitment rounds to take place (as necessary on an ongoing basis) until all posts are filled.

The Clinical Pharmacists are embedded within the neighbourhood delivery model.	The Tameside & Glossop model of care includes 5 Integrated Neighbourhoods (IN) designed to facilitate provision of / access to bespoke person centred solutions, working to the following principles of place based care: ▪ Integrated local services responsive to local need ▪ Services that build on assets of the community & intervene early in an emerging problem ▪ One team, knowing their area & each other ▪ Person centred approach within the context of family & community ▪ Services delivered within the community, close to home from a flexible asset base GP practices currently have 80% coverage most via BCF but some practice funded. The GPs themselves made applications to the CCG themselves to receive BCF to cover the practice pharmacist input. Practices have fully embraced the role that the Clinical Pharmacists provide and the benefits and the existing pharmacist resource has become integral members of practice teams. The Integrated Neighbourhood model is developing a culture of practices working together in order to manage and improve the health and care of their populations, across the wider footprint, rather than just on an individual practice basis. Pharmacy is considered by the Neighbourhoods to be a core	In place

	element of the integrated Neighbourhood model. The operational lead for the development of the Integrated Neighbourhoods is the ICFT, who will ensure that there is a whole system approach to health and care provision on a place-based basis and this will translate to the INs.	
The provider engages with GM and other parts of the system in order to share learning and experience of the clinical pharmacist programme in order to optimise this role as part of the primary care workforce.	Recruitment would take place such that there would be two Senior Clinical Pharmacists who would be capable of providing regular supervision sessions for each Clinical Pharmacist they are responsible for, in line with the minimum requirements of 1 session per month. Similarly, the Senior Clinical Pharmacists will receive a minimum of 1 supervision session per quarter by a GP clinical supervisor, in line with requirements. This will be managed via the Neighbourhood organisational structure which has 5 GP Neighbourhood Leads. This network would provide supervision and mentorship for the pharmacists as part of the scheme. The pharmacists employed will be fully supported to attend the Clinical Pharmacist in GP Practice Phase 2 Pilot training pathway. The ICFT will manage a robust process for maintaining the training and accreditation of the CPs, in line with required standards. As employees of the ICFT the practice pharmacists would form part of a wider pharmacist FT Community Services body and be able to participate fully in all educational events accessible via the organisation. They would work in close conjunction with the CCG	To take place in conjunction with recruitment and individuals becoming embedded into the roles.

	MMT and be able to access locally organised educational courses aimed at NMPs or prospective NMPs. Senior management in the FT pharmacy and CCG MMT teams would be available to provide support and advice to the practice pharmacists. The pharmacists would have access to all reporting/BI support and overarching systems leadership via the Neighbourhood Management System (Commissioning Business Managers, Neighbourhood Operational Managers and Neighbourhood Clinical Leads). The educational support will also include a managed programme to ensure that the qualification to be independent prescribing pharmacists is also achieved by 2020/21 in line with the GPFV. The CCG and FT have NMP Leads who would work to support the practice pharmacists.	
Clinical Pharmacists participate in the GM network to provide peer support and shared learning.	The Clinical Pharmacists will engage with the GM Network as required in order to ensure the shared learning and peer support takes place outside of the Locality footprint, acknowledging the various models of delivery across GM.	To take place in conjunction with recruitment and individuals becoming embedded into the roles.
There is a clear governance and accountability process between the CCG and the provider for use of resources.	A signed agreement between the ICFT and the lead GMS provider is in place to confirm the transfer of	In place

	funding and associated responsibilities to enable the ICFT to be the employing organisation.	

Schedule 4 - National Requirements – Primary Care Contribution

This section is meant to understand the locality response to the primary care related national requirements aligned to the 9 'Must Do's' mandated in the in the NHS England Five Year Forward View / Planning Guidance 2017-19. Please provide a locality response as to how you are meeting these requirements and how the primary care reform programme will support the delivery against those. Where this is already detailed within your Operational Plan, please insert relevant section.

Ref	Requirements	Locality Response
3	Support general practice at scale, the expansion of emerging new models of care such as MCPs, PACS and other provider forms and enable and fund primary care to play its part in fully implementing the forthcoming Enhanced Care Homes Framework[7] for improving health in care homes.	In Tameside and Glossop we have developed our local care organisation (LCO), Tameside and Glossop Integrated Care Foundation Trust (ICFT), and also the development of our five Integrated Neighbourhoods (INs). The Integrated Neighbourhood model has been developed with significant input from a range of stakeholders, and the implementation of the model is now being led by the ICFT across each of our five geographical neighbourhoods. Each neighbourhood has a Clinical Director and an Integrated Neighbourhood Manager in place. The model for each neighbourhood brings together a wide range of services across a number of sectors, with primary care being a key element, facilitating care delivered by a

[7] NHS England – The framework for enhanced health in care homes https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf

Ref	Requirements	Locality Response
		range of partners, minimising duplication of services providing care for the same patient. There are five INs across the Tameside and Glossop CCG footprint. Four of the Neighbourhoods are co-terminous with the Tameside Metropolitan Borough Council Neighbourhoods. Glossopdale will be supported by Derbyshire County Council from a social care perspective. INs will bring wider health and social care teams into these place based hubs to deliver a wide range of services that not only treat illness but promote wellness and behaviour change. This will involve a comprehensive response from community services, social and primary care, outreach from hospital specialists, mental health and support from public health and preventative services. Input from the voluntary and community sector will be central to the success of this approach. The Integrated Neighbourhood model is based on the inclusion of our member practices as part of the multi-disciplinary team / offer to our residents. Primary Care is at the heart of integrated care and our GPs have a unique opportunity to contribute to and lead the development of the ICFT. The evolving agenda requires leadership and engagement to ensure that the pathways, models of care, quality and performance are designed with primary care at

Ref	Requirements	Locality Response
		the centre, working as a fully integrated partner in the new delivery models/provider. Further plans have been developed, building on the new models of care, for the formation of partnership working between three of our providers (ICFT, gtd and Orbit (GP Federation)), initially for the delivery of Urgent Primary Care, however with the potential to expand to the delivery of wider (core) primary care services. This is expected to develop overtime as a Primary Care Co.
3	Ensure the sustainability of general practice in your area by implementing the General Practice Forward View, including the plans for Practice Transformational Support, and the ten high impact changes.	Our primary care strategy will set out our response and timescales and the model for delivery of the 'must dos' from the NHS Operational Planning Guidance and the delivery of transformation through the 10 high impact changes set out in the GPFV and the design of new models of care to ensure the sustainability of primary care for the future. This will align to the GM Primary Care Contribution.
3	Tackle workforce and workload issues, including interim milestones that contribute towards increasing the number of doctors working in general practice by 5,000 in 2020, co-funding an extra 1,500 pharmacists to work in general practice by 2020, the expansion of Improving Access to Psychological	The actions to address the current primary care workforce pressures aligns to the development of integrated neighbourhoods and to the development of inter-professional workforce to support access to primary care services. The training of Care Navigators and Medical Assistants are another development to the workforce identified within the GPFV and, as with clinical pharmacists, are a clear part of our Primary Care strategy with both of these workstreams

Ref	Requirements	Locality Response
	Therapies (IAPT) in general practice with 3,000 more therapists in primary care, and investment in training practice staff and stimulating the use of online consultation systems. Participate in the roll out of GM workforce / workload capacity and demand tool and share high level data.	progressing in year. We are a wave 2 site for Clinical Pharmacists in General Practice. Millgate Health Partnership, within our Denton Neighbourhood, is an ETP and is therefore supporting this agenda in the heart of our locality and, as an accredited training practice, is committed to supporting a total of 80 students incrementally over a three year period to increase the learning capacity in primary care. Our primary care and Mental Health strategies set out our plans for the development of the Community Mental Health Team. The Denton Neighbourhood carried out a pilot for the cohort of patient's out with IAPT or secondary care. The outcomes of the pilot were positive and provided evidence that would support roll out. Tameside and Glossop will participate in the roll out of GM workforce / workload capacity and demand tool and share high level data.
4	Implement the Urgent and Emergency Care Review, ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020 in each STP footprint, including a clinical hub that supports NHS 111, 999 and out-of-hours calls.	Our proposed model is fully aligned to the vision of patients being treated within primary care and neighbourhoods wherever possible and the Urgent Treatment Centre providing a single access point for those people who choose to seek help outside of their neighbourhood or need a more specialist level of care. The key principle being people with emergency or urgent needs are supported by the right

Ref	Requirements	Locality Response
		person first time. In September 2016, all A&E Delivery Boards and Acute Trusts were nationally mandated to implement A&E streaming at the front door to ambulatory and primary care. We have developed a detailed plan and proposed model in response to this requirement to implement A&E Streaming to Primary Care whilst ensuring that where possible patients will be able to access Urgent Primary Care through their own GP or other neighbourhood based primary care services. The vision is that: • People with an urgent primary care need are assessed by an appropriate primary care service and advice or a treatment plan is provided within the community. • Strong neighbourhood based access to general practice with other support services readily accessible will reduce the need for people to attend A&E unless they have an accident or need emergency care. It will also support a seamless transfer for people who present as urgent but would be best managed as more routine. This model is subject to consultation (Autumn 2017). By 2021 we expect people who develop an urgent primary care need to be assessed on the same day within primary care (whether this is registered GP practice, dentist or

Ref	Requirements	Locality Response
		pharmacy or optician or through a locality wide service) by the most appropriate person and either a treatment plan agreed to manage the immediate need within the service or a safe transfer made to the care of another neighbourhood based service. The first stage to delivering this is to reduce the duplication that exists in the current services and the multiple points of 'walk in' access as the proposal is to align provision of the Walk-in Centre, Out of Hours, the Alternative to Transfer service, Extended Access and Primary Care Streaming at A&E. To provide 24/7 phone access either through a practice or GTD Healthcare from which appropriate advice or an appointment will be provided to enable the patient to be seen by the right professional on the same day or at a later date as required.

Schedule 5 GM Metrics – this schedule does not need to be populated at this time.

Additional metrics will be developed over time and in conjunction with the signatories to this agreement.

Additional Access

Confirmation that the extended access Directed Enhanced Service **is not included** as part of the core requirement of 30mins/1000 population provision	YES/NO
Evidence available for the disposition of services across the week – this could include evidence of patient demand or activity of current 7 day services or activity data from other services, i.e. A&E, WiC, OoH etc.	
How is this allocated to deliver a minimum of 30mins /1000 weighted population per week?	
Is there a communications strategy in place for promoting new services for patients locally? Please attach	

Evidence that practices are telling staff to promote the new service? (please outline)	
Has every practice updated their websites with new access patient offer clearly outlining: - modes of access - Appointment availability - local evidence of publicity available (please provide details)	
Evidence of the local assessment / impact analysis of inequalities?	
Provision of quarterly monitoring utilisation of appointments and how this is responsive over time to meet patients needs?	
Can you confirm the service offer includes the ability for patients to have a face to face appointment with a GP in your locality if they wish?	
Please can you outline the model in place to accommodate this.	

Workforce

A GM Primary Care Workforce Reference Group has been established with representation from primary care leads and workforce leads from across Greater Manchester. GM HSCP will work with localities to support workforce planning including providing baseline data information, identifying opportunities for recruitment and retention initiatives and working closely with Health Education England North to ensure a consistent offer to localities.

Planned annual increase in the number of doctors working in primary care				**Planned annual increase in the number of other clinicians working in primary care**		
i. Number for the overall increase (headcount or wte)	ii. Intended sources for securing that	iii.If other please list in column B.	iv. Types of doctors planned to work	**i. Number for the overall increase (headcount or wte)**	ii. Intended sources for securing that	iii.If other please list

				increase		in primary care					increase	
2017/18	2018/19	2019/2020	2020/21				2017/18	2018/19	2019/2020	2020/21		

Additional investment (CCG plans for £3ph non recurrent investment)

Year	Planned spend	Spend
2017/18		
2018/19		

Participation in GP Excellence Programme

- Evidence of neighbourhood peer review system in place to review / discuss GM metrics
- Evidence of quality improvement initiatives as a result
- No of practices engaged with GM Excellence Programme
- Evidence of high level outcomes

Training and upskilling staff – Care Navigators/Active Signposting/Workflow Optimisation
Annual report of initiatives, outcomes in order to showcase and share learning

Online Consultations

	Baseline	2017/18	2018/19	2019/20	Total
Number of practices offering online consultations to their patients					
Total number of patients covered by the offer of online consultations					
% of practices offering online consultations to their patients					
% of patients covered by the offer of online consultations					
Total number of patients using online consultation					

Ongoing monitoring and shared learning
A rolling programme to monitor outcomes will be co-designed with localities in order to, illustrate the benefits of the primary care reform programme, to demonstrate increased investment in primary care as well as facilitate shared learning across the system.

Schedule 6 - Dispute Resolution

This Investment Agreement will be subject to a dispute resolution agreed by Greater Manchester.

This dispute resolution process is still in development, will be inserted at such time the agreed version is available.

Schedule 7 Locality Management and Governance Arrangements

Our Primary Care Committee has always worked well for us and our practices. We have used the broader membership of our Primary Care Committee to discuss our options over the last couple of months while waiting to see the IA and, with particular relevance to our own plans, what National Guidance there would be on Primary Care Streaming and any specification for the 'super' hub we are developing.

We are now working through the governance for the management of these resources. We anticipate that the governance and oversight will be led by our Primary Care Committee which includes membership from the CCG, LMC, and GMHSCP. We will also look to involve our GP Federation, gtd (our Out of Hours provider) and the ICFT.

The CCG's Primary Care Committee is constituted in line with national guidance and it meets in public. It formally reports to the Governing Body.

The clinical pharmacist workstream is already in progress in conjunction with the ICFT with recruitment expected in October 2017.

We will engage with our member practices, through neighbourhood commissioning meetings, to determine the commissioning of training and systems under the care navigator and medical assistant roles and online consultation systems funding streams. We will consider the planning for these workstreams in conjunction with the ICFT to ensure delivery of these agendas as part of the wider system transformation.

The delivery against the extended access funding is being incorporated as part of our urgent care review to ensure a streamlined and 'clear to navigate system' for patients. The final delivery will be incorporated into the overall model of primary care provision outside of core primary medical services access; this will be subject to a public consultation.

We will discuss the governance proposal at the Primary Care Committee meeting on 6 September 2017 and we will update this section and forward on as soon as possible.

Appendices:

Appendix one outline of care navigator role
Appendix two outline of workflow optimisation / medical assistants
Appendix three NHS England Health Inequalities guidance

Appendix one

Care Navigation / Active Signposting

The Care Navigator role can enable GPs and nurses to focus more on managing complex care, including medical care, where Care Navigators provide continuity and spend longer less pressurised time with patients and carers.

What is care navigation and why is it important?

Care navigation is a simple, sustainable model of care that improves access to primary care and reduces GP pressures. By providing clear information about the range of services available both inside and outside of the GP practice, care navigation provides real choice to patients allowing them to go straight to the service that best meets their health and social care needs.

Care navigators' can play a crucial role in helping people to get the right support, at the right time to help manage a wide range of needs. This may include support with long term conditions, help with finances and signposting to a range of statutory and voluntary sector services such as services within the practice, housing, debt management, benefits advice, the voluntary sector or varied community assets for those who feel isolated.

Age UK defines care navigation to include Personalisation support, Co-ordination and integration across health, social care and voluntary sectors.

Effective navigation is a key element of delivering coordinated, person-centred care Evidence suggests navigation services can enhance patient and carer experience, reduce unnecessary hospital readmissions and promote independent living at home.

The Care Navigator role can enable GPs and nurses to focus more on managing complex care, including medical care, where Care Navigators provide continuity and spend longer less pressurised time with patients and carers.

Who provides care navigation?

Navigator roles, job titles and day-to-day tasks vary depending on local context, including organisation function, peoples' existing skills and local population need. For example 'care coordinators' and 'care navigators' may work in hospitals, focusing on discharging people safely from hospital to home, or as part of a general practice in a multidisciplinary team.

Titles include:

Health and social navigator, Social prescriber / link worker, Community connector, Non-clinical navigators, Care coordinator, Locality navigator, Stroke navigator, Primary care navigators for dementia

People who provide care navigation build relationships, problem solve and help locate resources, serving as a link between community, health and social services. They advocate the needs of people; they are enabling and focused on recovery, to strengthen the work of the multidisciplinary team. A key purpose is to ensure patients experience seamless, joined up care and support.

Currently there are a range of care navigation service models. Non-clinical staff who deliver care navigation in the UK tend to occupy a plethora of roles, work in many settings and have varying job titles and backgrounds such as reception staff, administrative staff, trained volunteers, staff with health or social care backgrounds.

There is no ‘one size fits all’ navigation service, with variations throughout the UK and internationally, people who provide care navigation build relationships, problem solve and help locate resources, serving as a link between community, health and social services. They advocate the needs of people; they are enabling and focused on recovery, to strengthen the work of the multidisciplinary team. A key purpose is to ensure patients experience seamless, joined up care and support.

A person providing in care navigation is usually based in a multi-disciplinary team, helps identify and signpost people to available services, acting as link workers. There is a variety of different approaches to solving local problems around coordinating and signposting patients.

There is a current lack of clarity, clear consensus and coherence in such navigation roles and the necessary skills, attributes and training requirements.

Competency Framework

Health Education England has produced a competency framework describing three different levels of competency for care navigation.

These core competencies are brought together in a tiered competency framework, recognising three successive levels; essential, enhanced and expert. This will help provide a coherent benchmark or set of standards for care navigation, to help ensure that relevant staff receive the necessary education, training and support to work effectively.

Three levels of competencies for care navigation:

Essential – At this level people may have no or minimal experience of working in a health/social- voluntary care setting; or some experience already working within administrative roles. Signposting to local service; inputting data to directory and
databases; supervised

e.g. GP Receptionist ward clerks, non-clinical navigator

Enhanced – At this level people will have some level of expertise, background in health/social care and/or voluntary sector and some experience of working with people with long term health/mental health needs. Some people may progress from the essential navigation level, or may enter at this level if competencies are already
achieved. Greater level independent working, enhanced communication skills i.e. health coaching
e.g. care navigators, locality navigators

Expert – At this level people will possess a greater depth and breadth of knowledge/
experience of health/social care, enabling a greater ability to support person-centred
care and wellbeing. Some may progress from the enhanced navigation level or enter at this level if competencies are already achieved.
Individuals will have some experience in managerial aspects of healthcare, and
will need to lead a team of others in navigation-roles.

At this level, individuals will mentor and supervise others in navigation-roles. Developing services; Dealing with more complex cases; advanced communication skills; mentoring other staff
e.g. Navigator team leader, Discharge co-ordinator

Areas to consider prior to roll out of Care Navigators

Simply having services and trained people in place are not enough; there are a few areas to consider before training takes place:

- Each practice will need to be in a **state of readiness** where care navigators have knowledge of the community assets and local services available in order to effectively signpost and support patients. Therefore a **mapping process resulting in a directory of local services** will need to be in place**.**
- Each practice will have diverse community needs so there needs to be an **understanding of the culture within each locality** so that the needs of each locality are met.

- Each individual practice will have varied capacity within their workforce, which will determine how they cope with the change in role so there needs to be a capability assessment.

Care Navigation Models

There are various examples of care navigation models and training programmes in place, across the UK, which we can learn from:

West Wakefield Health & Wellbeing

Based in West Wakefield, this social enterprise was established to support primary care transformation, initially through the Prime Minister's GP Access Fund and later as part of the new care models vanguard program.

They have developed and implemented a highly effective care navigation model that has helped to signpost over 9500 patients and saved over 1685 hours in GP time across Wakefield in just seven months. They have developed the country's first Accredited Certificate in Care Navigation training programme for frontline staff.

Training includes interactive guided learning, flexible online sessions and consultancy to support the development of systems and processes. Each learner receives a certificate of achievement and access to a progression pathway giving frontline staff chance to build on their skills and competencies even further.

Care co-navigator/health and social care navigators
Waltham Forest and East London (WELC)

Navigators are part of an integrated care pioneer programme and embedded within a care coordination **for high risk patients model** (long term health conditions, older
people for example)

Navigators work within an integrated team, including other key workers such as GP, lead nurse, social workers, acute trust geriatrician

Some of the key tasks of the navigator include:-

- supporting assessment and development of a personal care plan based on needs, together with relatives, patient, health and social workers

- being a point of contact for patients to help coordinate care across primary secondary and community care

- attending case conferences and multidisciplinary meetings
- reaching out to providers for appointments and to clients to check the care plan is followed
- supporting people to access services from a range of statutory and non-statutory sectors including arts, faith, voluntary, education.
- being flexible, able to multi-task, prioritise jobs, cope with stress, deal with challenging clients.

Greenwich Care Navigators

- Greenwich Coordinated Care is **made up of partners including CCG, acute trusts, mental health trust and local Healthwatch**
- Care navigators were introduced to help co-ordinate multidisciplinary care planning, scanning and integrating different sectors including health, social and community sectors.
- **Navigators work to develop 'I' statements, personalised care plans which build upon a person's goals, desires and needs.**
- Key elements of the job include: speaking with people over the phone to determine their individual needs, working closely with other agencies which may reach far and wide including housing, voluntary organisations, using a motivational interviewing style, acting as a main point of contact for the carer or client, take part in team meetings and being able to communicate confidently and assertively when necessary, to help champion the needs of a person. Education and training is in-house.

Camden Care Navigators, Age UK

- Navigators work as a team of six with a team manager, who oversees and supports the training and work of the navigators
- Navigators focus on supporting people to access mainly community and voluntary sector services in Camden
- Navigators have a wide range of background in health social care e.g. Macmillan nursing, substance misuse services.
- They work across a network of services

- **A local directory is created and team members share information and knowledge – it is important to meet with one another to learn together and reflect on challenging cases**

- Key tasks include signposting people to services, provide advice, contribute to MDT meetings, help coordinate care people e.g. to attend appointments at the hospital

- Receive referrals from GP, and may involve speaking to clients over the phone or arranging home access visits

- They help set goals and develop individual personalised care plans

  Important elements of the job include: understanding some basic medical
- terminology, knowledge of impact of long term conditions on health, mental health and capacity issues, confidence, excellent communication, presenting information at a meeting, persistence

- Education and training is usually in house, where the team leader seeks available on-line and other courses.

Appendix two

Workflow Optimisation / Medical Assistants Summary

What is medical assistant/workflow optimisation?

A member of clerical staff (although this can be other staff groups such as Physician Assistants, etc) in the practice is given additional training and relevant protocols in order to support the GP in clinical administration tasks. These may include tasks such as to read, code and action incoming clinical correspondence according to a standard protocol, ordering tests, chasing results and outpatient referrals, liaising with other providers and explaining care processes to patients. In some practices, the medical assistant works very closely with the GP, sitting alongside them during telephone clinics.

The aim is to reduce the number of letters requiring processing by a GP.

The benefits are:

- GPs typically save 30-60 minutes per day (e.g. mean of 45min in Brighton –see case study below)
- With training and a standard protocol, safety is very good (e.g. zero adverse events in 15,000 letters, Brighton – see case study below)
- Coding improves.
- Staff satisfaction improves: enhanced role and greater contribution to the practice.

Managing clinical correspondence is an enhancement to typical administrative tasks of handling correspondence, such as scanning, forwarding to GPs and filing. It requires the staff member to be skilled and confident to make decisions about how to code a letter and its contents in the patient record, how to use an approved protocol for deciding which letters need to be sent to a GP and with what level of urgency, and when to ask for help. Training should also support the practice in establishing its own internal systems including a safe and appropriate protocol to guide staff, a system of supervision (especially for the early stages of implementation) and regular audits of safety and effectiveness. Ideally a training experience should provide opportunities for practice managers, GPs and staff to hear from others who are already working in this way.

Other training needs for clerical and reception staff (for example, customer service, information governance, understanding Read or Snomed codes, safeguarding) remain the responsibility of the employer, and are not covered by this funding.

Areas to consider prior to training

- Support for the practice to develop its own internal systems including a safe and appropriate protocol to guide staff, a system of supervision (especially for the early stages of implementation) and regular audits of safety and effectiveness. This should include the opportunity to learn from other practices' examples.
- Create opportunities for practice managers, GPs and staff to hear from others who are already working in this way.

Examples of models/case studies from elsewhere

"Here"

Here is a not-for-profit social enterprise and primary care federation, bringing together GPs, clinicians, staff and other health partners to improve services and patient care.

Training for document management

Workflow Optimisation was an approach to document management developed as part of the Prime Minister's GP Access Fund. It provides a proven framework giving practices the confidence to redirect the flow of clinical administration work within the practice – releasing GPs to spend a greater proportion of their time with their patients. Practices are assured that clinical administration will be handled safely and accurately.

The outcome is that up to 80% of the patient correspondence is completed without the GP, freeing up approximately 40 minutes of GP time each day. Patients and their clinicians can then make informed decisions about their health which allows people to move onto the next step in their health care journey safely and efficiently.

The Training Programme

The training programme consists of:

- 4-day training course for administrators. Administrators are trained to read, code and action incoming clinical correspondence safely and accurately. Administrators are trained on their practices own patients – ensuring that the training is as realistic as possible. Training courses are taught in small groups of up to 16 trainees with a maximum ratio of 4 trainees to every trainer.

- Half-day training course for GP Champions. GP Champions attend a half-day training course learning the key responsibilities of their role – the role is pivotal in ensuring the practice achieves a safe, sustainable and full implementation of Workflow Optimisation. The training includes; the principles and processes underpinning Workflow Optimisation, the role of auditing and feedback in ensuring clinical governance and assurance, the medication protocol and other key protocols.
- Follow-up visits to support implementation. Follow-up visits can be provided to support practices in implementing Workflow Optimisation, to provide a refresher on any aspects the practice remains unsure of and to troubleshoot any issues encountered by the practice.

In addition to the training programme, practices also benefit from:

- An e-learning platform
- Training resources (including manuals, policies, protocols etc).
- An online forum
- Remote support from the Workflow Optimisation team for the duration of the contract.
- Medical indemnity assurance for Workflow Optimisation as confirmed by the Medical Defence Union (MDU) and the Medical Protection Society (MPS).
- CPD accreditation for the GP Champion element of the training programme

Medical assistants processing letters, Brighton and Hove GP Access Fund

To reduce workload pressures and help practices improve access for patients, this GP Access Fund scheme developed a new standard protocol to allow clerical staff to play an active role in processing incoming clinical correspondence, rather than the GP having to deal with every letter.

The idea
Members of the practice clerical team are trained to read, code and action incoming clinical correspondence according to a standard protocol. The protocol was developed by local GPs and refined through live testing in practice, using feedback about its safety and efficiency.
A standard process has been developed for training staff in undertaking this new work. It has been found to be feasible for staff with no prior experience of general practice, as well as very experienced secretaries and clinical coders. It has been found to be important to include mentoring as well as information-giving in the training, and for a GP at the practice to meet regularly with staff in the early days.

Impact

In the first 6 practices to trial this, this has saved an average of 45 minutes of each GPs time each day, with no significant events having occurred in the first 15,000 letters to be processed.
GPs report being satisfied with the safety of the approach, the improved quality of coding and the release of their time. Clerical staff report that they are confident to run the new process and describe renewed job satisfaction. Some of the most experienced staff describe it as the best thing that has happened to their job.

Implementation tips
In the abstract, GPs often have concerns about the feasibility and clinical safety of this approach. It is useful for them to speak to a GP from another practice who has done it, as well as to reflect on the number of times currently that they feel it was not appropriate for them to have received a letter. Standard protocols are a very useful starting point, but can be adapted by a practice to adjust to their own ways of working and preferences about workflows and thresholds for insisting a GP handles a letter.

Link(s)
www.england.nhs.uk/ourwork/futurenhs/pm-ext-access/wave-one/pm-about/#pil5

AT Medics

AT Medics is London's largest primary care provider, serving 170,000 patients across 30 sites. The group provides innovative services and has a track record of innovation in training and improving quality and productivity.

Training for document management
EZ DOC™ is a systemised approach to managing GP letters, safely enabling administrative staff to handle most of the letters traditionally forwarded to GP's. EZ DOC™ focuses on managing incoming correspondence safely and efficiently, reducing the amount of time GPs spend on administration, and building resilience and a well-connected practice team. The benefits have been:

- efficiency: an hour of GP administration time saved every day per GP
- safety: significant improvement in clinical safety
- cost saving: £11,000 worth of annual savings per practice per 1000 patients
- satisfaction: huge increase in clinical and administration staff satisfaction

The training programme
EZ DOC™ was developed by GPs at AT Medics, and a standard training approach has been developed, which has successfully rolled out the approach in over 25 GP practices to date.

The approach combines face to face training with the EZ DOC web-tool which enables individual practice teams to easily access information, training, assessment to ensure proficiency, and regular audits to ensure accurate and safe document management. We also recognise the need to allow Federations and CCG's the opportunity to localise systems and this is built into our approach.

The standard process for introducing EZ Doc includes:

- Understanding current practice identifying your complete document workflow process
- Co-designing the new working model, with face-to-face workshops to develop a localised solution, based on the EZ Doc model
- Training – web training includes an assessment to ensure staff proficiency and perpetual learning
- Implementation – development of a guided strategy to ensure a sustained improvement and change, step by step
- Audit – measuring the effectiveness and accuracy of the new document management process, periodically

Clerical staff processing letters, Wincanton Health Centre
The five GPs at this practice were feeling overwhelmed with burgeoning admin work, but found the solution was in working smarter, not harder.

The idea
In autumn/winter 2015 Wincanton Health Centre in Somerset decided the long working hours and administrative demands for GPs had to be addressed. Practice GPs receive about 200 pieces of paperwork every day which need to be processed. With each GP holding a list size of more than 2,000 patients and demands ever increasing during the day, the paperwork was being pushed to the end of the day.
The practice handed over more administrative duties to admin staff and provided training to help them take over more of the procedural tasks previously handled by the GPs. As new processes were implemented, practice GPs found they could hand over an increasing number of duties to their clerical colleagues.

GP Dr Fox says: "We started by identifying letters that we felt we never needed to see, such as 'did not attend' letters and diabetic retinopathy screening notifications. We put in place systems to make sure these were dealt with appropriately by a member of the admin staff. This was a small help but didn't make a sufficient dent in the workload so we pushed the envelope further. We trained one of the admin staff to code diagnoses, procedures and values in the letters and set the computer system so that on viewing the letters the GPs could deal with actions that were required but not have to go to the

trouble of doing the coding - another improvement but still not enough.

“Finally we took the plunge and decided that a lot of the work being done by the GPs could be done equally well and possibly better by a member of the admin staff. A senior member of the admin team would then go through the post and weed out the letters that needed to be seen by the GPs but send the remainder to the admin team for task completion, coding or simply for scanning if no action was required. The initial letter reading was checked by a second senior staff member to ensure there were checks in the system. The general rule of thumb is if there is any doubt then the letter should be presented to the GP.”

Impact
The number of letters being sent to the GPs has dropped to about 10 to 20% of what was previously being received. GPs are now feeling more in control of their workload and regaining more of a sense of work-life balance. Working hours have been reduced – something that will be attractive whenever the practice next needs to go to GP recruitment.

Implementation tips
Dr Fox says: “It has been a great process for us although it may not work for all as it does require an amount of trust being placed in the senior staff on behalf of the GPs. I am aware of GPs even in my area who feel uncomfortable with that but I would strongly encourage them to consider how certain processes within their practice can be handled differently.”

Link(s)
naomi.witcomb@nhsiq.nhs.uk
www.wincantonhealth.co.uk

Local HEE support

Health Education England North also intends to commission a training provider to upskill the workforce across the North Region. The training will provide 90 places across the Northwest as a pilot and education model. Training will begin by September with two cohorts in spring and autumn. There will be a 6-9 month program of work based learning. It will target existing staff.