Public Document Pack

NHS
Wolverhampton
Clinical Commissioning Group

Meeting of the Primary Care Joint Commissioning Committee (Public)
Tuesday 4th October 2016
2.00 pm
PC108, 1st Floor, Creative Industries Centre, Wolverhampton Science Park, Stephenson Room

A G E N D A

1	Welcome and Introductions	Chair	
2	Apologies	Chair	
3	Declarations of Interest	All	
4	Minutes of the meeting held on 6th September 2016	Chair	1 - 8
5	Matters arising from the minutes	Chair	
6	Committee Action Points	Chair	9 - 10
7	NHS England Update	AM	11 - 64
8	NHS England Finance Update	CH	
9	Wolverhampton CCG Update	MH	
10	Primary Care Programme Board Update	MG	65 - 70
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13	Social Prescribing Report - For Information	SM	75 - 90
14	Any Other Business		
15	Date of next meeting Tuesday 1st November 2016 at 2.00pm in the Stephenson Room, 1st Floor, Technology Centre, Wolverhampton Science Park		

For further information on this agenda or about the meeting generally, or to submit apologies for absence, please contact Laura Russell - laura.russell4@nhs.net

MEMBERSHIP	
Wolverhampton CCG	Ms P Roberts (Chair) Mrs M Garcha Dr Kainth Mr S Marshall Dr D De Rosa Dr H Hibbs Dr Reehana
NHS England	Alastair McIntyre Gill Shelley Anna Nicholls
Patient Representatives	Sarah Gaytten Jenny Spencer
Invitees (Non-Voting)	Donald McIntosh (Healthwatch) Ros Jervis, Service Director Public Health and Wellbeing

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
PRIMARY CARE JOINT COMMISSIONING COMMITTEE

Minutes of the Primary Care Joint Commissioning Committee Meeting
Held on Tuesday 6th September 2016
Commencing at 2.00 pm in the Stephenson Room, Technology Centre,
Wolverhampton Science Park

MEMBERS ~

Wolverhampton CCG ~

		Present
Pat Roberts	Chair	Yes
Dr David Bush	Governing Body Member / GP	Yes
Dr Manjit Kainth	Locality Chair / GP	Yes
Dr Salma Reehana	Locality Chair / GP	No
Steven Marshall	Director of Strategy & Transformation	Yes
Manjeet Garcha	Executive Lead Nurse	Yes

NHS England ~

Alastair McIntyre	Locality Director	Yes
Gill Shelley	Senior Contract Manager (Primary Care)	Yes
Anna Nicholls	Contract Manager (Primary Care)	No
Emma Cox	Senior Finance Manager	Yes

Independent Patient Representatives ~

Jenny Spencer	Independent Patient Representative	Yes
Sarah Gaytten	Independent Patient Representative	Yes
Peter Price	Vice Chair	No

Non-Voting Observers ~

Katie Spence	Consultant in Public Health	Yes
Donald McIntosh	Chief Officer – Wolverhampton Healthwatch	Yes
Dr Gurmit Mahay	Vice Chair – Wolverhampton LMC	No
Jeff Blankley	Chair - Wolverhampton LPC	Yes

In attendance ~

Mike Hastings	Associate Director of Operations (WCCG)	Yes
Peter McKenzie	Corporate Operations Manager (WCCG)	Yes
Jane Worton	Primary Care Liaison Manager (WCCG) (Minute Taker)	Yes
Trisha Curran	Interim Accountable Officer (WCCG)	Yes
Claire Skidmore	Chief Finance and Operating Officer (WCCG)	Yes
Laura Russell	Primary Care PMO Administrator	Yes

Welcome and Introductions

PCC180 Ms Roberts welcomed attendees to the meeting and introductions took place.

Apologies for absence

PCC181 Apologies were submitted on behalf of Dr Helen Hibbs, Peter Price, Ros Jervis, and Anna Nicholls.

Declarations of Interest

PCC182 Dr Kainth and Dr Bush declared that, as GPs they had a standing interest in all items related to primary care.

Ms Gaytten and Ms Spencer declared that, in their role as employees of the University of Wolverhampton, they worked closely with practices to arrange placements for student nurses and therefore had a standing interest in items related to primary care.

As these declarations did not constitute a conflict of interest, all participants remained in the meeting whilst these items were discussed.

Minutes of the Meeting Held on 2nd August 2016

PCC183 RESOLVED:

That the minutes of the previous meeting held on 2nd August 2016 were approved as an accurate record.

Matters arising from the minutes

PCC184 **GP Peer Review Terms of Reference**
It was noted the Terms of Reference were shared with the Committee for information.

RESOLVED: That the above is noted

Committee Action Points

PCC185 **Minute Number PCC121 - Primary Care Joint Commissioning Committee Terms Of Reference**
It was noted this item was on the meeting agenda.

Minute Number PCC174 – Wolverhampton CCG Update
Mr Hastings confirmed he had responded to Wolverhampton LMC queries within in the 7 day deadline.

Minute Number PCC174 – Primary Care Support England (PCSE)
Ms Worton confirmed an e-mail went out to all Practice Managers on the 11th August requesting PCSE feedback. All the responses had been collated and sent to NHS England where the information will be discussed in a forum meeting between Capita Services and NHS England. It was confirmed any feedback would be escalated back to the CCGs this could be fed back to the GP Practices.

Minute Number PCC175 – GP Peer Review
It was noted this item was on the meeting agenda.

Minute Number PCC176 – Acute Discharge Process
Mr Blankley confirmed he had met with Dee Harris and discussions have commenced regarding prescribing within the acute discharge process.

Minute Number PCC176 – Premises Charges
Mr Hastings agreed to chase Anna Nicholls regarding this action.

Minute Number PCC177 – Workforce Strategy
This item is due to be presented at the October meeting.

RESOLVED: That the above is noted.

NHS England Update – Primary Care Update

PCC186 Mr McIntyre presented the NHS England update to the Committee outlining the latest developments in primary care nationally and locally. Mr McIntyre highlighted to the Committee the deadline for delegated applications for full delegation is the 5th December 2016. The outcomes of the approval process will be communicated in January 2017 with the go live date for new delegated arrangements on the 1st April 2017.

Mr McIntyre stated the application documents will be published within the next month and asked for the CCG to ensure they are prepared in order to meet this deadline. Mr McKenzie confirmed that the CCG will be provided a report on this process to the Wolverhampton CCG Governing Body Meeting next month.

Ms Roberts queried the Primary Care Commissioning Activity Report and who would be submitted the return to UNIFY. It was confirmed that NHS England would complete this return on behalf the CCG. Mr McIntosh asked if the completed return would be shared with the Committee, Ms Shelley agreed this would be shared at the October meeting.

Ms Roberts queried in relation to the GP Resilience Programme it notes that comments are invited on this document by 2nd September 2016 and asked if the CCG have/or needed to make a response. Mr Hastings confirmed there is a programme of work on the GP Forward view, which NHS England has held a workshop that the CCGs were in attendance. Mr Hastings agreed to confirm and report back.

RESOLUTION: Primary Care Commissioning Activity return to be shared with the Committee in October 2016.

Mr Hastings agreed to report back if the CCG had/or needed to make a response on the GP Resilience Programme document.

NHS England Finance Update

PCC187 Ms Cox presented the Wolverhampton CCG's (2016/217) GP Services month 4 finance position report to the Committee. The forecast outturn is £33.1m delivering a breakeven position. The allocation has reduced by £881k, in relation to month 2 transfer of budget allocations from NHS England to the CCG due to contracts now being held by the CCG.

A number of reviews have been carried in month 4 in relation to GP forecasts including;

- Recalculation of Global Sum Payments, PMS and APMS Contract payments based on the July 2016 updated list sizes
- Review of QOF outturn for practices who had not received their 2015/16 finalised position in month 2
- Review of DES Forecasts based on practice sign up

A drawdown of £45k against the 0.5% contingency was required to deliver a breakeven position, with a balance of £125k remaining for further in year cost pressures. Ms Curran queried whether any unspent contingency reserves would roll over to 2017/2018. It was noted that it was not possible to roll over the contingency reserve however, at month 10 discussions take place around how any remaining money could be allocated, which the CCG will start to forecast and plan for in advance.

RESOLVED: That the above is noted.

Wolverhampton CCG Update

PCC188 Mr Hastings provided the following update to the Committee in relation to Wolverhampton CCG Primary Care:

Estates and Technology Transformation Fund (ETTF) – The outcome of all bid applications will be received by November 2016, therefore no commitments can be made until the outcomes are received.

Estates – A lot of progress has been achieved in relation to the Locality Hubs for the better care fund.

Digital Road Map – Positive feedback has been received in relation to the plans that have been submitted. There have been good stakeholder relationships and the plan is making good progress and the plan continues to be refined which will be submitted as a final submission within the next few weeks.

Capita / Primary Care Support England - Feedback is awaited via the Primary Care Operational Group Meeting in respect of outcome/concerns from the forum meeting held with NHS England and Capita, where GP responses are discussed.

Vertical Integration – There are three GP Practices currently integrated with RWT with another two waiting expressing an interest.

RESOLVED: That the above is noted.

Primary Care Programme Board Update July 2016

PCC189 Ms Garcha presented an update on the delivery of the work being undertaken by the Primary Care Programme Board. The Interpreting Procurement closing date had been extended until the 30th August 2016 and a review of the bidders will take place during September. The new contract will start on the 1st December 2016.

In relation to the Community Equipment Procurement a paper had been presented to the Commissioning Committee in August with a view of taking a joint procurement process with Wolverhampton City Council. The assurance provided at the Commissioning Committee is that Wolverhampton City Council will procure a like for like service. The Commissioning Committee have rejected this proposal and agreed for the Wolverhampton CCG to go ahead and procure their own services. It was confirmed the joint discussions with Wolverhampton City Council has delayed the process by six months.

A paper was presented to the meeting in August on Choose and Book, Advice and Guidance, where it was confirmed that advice and guidance services are not available for Neurology and Geriatric Medicine. After a number of escalations it has been highlighted there are vacant posts within these specialties. Further work is being undertaken to understand if GPs are using the service overall and the system correctly. These discussions will take place at the next Clinical Reference Group in September.

A new proposal for Atrial Fibrillation had been presented to the QIPP Board, where the Board reviewed the options available. It was agreed to introduce a scheme as a pilot within one Locality for a 12 month period, with a view to start in line with the flu vaccination process. Discussions took place around when the pilot should be undertaken and around the targeted age group for Atrial Fibrillation.

Ms Garcha provided an update on the timeline for Primary Care Review (Basket and Minor Injuries) which was as follows:

- Sign off of the costing template at the July 2016 Finance and Performance Committee.
- Review of specifications with revised tariffs at the August 2016 Clinical Reference Group.
- Proposal to be shared for support at the Septembers LMC Officers Meeting.

An A&E chest pain audit had been undertaken and indicated out of the 21 patients reviewed only one patient was deemed suitable for CDU. This is now being addressed through contact discussions with The Royal Wolverhampton Trust.

RESOLVED: That the above is noted

Primary Care Operations Management Group Update

PCC190 Mr Hastings provided an overview of the key areas covered at the Primary Care Operational Management Group Meeting which took place on the 23rd August 2016.

Ms Roberts asked if the Primary Care Operational Management Group were happy with the percentage of returns and the comments received in relation the Friends and Family Test results. Mr Hastings confirmed that the responses are reviewed, however there are two GP Practices who fail to submit data even after support has been given. The Primary Care Operational Management Group have agreed to give the GP Practices a month to improve performance and if no improvement has been made this will be brought to the Committee recommending a breach notice.

RESOLVED: That the above is noted

Mr Marshall left the meeting

Terms of Reference

PCC191 Mr McKenzie informed the Committee the Terms of Reference were reported upon in June 2016. It was noted at the June meeting further changes would

need to be undertaken, following publication of an updated Guidance on Managing Conflict of Interest for CCGs by NHS England.

The amended Terms of Reference were shared with the Committee highlighting the changes, the main changes are the inclusion of the Lay Member for Finance and Performance within the Committee Membership (as a Deputy Chair) and GP members no longer having formal voting rights. It has also included clarification that CCG's requirements around registration of interest apply to NHS West Midland Representatives.

Mr McKenzie highlighted at this point no changes have been made to the Committee's remit and responsibilities. As part of the process for applying for full delegation of Primary Care, the CCG will need to establish a Primary Care Committee and have discussions on whether any additional functions will be delegated to the Committee by the CCG.

It was noted that the two independent patient representatives needed to be added to the membership of the committee.

RESOLVED: That subject to the amendment to the membership to include the patient representatives, the Terms of Reference be approved.

Any Other Business

PCC192 **Primary Care Full Delegation**

It was confirmed the application needs to be submitted by the 5th December 2016 and full delegation of Primary Care will commence as of the 1st April 2016.

RESOLVED: That the above is noted.

Date, Time & Venue of Next Committee Meeting

PCC193 Tuesday 4th October 2016 at 2.00pm in PC108, Wolverhampton Science Park

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Primary Care Joint Commissioning Committee Actions Log

Open Items

Action No	Date of meeting	Minute Number	Item	By When	By Whom	Action Update
35	**02.08.16**	**PCC176**	**Premises Charges** Ms Nicholls to look into support available to GP practices with increased premises charges and provide an update at the September 2016 Committee meeting.	September 2016	Anna Nicholls	06.09.16 - Mr Hastings agreed to chase Anna Nicholls regarding this action.
36	**02.08.16**	**PCC177**	**Workforce Strategy** Ms Garcha to bring an update on the Workforce Strategy, with specific reference to GP growth, to the October 2016 meeting.	October 2016	Manjeet Garcha	06.09.16 - This item is due to be presented at the October meeting.
37	**06.09.16**	**PCC186**	**NHS England Update – Primary Care Update** Primary Care Commissioning Activity return to be shared with the Committee in October 2016.	October 2016	Gill Shelley	
38	**06.09.16**	**PCC186**	**NHS England Update – Primary Care Update** Mr Hastings agreed to report back if the CCG had/or needed to make a response on the GP Resilience Programme document.	October 2016	Mike Hastings	

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NHS
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WOLVERHAMPTON CCG

PRIMARY CARE JOINT COMMISSIONING COMMITTEE
October 2016

Title of Report:	**Primary Care Update**
Report of:	Alastair McIntyre
Contact:	Martina Ellery
Primary Care Joint Commissioning Committee Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To update the Committee on latest developments in Primary Medical Care nationally and locally
Public or Private:	This Report is intended for the public domain
Relevance to CCG Priority:	
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	
• **Domain 2a:** Performance – delivery of commitments and improved outcomes	
• **Domain 2b:** Quality (Improved Outcomes)	
• **Domain 3:** Financial Management	
• **Domain 4:** Planning (Long Term and Short Term)	
• **Domain 5:** Delegated Functions	**Update on Primary Care**

NHS
Wolverhampton
Clinical Commissioning Group

NHS England (West Midlands)
Primary Care Update – September 2016

GPFV Event
We are holding two events along with the national team on 5th October 2016 at the Birmingham City Stadium. The afternoon event is for CCGs, LMCS and NHSE and the evening event is for General Practices and will provide attendees with updates on the work to date as well as programmes planned forward.
Links to book on are below:

https://www.events.england.nhs.uk/nhsengland/274/home (Afternoon)

https://www.events.england.nhs.uk/nhsengland/275/home (Evening)

General Practice Development Programme Funding
All CCGs have received an allocation for 2016/17 for the General Practice Development Programme – specifically for Receptionists and Clerical staff training. The enclosed guidance provides additional information on governance process required and how to access approved providers.


GP Development programme - 8 Septe

Sustainability and Resilience Programme – GPRP

Local teams (DCO) have been asked to confirm practice selections for the GPRP by 18th October 2016. That includes practices that have self-referred as well as practices identified by CCGs. An assessment template to aide CCGs in the task is enclosed – please complete the template and forward it to Martina Ellery by Friday 7th if at all possible so we can collate them and print them in readiness for the meeting on 11th.

The central team are working on the procurement strategy to enable the required support to be out in place and we should have much more information by the sub-group meeting on 11th October. Commissioning Organisations must follow SFIs and procurement Regulations need to be adhered to. In the absence of a complete supplier framework, it would be helpful for CCGs to come with suggestions of support if possible.

We recognise that self-referral is a key way of accessing this type of support. Practices who think they would be benefit from this support – including upstream support ahead of any difficulties occurring - are strongly encouraged to make contact with their local team.


GPRP Practice assessment template..


NHS England General Practice Resilience Prc

Update on Indemnity Scheme
The National programme is now in Phase 2, the team are covering a work programme that includes the following:

1. Finalising the scheme for the payment of the short term financial assistance. This is being paid to reflect in-hours sessions. Circa £30 million has been allocated for this scheme in 2016, and the scheme will be in place for 2 years. Details currently being finalised.

2. Winter indemnity scheme for this year, which is intended to run from October 2016 to March 2017. Details of the scheme are currently being negotiated.

3. Working with the New Care Models team and DH to ensure that indemnity is appropriately considered through the development of the MCP contract and new care models more widely.

4. The team are working to resolve the problems currently being experienced by the clinical pharmacy pilots, to ensure the programme remains viable and that roll out will be successful.

5. The team are taking an in-depth look at the costs of out of hours indemnity which will inform CCG commissioning of OOH and unscheduled care services in 17/18.

6. We are assisting DH with their work that they are undertaking on trying to bring about legal reform to address the drivers of indemnity premia increases.

PC Commissioning Activity Report (PCAR)

All organisations commissioning Primary Care are required to complete a return via UNIFY to support greater assurance and oversight of NHS England's primary care commissioning responsibilities, and inform the strategic direction for general practice.

All delegated CCGs need to complete the return by 30th September 2016; NHSE team has completed the return for all other CCGs. Guidance is enclosed.

pc-comm-activity-report-guidance.pdf

Biannual Extended Access Data Collection

From October 2016, as set out in regulations, every GP practice in England will be required to submit an online return twice a year through the Primary Care Web Tool: www.primarycare.nhs.uk within a new module titled "Biannual Extended Access" (enclosed). This will set out what access to appointments the practice offers to patients either itself or through other arrangements, seven days a week.

This module will be made automatically available to GP practice staff who currently have ability to submit mandatory data returns to NHS England, and will be available in the website when the collection opens.

The first return will be open for submission from **3 October 2016 to 31 October 2016** inclusive.

Further guidance including who to contact for further assistance has been attached and will also be made available shortly on the NHS England's website:

https://www.england.nhs.uk/commissioning/gp-contract/.

ExAcc GP Guidance (Final).pdf

Premises cost directions
DH have started drafting the revised 2016 Premises cost directions. This should mean the directions will come into force in November and will be disseminated via the usual channels.

My NHS
"The My NHS data comparison website has recently been refreshed with a new look and has been updated with a new smaller set of GP practice indicators.

https://www.nhs.uk/service-search/scorecard/results/1171?metricGroupId=596&radiusInMile=400&recordsPerPage=10

The indicators chosen for publication have been selected from those used by NHS England and CQC to assure and regulate general practice. A process was run to identity a small subset following recommendations from the Health Foundation to the Secretary of State to focus on what matters most to public, profession and nationally. The aim was to help the public 'identify the signal from the noise'. These are not new indicators just a set of indicators which have been brought together in a more meaningful way.

GMS Contract Changes

There have not been any completed contract changes in the last month

8 September 2016

GP Development Programme – Reception and Clerical Training Allocations in Month 5

Please find below further details regarding the month 5 allocation distributed to CCGs for Reception and Clerical Training.

1. This money is this year's instalment of the new £45m fund for training practice staff for active signposting and document management. This was announced in the General Practice Forward View, and details are available at www.england.nhs.uk/ourwork/gpfv/gpdp/reception-clerical/. Active signposting and document management are promising innovations that release time for GPs. They are part of the 10 High Impact Actions to release time, announced in the Forward View and supported by a growing evidence base currently housed here – http://bit.ly/gpcapacityforum The new Time for Care programme provides support for groups of practices to implement innovations that release time for care, and is supported by a £45m fund towards the cost of online consultations as well as this fund for staff training.

2. In 2016/17, £5m is available, and £10m will be available in each of the subsequent four years. The funding will be allocated on a non-weighted per-patient basis. CCGs are welcome to top up the funding available for their practices.

3. As confirmed on the NHS England website, this funding is allocated solely for this purpose and should not be used for any purpose other than those stated in the criteria.

4. A low-burden approach will be taken to reporting spend of this fund and activity across the CCG with respect to the training. Details of this are expected to be announced by NHS England in coming weeks.

5. Relevant training for practice staff is currently available from a limited number of training providers across England. These have plans to grow their capacity rapidly, and we anticipate a vibrant market developing over the next two years. NHS England will not formally approve or accredit training products, but an online directory of providers will be published in the near future and kept updated as new offers become available. The staggered release of the £45m fund over five years will help to mitigate against the risk of demand outstripping supply. It also recognises the fact that some practices and areas will wish to take time planning to introduce these innovations.

6. The staggered release of funding means that most CCGs will wish to work with their practices and other CCGs in their STP footprint to plan how best to deploy the fund. In discussion with CCG leaders thus far, it seems that the most productive approach will be to share funding to allow successive cohorts of practices to receive their full five-year allocation at one time. This will allow avoid practices having to wait a number of years until sufficient funding accrues for them to purchase a training package. It will also create a critical mass of practices in an area for them to benefit from collaboration and sharing of learning among themselves.

7. NHS England will notify CCGs and practices when the new directory of training providers is launched. This will include information to support local discussions about choosing a training offer and implementing new ways of working within practices. This is expected by the end of September.

Sustainablity and Resilience Programme - CCG level assessment

1. Use this worksheet to document your assessment of individual or groups of practices within a CCG area. (Copy as necessary this template for each CCG with the local team area or adapt as necessary for other footprint e.g. local team, town etc. if required).
2. Latest data is available in the raw data file provided
3. Criteria should only be completed if there is evidence relevant to the case for selection for support - descriptions of the criteria and support matrix are provided in the orange tabs.

Commissioner/provider details					Safety		Workforce			External Perspective			Organisational issues			Efficiency		Patient Experience / Access				Support Matrix			Free text for comments
CCG code	CCG name	Practice code	Practice name	Practice Group? (Please identify group support through unique name or reference applicable to all constituents practices)	CQC rating - inadequate or requires improvement?	Any individual professional performance issues?	Number of patients per WTE GP	Number of patients per WTE Nurse	Any vacancies (include long term illness)?	Significant support from LMC, CCG or NHS England?	Practice self-referring for supporting?	Primary Care Web Tool – 5 or more outlier indicators?	Any practice leadership or partner relationship issues?	Any significant practice changes? (splits or mergers)	Any risk of professional isolation currently?	QOF % achievement	Is practice a clear outlier for referral or prescribing performance compared to CCG average (e.g. top/bottom 5%)	List closure (include application or neighbouring practices)	GP Patient Survey - Would you recommend your GP surgery to someone who has just moved to your local area? (% no).	GP Patient Survey – ease of getting through by phone (% not at all easy).	GP Patient Survey – ability to get an appointment to see or speak to someone (% no).	Scope to support (5 = Very Likely, 1 = Rare)	Impact of support (5 = Very High, 1 = Very Low)	Overall Support Score	Free text for comments for local use. You should use this section to confirm any other information relevant to selection decision.
																						5	5	25	
																						4	4	16	
																						3	3	9	
																						2	2	4	
																						1	1	1	
																						1	2	2	
																						1	3	3	

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Domain		Criteria	Description and rationale for inclusion
Safety			
	1	CQC rating – inadequate	Practices rated as inadequate by the CQC are already directed to the RCGP peer support scheme. It is not proposed that this is changed but is included within the criteria for the sake of completeness and recognising practices moving out of special measures may still need additional 'upstream' support.
	2	CQC rating - requires improvement	Practice rated as requiring improvement where there is greatest need for support are already directed to the vulnerable practice programme. It is not proposed that this is changed but is included within the criteria for the sake of completeness and recognising additional 'upstream' support may still be needed.
	3	Individual professional performance issues	This reflects that sometimes the overall operations of the practice can impact on or be impacted by professional performance issues.
Workforce			
	4	Number of patients per WTE GP and/or WTE Practice Nurse	These criteria help detect significant workload facing a practice in comparison to other practices. Neither criteria are an indicator of the need for support in themselves but they may indicate opportunities for improvement support, including skill mix.
	5	Vacancies (include long term illness)	This is a key local indicator of a practices sustainability and resilience. It is a crude 'measure' however in that long term or sudden critical vacancies may impact on operations of the practice in different ways. It will be important to consider the nature of the vacancies. The proportion of staff in the practice aged 55 and over may also be an important consideration given potential for early retirements.
External Perspective			
	6	Other external perspectives not covered in the above criteria, for example significant support from LMC, CCG or NHS England local team.	**This is a key criteria**. The level of support increases dependent upon how many local external bodies have significant concerns. Practices self-referring for support may also be considered here.
	7	Primary Care Web Tool	Using this tool and in particular those practices that trigger 5/6 or more outlier indicators provides an indication of some issues in a practice that may require support.
Organisational Issues			
	8	Practice leadership issues (partner relationships)	This is a key area where practices may need support but it is difficult to define so will be for local commissioners to reflect and justify.
	9	Significant practice changes	It is self-evident that this increases the need for support for individual or groups of practices. Practice mergers may make local practices stronger and more resilient, practice splits less so but still requiring support to ensure sustainable operations.
	10	Professional isolation	This is a self-evident criteria, but there are many resilient single handed practices that continue to operate successfully. However by definition a single handed practice has less resilience than a larger practice. Again it would be for local commissioners to reflect a risk rating against this.
Efficiency			
	11	QOF % achievement	This is often used as a short hand measure of how well a practice is operating. The vast majority of practices score well above 90% with average 94% achievement. Just 500 practices score under 80% achievement, 100 practices score under 65% achievement. 21 practices achieve a score which is half of England average achievement (47%). Significant changes in achievement could also evidence changes in operations in need of support.
	12	Referral or prescribing performance compared to CCG average	It is proposed that this is flagged where a practice is a clear outlier (e.g. top / bottom 5%) for aggregate prescribing or referral rates compared to the CCG average.
Patient Experience/ access			
	13	List closure (including application to close list)	This is a key indicator and is akin to the practice self-declaring that they need support. It is a crude 'measure' in that the practice may need support to meet an increase in demand or it may need support to better manage its current demand. It will be important to consider the reasons for list closure. It will be important for local commissioners to also reflect here on practices with refused applications or practices bordering onto a closed list practice.
	14	GP Patient Survey - Would you recommend your GP surgery to someone who has just moved to your local area? (% no).	This is one of a set of patient experience criteria that could be usefully included. Patient advocacy is known to correlate with good quality care.
	15	GP Patient Survey – ease of getting through by phone (% not at all easy).	Could be usefully included in that it provides an early indication where practices may be supported to better match or manage capacity and demand issues.
	16	GP Patient Survey - ability to get an appointment to see or speak to someone (% no)	Could also be usefully included in that it provides an early indication where practices may be supported to better match or manage capacity and demand issues.

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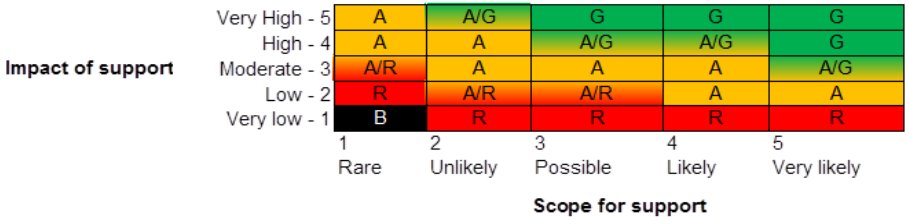
Sustainability and Resilience Support Matrix

Following an assessment of the national criteria local teams should decide where individual practices should be placed on the support matrix below. Placement should be scored between 1-5 for both scope for support and impact of support. Descriptions for scoring are also provided.

Support Matrix



Description: Scope for support

	Likelihood Scoring				
	1	**2**	**3**	**4**	**5**
Descriptor	Rare	Unlikely	Possible	Likely	Very Likely
Frequency / What is the scope for support the practice?	There is no evidence that support is needed	Do not expect it to need support, but it is possible it may do so in the future	Might need support on basis of evidence presented	Likely need support because of specific issues/circumstances but not expected to persist.	Very likely to need support because of persisting local issues or circumstances. Very likely to need support because of specific urgent issue of circumstance.

Description: impact scoring

	Likelihood Scoring				
	1	**2**	**3**	**4**	**5**
Descriptor	Rare	Unlikely	Possible	Likely	Very Likely
Frequency / What is the scope for support the practice?	Very minor support needs Minimal impact for practice, staff, patients	Single support issue Low impact on practice and staff, and negligible impact for patients	Moderate impact of support for practice, staff and for multiple patients	Significant effect for practice and staff if support provided, and moderate impact for patients.	Very significant impact for practice, staff and patients if support provided

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General Practice Resilience Programme

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General Practice Resilience Programme

Operational Guidance

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Prepared by: Primary Care Commissioning Team, Medical Directorate

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1 Summary

This guidance document describes how the new General Practice Resilience Programme (GPRP) will operate to deliver the commitment set out in the General Practice Forward View[1] to invest £40m over the next four years to support struggling practices.

This programme aims to deliver a menu of support that will help practices to become more sustainable and resilient, better placed to tackle the challenges they face now and into the future, and securing continuing high quality care for patients.

The intended audience for this guidance is:

- NHS England local teams working under Directors of Commissioning Operations who will lead delivery of this programme.
- Clinical Commissioning Groups and local provider GPs and their Local Medical Committee (LMC) representatives and Royal College of GPs (RCGP) Faculties and Regional Ambassadors who will work in close collaboration with local teams to support this programme.

As part of agreed devolution arrangements, Greater Manchester has been allocated a transformation fund which includes an appropriate share of NHS England funding for primary medical care initiatives. It will be for Greater Manchester to determine how it is spent in the local area.

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

2 Introduction

Rising GP workload pressures are widely recognised in England. Managing GP services that are at or beyond capacity risks locking those practices into responding reactively and inhibits effective strategic leadership and practice management. Recruitment challenges exacerbate these difficulties. In addition, practices do not exist in isolation and the impact of these pressures can have a 'domino effect' in local areas. One or two local problems can quickly impact on otherwise functioning and stable practices.

[1] https://www.england.nhs.uk/ourwork/gpfv/

NHS England is committed to supporting GP practices to improve their sustainability and resilience; securing operational stability; developing more effective ways of working and helping practices to explore new care models.

Two national programmes are currently operating to offer turnaround support to those GP practices where there is the greatest need to improve sustainability and resilience:

- £10m investment in externally facilitated support – the Vulnerable Practice Programme[2]; and,
- RCGP Peer Support Programme[3] providing support to practices entering CQC special measures.

We have worked with the RCGP, British Medical Association (BMA) General Practitioners Committee (GPC) and NHS Clinical Commissioners (NHS CC) to consider how best to offer further support.

This guidance sets out how the GPRP will be delivered and confirms:

- Operational and funding arrangements at NHS England local team level
- Practices (individual or groups) will be identified for support using existing national criteria
- A menu of support will be offered by local teams, ranging from support to stabilise practice operations where there is a risk of closure, through to more transformational support that will secure resilience in to the future.
- Local teams will tailor this support and decide how to deliver this in view of local practice needs working in conjunction with CCGs, provider GPs, LMCs representatives and RCGP Faculties and Regional Ambassadors (referred hereafter as 'key partners').
- We will work nationally to quality assure support by enabling learning and sharing of best practice, working with RCGP to maximise learning from local peer support and through the roll out of regional events.

In 2016/17 the GPRP will operate in addition to existing national programmes of turnaround support. This means the additional funding from GPRP can be used to support even more GP practices this year.

3 Funding

NHS England is committed to investing £40m in the GPRP over the next four years.

In 2016/17 there is £16m available to be invested in support to help practices become more sustainable and resilient, with £8m available per year thereafter until March 2020.

[2] https://www.england.nhs.uk/wp-content/uploads/2015/12/letter-support-vulnerable-gps-final-finance.pdf
[3] http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/2016/RCGP-Supporting-practices-FAQ-April-2016.ashx

This means local teams will be able to invest in support arrangements over the medium term, giving greater certainty and continuity in the support offer available to GP practices over the lifetime of the GPRP (notwithstanding local ambitions to ensure support continues to be responsive and evolving with local practice needs).

The funds will be transferred direct to local teams. Fair shares at this footprint have been calculated on a registered patient population basis. Local teams will work with key partners to ensure the funding is used to target support at areas of greatest need and will work in line with the processes set out in this guidance to deliver support to practices.

GPRP allocations for 2016/17 will be made to local teams by end of July 2016 and future years will be made at the start of each financial year. Annex A provides details of funding allocations for each NHS England local team and region.

4 Menu of support

There are many definitions of struggling practices in need of support to become more sustainable and resilient. This means there is a wide range of support needed.

We have identified a menu of support for which the GPRP funding should be used to secure this at a local level. This will include the provision of immediate help to practices facing urgent operational pressures, to transformation support to move to more resilient care models. The menu of support comprises:

- **Diagnostic services to quickly identify areas for improvement support.**
  For example, seven practices in London were put forward for a diagnostic assessment from chosen suppliers (a local GP alliance and a non-local GP federation). This has helped identify some common themes to target support including lack of practice direction following significant personnel changes (a need to develop practice vision) and scope to improve operational efficiency (leading to redesign of practice processes improving both practice responsiveness and efficiency).

- **Specialist advice and guidance – e.g. Operational HR, IT, Management, and Finance**
  For example, a small number of practices in Cumbria & North East local team wanted to take ‘working together’ to the next stage and agreed in principle on a merger. The limiting factor to making progress had been limited local practice capacity and expert advice to assist with proposals. These were addressed through programme funded support.

  The programme funding can be used to secure expert advice and support on delivering any operational changes (e.g. help with demand and capacity planning, effective use of operational systems and processes including help to release capacity).

- **Coaching / Supervision / Mentorship as appropriate to identified needs**
  For example, South Central local team secured support from a multi-professional team helping a practice conduct a detailed review of safeguarding arrangements. The scheme supported training for all staff, as well as support and advice on developing an approach to clinical audit, and help and advice to individual GPs, through appraisal and access to occupational health support.

- **Practice management capacity support**
  For example, South Central local team has provided cover for practice manager sick leave, using an experienced business manager to help provide stability, support a practice diagnostic review and help to develop a practice action plan.

- **Rapid intervention and management support for practices at risk of closure**
  For example, the Central Midlands local team works with CCGs to offer assistance with practices that receive poor CQC ratings (in addition to the RCGP Special Measures peer support programme) to maximise prospects for turnaround.

  This element of the menu of support is not just about working with practices with poor CQC ratings and we recognise there are many definitions where practices may need rapid intervention support to prevent closure e.g. following sudden critical vacancies. One of the key concerns has been the ability to provide support quickly to practices to help coordinate key activities. This means the funding can be used to deliver rapid support including help to secure any immediate clinical capacity needs, assuring and supporting continuing operations and coordinating additional improvement needs to help with operational delivery and effectiveness.

- **Coordinated support to help practices struggling with workforce issues**
  For example South Central local team helped a practice secure capacity for a practice nurse home visiting service for non-urgent chronic disease management for 3-months. This was to inform development of the practices skill mix and provide additional short-term capacity.

  This element of the menu of support has been included as it is recognised that maintaining clinical sessions is a priority for practices struggling with workforce issues (e.g. sudden critical vacancies, sickness, and long term vacancies) and increasing competition for a diminishing workforce can escalate workforce challenges in local areas.

  The funding can be used flexibly to secure practical workforce support. For example, local teams can create a local pool of expert peer support by funding key elements of GP costs (e.g. General Medical Council, Medical Defence Organisation and appraisal toolkit fees) in return for securing a minimum clinical commitment (e.g. 2 sessions per week) to work to support practices. This would be a portfolio career choice, targeting experienced GPs who may have recently retired or who can offer additional clinical commitments,

supporting GP retention/returners locally. Salary costs would remain practice responsibility. Alternatively, it can be used to establish post(s) in local teams with responsibility for (and attached to) a locality, working with practices to help plan, coordinate and match their recruitment needs and opportunities. This could also include leading on developing pragmatic solutions for practices where short term barriers exist (e.g. help to support skill mix alternatives to GP recruitment during periods of maternity leave).

- **Change management and improvement support to individual practices or group of practices**
  For example, South West local team identified through local provider GPs and other local stakeholders a strong need for change management resource to support practices in thinking about and delivering future resilience. Support to practices was underpinned by a Project Management Office approach with project/change managers linking with practices to plan and deliver across 4 main work streams (new care models, infrastructure, working at scale and provider development).

  The emphasis here is on providing dedicated project or change management support available to practice to help plan, develop proposals and implement changes. The GPRP funding can be used to target support at groups of practices including support for local strategic planning, future vision and review of practice business models, help to identify and realise opportunities to working at scale, succession planning, facilitating premises improvements or better use on IM&T etc.

Much of this initial menu of support should already be in place and being delivered as a consequence of the existing national programmes of turnaround support but we want to ensure the GPRP improves accessibility by developing local capacity and capability to deliver a wider range of practice support to practices and in a more agile and responsive way.

Greatest impact should be achieved under the GPRP by local teams tailoring the menu of support to the assessed needs of practices in local areas. It is recognised there may be different views locally on the emphasis of practice needs, for example, whether investment boost this year should be used to prioritise help to practices with workforce issues or whether greater benefit would be achieved from targeting groups of practices at a scale to provide more upstream support.

Local teams will consult on their proposals for how this menu of support is to be delivered with their key partners. For example GPRP funding can be used to fund:

- **Additional local team capacity and capabilities to provide support directly** – for example ‘local resilience teams’, as established in some areas already, provide a resource with capacity to work with practices. Examples to date have included NHS England or CCG employed staff.

- **Contracted third party Supplier(s) to work with practices** – including GP Federation or other at scale providers. Suppliers can provide specialist aspects of the menu and there is also potential to extend to delivery of local resilience teams.

- **Backfill (or other costs) for individual GPs and other practice team members** – to work to provide peer support to practices locally, providing 'sender' practices have additional capacity to offer such support.

- **Section 96 Support and Financial Assistance** – where there are opportunities to support practices directly in delivering the menu of support.

Where existing support teams or equivalent arrangements apply, the GPRP funds can be used to deliver support further and faster to practices. Local teams are encouraged to consider how they can build on the foundations of the work they have started with the Vulnerable Practices Programme although the GPRP remains a separate programme. However, the emphasis on how this menu of support is delivered is on local flexibility.

Personal resilience training

There is also the human dimension to supporting practice sustainability and resilience. Personal resilience is widely recognised and evidenced as an important factor in organisational resilience which is recognised in the GPRP.

In parallel to the GPRP, NHS England is working to introduce the NHS GP Health service, a new treatment service providing GPs suffering stress and burnout access to mental health support from December 2016 and the procurement[4] for this service is underway.

Local teams will recognise the upstream benefits of supporting GPs and practices team members to develop personal resilience skills and will consider with their key partners whether access to personal resilience training would be a helpful facet of the local GPRP support.

5 Identifying practices to support

In view of the continuing operation of the Vulnerable Practice Programme[5] in 2016/17 the same national criteria applied here will be used by local teams to identify practices for support under the GPRP. Resources under the GPRP will allow support to be made available to even more practices, including providing 'upstream' support i.e. practices at the tipping point who may be struggling with workload but who are otherwise operationally stable, and retain the lessons learned from the implementation of the Vulnerable Practices Programme.

Local teams will have the flexibility to quickly identify practices for support under the GPRP by selecting:

- Practices assessed initially but not subsequently prioritised for support.

[4] https://www.contractsfinder.service.gov.uk/Notice/325d71bd-ebfd-4068-819c-6ff0b911b546
[5] https://www.england.nhs.uk/wp-content/uploads/2015/12/letter-support-vulnerable-gps-final-finance.pdf

- Practices offered support but who did not take up the offer.
- Groups of practices where practice based assessments identify a need in a particular locality or place (e.g. support offered to a group of 5 practices in a locality because 3 practices are struggling and there is a risk of domino effect impacting other practices unless support targeted at scale).

Decisions and thresholds set locally should be made on the basis of local intelligence and decisions as to where the greatest impact can be achieved using the available resources. Local teams will again need to work in conjunction with key partners here.

Local teams will need to keep assessments under regular review, updated as a minimum on a 6-monthly basis, and should ensure there are clear opportunities for practices to self-refer for assessment for improvement support under the GPRP. This will include making available a named local team contact for practice enquiries that can be included in local communications.

To support ongoing assessment and prioritisation of support we have refreshed the national criteria (annex B), to better reflect a practices' needs in developing their sustainability and resilience.

Local NHS England teams will need to be able to confirm details of those GP practices they have agreed to support. Further details will follow on the national reporting arrangements which will support accountability and oversight of the delivery of GPRP.

6 Practice commitment

Support to GP practices will be conditional on matched commitment from practices, evidenced through an agreed action plan which will need to include clear milestones for exiting support. Practices will not be required to match-fund the support.

GP practices selected to receive support under the GPRP will be expected to enter into a non-legally binding Memorandum of Understanding (MOU) with NHS England. A template MOU will be published as part of this guidance within which local teams and practices can record local arrangements, including objectives and responsibilities in respect of any support or funding provided. It is anticipated the template MOU will be available by 16th August for adaption by local teams.

GPRP funding should not be used where there is no identifiable exit strategy for support and where there is no engagement with the local primary care strategy.

7 National support

Local teams will be aware we are already working to deliver for October 2016 a sustainability and resilience procurement framework for primary care[6]. This will speed up local ability to secure support from a range of providers. Use of the

[6] https://www.contractsfinder.service.gov.uk/Notice/a2337154-494f-4202-a4ef-b39528028229

framework will not be mandatory given flexibilities in the local approach as to how support may be delivered under the GPRP.

Sharing learning and best practice under the programme will be important. We intend to work with key partners to secure and embed learning locally, including from RCGP peer support teams supporting practices in CQC special measures and to ensure local teams do not act in isolation of others approaches.

We are planning a series of regional learning events, to be led by RCGP peer support teams, to engage with local teams and other key partners. The timing of these will be confirmed but the first events are expected by end of November this year.

NHS England has introduced monthly monitoring to ensure that all the funding for the £10m Vulnerable Practices Programme is reaching practices, and is setting a deadline of 31st October for this funding to be fully committed for individual and groups of practices. Monthly monitoring will also be established for the GPRP so progress can be reviewed.

8 Key milestones

NHS England is committed to moving forward with the delivery of this programme rapidly and to ensure decision making is not protracted. The following milestones apply:

- **By 19 August:** NHS England local teams to share proposals for delivering the menu of support with their key partners.

- **By 23 September:** NHS England local teams will confirm to NHS England central team how they will deliver the menu of support, including single point of contact for practices. NHS England central team will publish these details nationally so there is clarity for all GP practices on the support arrangements in place. This will be in addition to local communications.

- **By 30 September:** NHS England local teams will confirm to the NHS England central team list of practices selected to receive support in 2016/17 (notwithstanding practices who may be subsequently assessed for support, including practices who self-refer) and that support offers have been made to practices listed. Offers will be followed up with agreed MOUs.

- **By 14 October:** where any practices have been identified in need of urgent support due to risk of closure, and are not already receiving support under the existing national programme, NHS England local teams will need to confirm to NHS England central team, that practices are now in receipt of practical support.

- **By 30 December:** local teams to confirm £16m investment support in GPRP (expenditure and/or evidence of investment being fully committed to named practices).

For any questions on the programme which you would like to raise which are not covered by the information in this guidance please send an email to england.primarycareops@nhs.net including in the subject heading ‘GPRP Question’.

We will be producing and maintaining a separate frequently asked questions (FAQs) document to accompany this guidance and will ensure these reflect key themes on issues raised.

9 Annex A – Indicative Funding allocations

Regional teams	Reg. Population (April 2016)	Indicative Allocation FY16/17	Indicative Allocation FY17/18*	Indicative Allocation FY18/19*	Indicative Allocation FY19/20*	Total Programme Allocation
North Region Total	**13,111,378**	**£ 3,640,040**	**£ 1,820,021**	**£ 1,820,021**	**£ 1,820,021**	**£ 9,100,103**
Cheshire and Merseyside	2,582,125	£ 716,861	£ 358,431	£ 358,431	£ 358,431	£ 1,792,154
Cumbria and North East	3,254,446	£ 903,514	£ 451,757	£ 451,757	£ 451,757	£ 2,258,785
Lancashire	1,533,553	£ 425,752	£ 212,876	£ 212,876	£ 212,876	£ 1,064,380
Yorkshire and the Humber	5,741,254	£ 1,593,913	£ 796,957	£ 796,957	£ 796,957	£ 3,984,784
Midlands & East Region Total	**17,427,264**	**£ 4,838,238**	**£ 2,419,119**	**£ 2,419,119**	**£ 2,419,119**	**£ 12,095,595**
Central Midlands	4,817,045	£ 1,337,330	£ 668,665	£ 668,665	£ 668,665	£ 3,343,325
East	4,460,295	£ 1,238,288	£ 619,144	£ 619,144	£ 619,144	£ 3,095,720
North Midlands	3,716,823	£ 1,031,882	£ 515,941	£ 515,941	£ 515,941	£ 2,579,705
West Midlands	4,433,101	£ 1,230,738	£ 615,369	£ 615,369	£ 615,369	£ 3,076,845
London Region Total	**9,443,052**	**£ 2,621,625**	**£ 1,310,812**	**£ 1,310,812**	**£ 1,310,812**	**£ 6,554,061**
North East London	3,618,132	£ 1,004,483	£ 502,241	£ 502,241	£ 502,241	£ 2,511,206
North West London	2,329,655	£ 646,770	£ 323,385	£ 323,385	£ 323,385	£ 1,616,925
South London	3,495,265	£ 970,372	£ 485,186	£ 485,186	£ 485,186	£ 2,425,930
South Region Total	**14,683,128**	**£ 4,076,398**	**£ 2,038,199**	**£ 2,038,199**	**£ 2,038,199**	**£ 10,190,995**
South Central	3,793,820	£ 1,053,258	£ 526,629	£ 526,629	£ 526,629	£ 2,633,145
South East	4,738,857	£ 1,315,623	£ 657,812	£ 657,812	£ 657,812	£ 3,289,059
South West	3,302,555	£ 916,871	£ 458,435	£ 458,435	£ 458,435	£ 2,292,176
Wessex	2,847,896	£ 790,646	£ 395,323	£ 395,323	£ 395,323	£ 1,976,615
Greater Manchester**	**2,966,954**	**£ 823,699**	**£ 411,850**	**£ 411,850**	**£ 411,850**	**£ 2,059,249**
England Total	**57,631,776**	**£ 16,000,000**	**£ 8,000,001**	**£ 8,000,001**	**£ 8,000,001**	**£ 40,000,003**

*****Indicative allocations as calculation will be subject to latest available registered population data.

**These amounts represent the proportion of the total allocations attributable to Greater Manchester based on the latest available population data. Primary Care Transformation funding has been made available for the Greater Manchester Strategic Partnership sufficient to cover the indicative amounts listed above.

10 Annex B - National Criteria

Identifying General Practice sustainability and resilience needs is challenging. There are elements of any assessment which are subjective and deciding on the nature, severity or weight of issues facing individual practices are even more problematic to measure. These criteria (as previous) seek to chart a middle route between those aspects that are measurable and those less tangible issues which can help identify and prioritise practices sustainability and resilience needs. The nature of the issues facing a practice can be grouped generally as follows; demand, capacity and internal issues.

The range of criteria identified below can be used as a screening tool by local commissioners to guide their assessment with local stakeholders on offers of support to improve sustainability and resilience. Based on this assessment local teams should use the support matrix (effectively rating the need and impact of support). This can be used to prioritise practices for support within a given organisational or geographical area as well as to target support between areas where there is likely to be greatest benefit.

It is suggested that local teams will utilise their judgement when completing the assessment working with their key partners. It should be noted that the criteria overlap in some cases, for example a practice with a high vacancy level may also seek to close their list to new registrations.

Considerations

Patient safety is paramount - when undertaking the assessment if it becomes evident that safety could be compromised, commissioners should be alert to the need for escalation through the appropriate channels, whilst recognising the need for continuing support.

Domain	Criteria	Description and rationale for inclusion
Safety		
1.	CQC rating – inadequate	Practices rated as inadequate by the CQC are already directed to the RCGP peer support scheme. It is not proposed that this is changed but is included within the criteria for the sake of completeness and recognising practices moving out of special measures may still need additional 'upstream' support.
2.	CQC rating - requires improvement	Practice rated as requiring improvement where there is greatest need for support are already directed to the vulnerable practice programme. It is not proposed that this is changed but is included within the criteria for the sake of completeness and recognising additional 'upstream' support may still be needed. FAQs provide further guidance.
3.	Individual professional performance issues	This reflects that sometimes the overall operations of the practice can impact on or be impacted by professional performance issues.
Workforce		
4.	Number of patients per WTE GP and/or WTE Practice Nurse	These criteria help detect significant workload facing a practice in comparison to other practices. Neither criteria are an indicator of the need for support in themselves but they may indicate opportunities for improvement support, including skill mix.
5.	Vacancies (include long term illness)	This is a key local indicator of a practices sustainability and resilience. It is a crude 'measure' however in that long term or sudden critical vacancies may impact on operations of the practice in different ways. It will be important to consider the nature of the vacancies. The proportion of staff in the practice aged 55 and over may also be an important consideration given potential for early retirements.
External Perspective		
6.	Other external perspectives not covered in the above criteria, for example significant support from LMC, CCG or NHS England local team.	**This is a key criteria**. The level of support increases dependent upon how many local external bodies have significant concerns. Practices self-referring for support may also be considered here.
7.	Primary Care Web Tool	Using this tool and in particular those practices that trigger 5/6 or more outlier indicators provides an indication of some issues in a practice that may require support.
Organisational Issues		
8.	Practice leadership issues (partner relationships)	This is a key area where practices may need support but it is difficult to define so will be for local commissioners to reflect and justify.

Domain	Criteria	Description and rationale for inclusion
9.	Significant practice changes	It is self-evident that this increases the need for support for individual or groups of practices. Practice mergers may make local practices stronger and more resilient, practice splits less so but still requiring support to ensure sustainable operations.
10.	Professional isolation	This is a self-evident criteria, but there are many resilient single handed practices that continue to operate successfully. However by definition a single handed practice has less resilience than a larger practice. Again it would be for local commissioners to reflect a risk rating against this.
Efficiency		
11.	QOF % achievement	This is often used as a short hand measure of how well a practice is operating. The vast majority of practices score well above 90% with average 94% achievement. Just 500 practices score under 80% achievement, 100 practices score under 65% achievement. 21 practices achieve a score which is half of England average achievement (47%). Significant changes in achievement could also evidence changes in operations in need of support.
12.	Referral or prescribing performance compared to CCG average	It is proposed that this is flagged where a practice is a clear outlier (e.g. top / bottom 5%) for aggregate prescribing or referral rates compared to the CCG average.
Patient Experience/ access		
13.	List closure (including application to close list)	This is a key indicator and is akin to the practice self-declaring that they need support. It is a crude 'measure' in that the practice may need support to meet an increase in demand or it may need support to better manage its current demand. It will be important to consider the reasons for list closure. It will be important for local commissioners to also reflect here on practices with refused applications or practices bordering onto a closed list practice.
14.	GP Patient Survey - Would you recommend your GP surgery to someone who has just moved to your local area? (% no).	This is one of a set of patient experience criteria that could be usefully included. Patient advocacy is known to correlate with good quality care.
15.	GP Patient Survey – ease of getting through by phone (% not at all easy).	Could be usefully included in that it provides an early indication where practices may be supported to better match or manage capacity and demand issues.
16.	GP Patient Survey - ability to get an appointment to see or speak to someone (% no)	Could also be usefully included in that it provides an early indication where practices may be supported to better match or manage capacity and demand issues.

Sustainability and Resilience Support Matrix

Following an assessment of the criteria above local NHS England teams should decide where individual practices should be placed on the support matrix below.

Placement should be scored between 1-5 for both scope for support and impact of support. Descriptions for scoring are also provided.

Local NHS England teams will need to ensure there is a record justifying placement based on their assessment of the criteria and demonstrating a consistent approach to the assessment of practices.

Support Matrix						
Impact of support	Very High - 5	A	A/G	G	G	G
	High - 4	A	A	A/G	A/G	G
	Moderate - 3	A/R	A	A	A	A/G
	Low - 2	R	A/R	A/R	A	A
	Very low - 1	B	R	R	R	R
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Very likely
		Scope for support				

Description: Scope for support

	Likelihood Scoring				
	1	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Very Likely**
Frequency / What is the scope for support the practice?	There is no evidence that support is needed	Do not expect it to need support, but it is possible it may do so in the future	Might need support on basis of evidence presented	Likely need support because of specific issues/circumstances but not expected to persist.	Very likely to need support because of persisting local issues or circumstances. Very likely to need support because of specific urgent issue of circumstance.

Description: impact scoring

	Likelihood Scoring				
	1	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Very Likely**
Frequency / What is the scope for support the practice?	Very minor support needs Minimal impact for practice, staff, patients .	Single support issue Low impact on practice and staff, and negligible impact for patients	Moderate impact of support for practice, staff and for multiple patients	Significant effect for practice and staff if support provided, and moderate impact for patients.	Very significant impact for practice, staff and patients if support provided .

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2016/17 Primary Care Commissioning Activity Report

Guidance notes for completion

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Target Audience	CCG Clinical Leaders, CCG Accountable Officers, NHS England Heads of Primary Care
Additional Circulation List	
Description	Guidance to support teh completion of the primary care commissioning activity report (PCAR).
Cross Reference	N/A
Superseded Docs (if applicable)	N/A
Action Required	For use during completion of the PCAR
Timing / Deadlines (if applicable)	**N/A**
Contact Details for further information	Primary Care Commissioning Medical Directorate NHS England 4W56 | Quarry House | Quarry Hill | Leeds | LS2 7UE england.primarycareops@nhs.net

Document Status

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2016/17 Primary Care Commissioning Activity Report

Guidance notes for completion

1 Introduction

The primary care commissioning activity report (PCAR) is a newly introduced bi-annual collection to support greater assurance and oversight of NHS England's primary care commissioning responsibilities, and inform the strategic direction for general practice. It seeks to replace what have often been variable and ad hoc requests for information with a more systematic approach.

The report which is being managed through UNIFY2 focuses on key operational areas for commissioned general practice services[1] although this could be extended to other primary care contractor groups in future years.
It seeks to collect information on local commissioning activity regardless of the commissioning route (e.g. NHS England or CCGs with delegated authority).

The key areas of interest for the 2016/17 reporting round include:

- Management of contractual underperformance
- Management of contract disputes
- Financial assistance to providers
- Procurement and expiry of contracts
- Availability of services, including closed lists.

Information gathered from this report will be used to support national oversight using the aggregated results, highlighting variation across local geographies and supporting review against our operational policies e.g. management of GP list closures and underperformance etc. It will also support more efficient management of Freedom of Information requests limiting the ad hoc burdens through planned bi-annual publication of the information collected and moving to a rolling 12 month reports produced bi-annually from October 2016.

2 Responsibility for completion

Local teams (Director of Commissioning level) 'hold the ring' on ensuring this report is completed but have the option on the approach to do this in a way that is most suitable for the local area.

[1] The core services commissioned from all GP practices under General Medical Services, Personal Medical Services and Alternative Provider Medical Services contracts.

There are two options on completion which should be decided on by local teams in discussion with CCGs:

Option 1. Local team and delegated CCGs complete. CCGs with delegated commissioning responsibilities in the DCO team area will need to complete the collection for themselves and the local team completes the return in respect of all other directly commissioned GP services i.e. for all non-delegated CCGs in the local team area. This approach could also include CCGs with joint commissioning responsibilities leading reporting if appropriate and agreed locally. If this is a team's preferred option, they must ensure they hold correct and up to date information for all CCGs within their geography

Option 2. Local team completes. The local team completes the return for the DCO area as a whole, not by individual CCG. The system will prevent CCGs, regardless of their co-commissioning function, from completing the return in order to avoid duplication. If this is a team's preferred option, they must ensure they hold correct and up to date information for all CCGs within their geography.

2.1 Online Collection

The collection will be made via UNIFY2, an online collection system used for collating, sharing and reporting NHS and social care data.

Each local team and CCG responsible for reporting should have a nominated person(s) responsible for completing the report.

Existing users should be able to use their current username and password to access the system.

New users will need to apply for a username and password. To access the UNIFY2 system, users need an N3 connection.

Those without an N3 connection can apply for one through the N3 website.

Local primary care teams (NHS England and CCGs) will need to decide whether to complete this directly or through their local assurances teams who will already have access to and experience of UNIFY2.

3 Reporting period

Reporting will be on a bi-annual (twice yearly) basis starting in October 2016.

Local teams and CCGs will therefore need to ensure they have appropriate local processes in place for capturing and recording the requested information. It is recognised some information will need to be applied retrospectively in respect of the first collection.

3.1 Key dates are:

Reporting periods (period of activity to be reported on)
1st April – 31st August
1st September – 31st March

Period for returns (period when local teams and CCGs will need to completed returns on Unify2)

1st – 30th September
1st – 30th April

3.2 Planned report publications

31 October 2016 (reporting on first 6 months of 2016/17)
30 May 2017 (aggregating returns from the first report to report on 2016/17)

Reporting period	Submission opens	Submission closes	Report due
1 April – 31 August	1 September	30 September	31 October
1 September – 31 March	1 April	30 April	30 May

3.3 Completion Guidance

Please ensure an answer is provided for every question, including nil returns using 0 value. Any answers left blank will jeopardise the validity of the collection.

4 Questions and terminology

NHS England ran a proof of concept for this collection and reporting in 2015/16 with all local teams participating. Feedback was clear a number of the questions included caused confusion and/or had led to varied interpretation in responses and therefore data reported. We have worked to improve clarity on the information requested and the following guidance is to be read in conjunction with the report. The following therefore is provided to give further insight and explanation of the information requested.

1. Managing contractual underperformance

- **Practices identified for review for contractual underperformance**

'Review' includes any local identification process to substantiate a need for managing contractual performance such as practice visit from the local team or further risk assessment.

- **Reviews that have been 'completed'**

Proposed action towards practices identified for review that have been actioned in the reporting period. If a practice has been highlighted for review but this has not yet been actioned, this should not be counted here e.g. a practice visit to be scheduled but not undertaken in the reporting period.

2. Managing disputes

- **Stage 1 – Local Dispute Resolution**

This applies to any instance when NHS England ceases all action in relation to a contractor's decision to dispute one or more decisions made against its contract or agreement and invites and considers supporting evidence in relation to the matter under dispute. The matter will be resolved in a local meeting by either NHS England continuing with the contract sanction or by the contractor ceasing to pursue the NHS dispute resolution procedure or court proceedings.

- **Stage 2- NHS Dispute Resolution**

This applies to a written request for dispute resolution submitted to the secretary of state (FHSAU process) by a local team/contract holder following Stage 1.

3. Equitable funding

- **Section 96 Support and Assistance**

This applies to any instance of financial assistance or support to a contractor using these specific statutory powers provided under the Health and Social Care Act 2012.

These will be specific and objectively justified payments to a contractor that are not provided for under the contract and will relate to exceptional instances (for example, financial support for an uninsured loss or event which might otherwise jeopardise continuing delivery of services due to contractors financial position and ability to recover). Do not include MPIG or PMS premium funding here.

4. Procurement and expiry of contracts

This applies to any new procurement exercise for primary medical services undertaken in the last 6 months.

This may take the form of the re-procurement of existing services due to:

- An expiring Alternative Provider Medical Services (APMS) contract
- Termination of a General Medical Services (GMS) or Personal Medical Services (PMS) contract
- Closure of a General Medical Services (GMS) or Personal Medical Services (PMS) contract

A procurement exercise may also be carried out for the procurement of new services to fill an identified need/gap.

Any appointments made during this exercise should be recorded by provider type. A record should be kept of any exercise that failed to appoint on to the grounds that they failed to meet set quality standards.

5. Availability of services

This refers to the closure of patient lists and GP practices resulting in reduced access for patients.

- **Practice applying to close their patient list**

This applies to the number of applications from a GP practices asking to close their patient lists that have been received in the last 6 months. If the same practice has sent through several requests within the last 6 months, please only count this as one. It should also be recorded how many of these applications have been approved in the last 6 months.

- **Practices operating with a closed list**

This applies to any GP practices in your area that are currently operating with closed patient lists. Please include the practice codes for any GP practices operating with closed lists.

- **Practice closures**

This applies to the number of GP practices that have closed during the last 6 months due to:

- A commissioner notice (notice from NHS England local team/CCG)
- A contractor notice (notice from provider)

- **GP Patient List Validation**

Has any additional activity been undertaken in the last 6 months to ensure that practice lists in your area are up to date e.g. only include registered patients? Please note that this is any separate activity to GP list maintenance carried out by PCS.

6. Patient and public engagement

- **13Q legal duty to involve the public**

The NHS England Board has agreed a 13Q assessment process, whereby teams assess whether the duty to involve applies to commissioning decisions, using a short form. Form and guidance can be found here. The inclusion of this information will allow for an annual audit and assurance on activity and practice.

5 FAQs

- **Is completion of this report a requirement?**

The report will provide assurance and oversight on the discharge of NHS England's direct commissioning responsibilities. This information will help to highlight any potential issues arising as well as help to reduce the burden on local teams to gather information for ad hoc requests (Freedom of Information requests, Health Select Committee hearings, questions from Ministers).

- **How do I register with Unify2 to complete the return?**

If you do not currently have access to Unify2, please register for an account via the following link: http://bit.ly/28Ptc9F. Please allow 3 days for your account to be set up.

- **Are there any tips on completing it?**

Teams should decide how and who is responsible for completing the return. Section 4, questions and terminology details what questions will be asked and what information will be required. Teams should ensure that this information is systematically collected, both within local offices and CCGs (if option 1) as this should help to make completion of the return quicker and easier. Ensure plenty of time is allocated to complete the return, to allow for the provision for any amendments before the closing date. If a team choses option 1, a conversation should be held with all delegated CCGs within the DCO footprint prior to the collection opening, to ensure they are aware of their upcoming role and responsibility. At this point, local teams should ensure that those delegated CCGs have registered for a Unify2 account.

- **How do I manage/delegate to a CCG(s)?**

At the start, a team will be required to select if they are responding on behalf of the whole DCO footprint (option 2), or only the non-delegated CCGs in their DCO footprint. If option 2 is chosen, the ability for CCGs to add to/complete the return will be removed. If a local teams choses option 1, it will be the responsibility of all delegated CCGs in the DCO footprint to log into Unify2 and complete the return themselves. Each local team is responsible for making all delegated CCGs within their DCO footprint aware ahead of each collection, which option they will chose. Local teams and CCGs will be made aware of the timeline for each collection ahead of schedule.

- **What happens if I don't submit the return by the due date?**

Once the reporting period has ended, the collection will close. Any local team or CCG who fails to provide a return within this timeframe will not be able to submit additional information until the next collection. Subsequent reports will be caveated to highlight this gap in the data collected.

- **Who do I contact if I have any queries?**

For any queries relating to the completion of the report, please contact england.primarycareops@nhs.net

NHS England

Extended access to general practice

A guide to completing the extended access survey

Publications Gateway Reference 05873

NHS England INFORMATION READER BOX		
Directorate		
Medical	Operations and Information	Specialised Commissioning
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	**05873**
Document Purpose	Guidance
Document Name	Extended access to general practice. A guide to completing the extended access survey.
Author	Sandra Rochfort, NHS England
Publication Date	26 September 2016
Target Audience	GPs, General Practice Staff
Additional Circulation List	
Description	This document provides GP practice staff with information to assist them in submitting data to NHS England about their practice's offer to patients of enhanced access to appointments.
Cross Reference	NA
Superseded Docs (if applicable)	NA
Action Required	To submit data as per guidance.
Timing / Deadlines (if applicable)	**Bi-annual**
Contact Details for further information	Seven Day Access to General Practice NHS England Medical Directorate Quarry House Leeds LS2 7UE https://www.england.nhs.uk/commissioning/gp-contract/

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Extended access to general practice: a guide to completing the extended access survey

Version number: 1.1

First published: 26 September 2016

Updated:

Prepared by: Sandra Rochfort, NHS England Analytical Services

Classification: OFFICIAL

Publications Gateway Reference: 05873

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

· Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

· Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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1 Summary

1.1 The government's mandate to NHS England sets out:

> "To ensure everyone has easier and more convenient access to GP services, including appointments at evenings and weekends"

1.2 A new general practice access collection has been set up to monitor the availability of pre-bookable appointments in general practice seven days a week. This was announced as part of the 2016-17 GMS contract[1].

Following negotiation, completing this survey will be a contractual requirement from October 2016. The amendments to the GMS contract will be published during October 2016 on the Government website[2].

1.3 This document provides GP practice staff with information to assist them in submitting data to NHS England about their practice's offer to patients of enhanced access to appointments.

1.4 Practices will submit their information through the Primary Care Web Tool (PCWT)[3].

Technical guidance on how to submit this data can be found on the PCWT itself.

2 Definitions

2.1 Definitions follow to help practices answer each question detailed in section 3 of this document.

Keyword	Definition
Pre-bookable	An appointment that is available on GP practice systems for booking by patients in advance. In advance is any time before the start time of the appointment.
Appointment	This is a scheduled slot with a GP, nurse or other member of general practice staff providing direct patient care.
Early morning	Early morning means before 08:00am on weekdays, Monday through to Friday.
Evening	Evening means after 6:30pm on weekdays, Monday through to Friday.
At your practice (Q1-4)	Extended access provided only to the practices' registered patients
Group (Q5-9)	A collaboration of GP practices set up to provide primary care services to their practices' combined registered population. An example of this is a federation.

[1] http://www.nhsemployers.org/gms201617
[2] http://www.legislation.gov.uk/
[3] https://www.primarycare.nhs.uk

3 Data to submit

3.1 All GP practices are required to submit responses to two sets of questions relating to:

i. the extended access services their practice provides and;
ii. the provision of the group of practices to which they may belong.

The first set of questions shown in Table 1 asks about extended hours offered at the **GP practice to their own registered patients**.

Table 1 – questions about the practice

#	Question
1	Do patients have the option of accessing pre-bookable Saturday appointments at your practice?
2	Do patients have the option of accessing pre-bookable Sunday appointments at your practice?
3	Do patients have the option of accessing pre-bookable early morning appointments (before 8.00am) during the week at your practice?
3a	If "YES" to question 3, on which weekdays does your practice provide pre-bookable early morning appointments? (Tick those that apply).
4	Do patients have the option of accessing pre-bookable evening appointments (after 6.30pm) during the week at your practice?
4a	If "YES" to question 4, on which weekdays does your practice provide pre-bookable evening appointments? (Tick those that apply).

3.2 The second set of questions is similar to the first set; however, instead of asking about the appointments available within the individual practice they ask about the availability of appointments to patients across the **group of practices of which the practice is a member**. The term 'group' encompasses several meanings; for example appointments could be provided by a federation or a network of practices in the local area.

Table 2 - questions about the group of which the practice is a member

#	Question
5	What is the name of the group of which your practice is a member, for example this could be the name of your federation?
6	Do patients have the option of accessing pre-bookable Saturday appointments through your group?
7	Do patients have the option of accessing pre-bookable Sunday appointments through your group?
8	Do patients have the option of accessing pre-bookable early morning appointments (before 8.00am) during the week through your group?
8a	If "YES" to question 8, on which weekdays does your group provide

#	Question
	pre-bookable early morning appointments? (Tick those that apply).
9	Do patients have the option of accessing pre-bookable evening appointments (after 6.30pm) during the week through your group?
9a	If "YES" to question 9, on which weekdays does your group provide pre-bookable evening appointments? (Tick those that apply).

3.3 Practices are required to answer both sets of questions. The combination of the sets of questions is aimed at giving a view of all approaches the practice has taken to providing their patients with enhanced access to pre-bookable appointments.

3.4 If a practice is not a member of a group, the practice should select 'No group' as the answer to question 5. In this instance responses will not be required for questions 6 to 9a inclusive.

3.5 In addition to the two sets of mandatory questions, there is one final question which is optional. Question 10 gives practices the opportunity to add additional comments, for example feedback on ease of survey completion or suggested improvements.

Table 3 - comments

#	Question
10	Do you have any additional comments?

4 Timeline

4.1 Submission of the extended access survey is mandatory as agreed in the 2016-17 contract negotiation.

4.2 Practices should respond to the extended access survey during the data collection window. The first data collection will be open from 3 October 2016 and all submissions must be made by close of the window on 31 October 2016.

4.3 Practices should provide information about the pre-bookable appointments that will be offered, or are expected to be offered, in the survey week. The survey week for the practice ordinarily being the week during which the collection window closes, as shown in table 4. If that week is exceptional for the practice, for example the practice is unexpectedly closed, then the practice should complete the survey using the nearest 'normal' week as their survey week.

4.4 The survey will be repeated every six months and it is expected to continue until 2020-21.

The timetable of future collections is shown in Table 4.

Table 4 - data collection timetable

Year	Collection window open	Collection window close
2016-17	3 October 2016	31 October 2016
2016-17	1 March 2017	31 March 2017
2017-18	1 September 2017	29 September 2017
2017-18	1 March 2018	30 March 2018
2018-19	3 September 2018	28 September 2018
2018-19	1 March 2019	29 March 2019
2019-20	2 September 2019	30 September 2019
2019-20	2 March 2020	31 March 2020
2020 -21	1 September 2020	30 September 2020
2020 -21	1 March 2021	31 March 2021

5 Submission Route

5.1 Practices are required to submit their survey return through the Primary Care Web Tool (PCWT). This system enables GP practices to submit data returns through dedicated modules and should be familiar to GP practices as it is already used for the annual practice e-declaration (eDEC) and the K041b Annual complaints data return. The module for the extended access collection is called Biannual Extended Access.

5.2 Users require an account to log in. The ability to view/edit and submit data returns is governed by specific permissions assigned to GP practice staff member accounts (usually senior partner and/or practice manager).

5.3 Permission to access the biannual extended access module has been granted to any GP staff member who has been assigned permission to the eDEC or the K041b collections. Users can complete the collection by selecting the “Biannual Extended Access User” role associated with their name.

5.4 New practice managers and/or senior partners should register to use the primary care website[4] They should also contact their NHS England local office with notification of their new role and contact details and request access to submit mandatory data returns to NHS England. This will enable account permissions and access to the extended access module to be authorised on time for the collection.

If you have any further questions about the extended access collection please contact the national NHS England Seven Day Access to General Practice team at england.gpaccess@nhs.net

For any other general enquiries regarding the Primary Care Web Tool please email info.primarycareweb@nhs.net

[4] https://www.primarycare.nhs.uk/register.aspx

6 Publication of the data

6.1 Results of the survey will be published every six months on NHS England's website, with the first publication expected to be available in November 2016. Information on individual practices and aggregated reports will be made available to the public.

6.2 Presentation of information is expected to include:

A. Data Collected. For each GP practice the publication will show:

- The response to each question;
- An extended hour's classification for the practice. Each practice will be placed in a group calculated based on the answers provided, for example "full extended access".

B. Aggregated reports. Nationally and for each CCG a report will show:

- Number and % practices cross-tabulated by extended access category;
- Number and % registered population cross-tabulated by extended access category;
- Number and % practices who submitted data;
- Number and % practices who are included in the measurements.

6.3 A secondary indicator called 'Primary care access' will also use this information. It will be published on MyNHS as part of the CCG Improvement and Assessment Framework (CCG IAF). This will show the proportion of practices in a CCG that provide full extended access.

7 Validation

7.1 Data will be extracted from the PCWT on the first working day after the collection window close date. Practices will be able to input or amend their submission up to the collection end date but will not be able to alter the information provided once the collection window has closed.

7.2 NHS England local offices (formerly area teams) and fully delegated CCGs in your local area will be able to monitor the collection and identify which practices have submitted or not as well as view submitted content. Contracting teams at NHS England local offices and fully delegated CCGs will not check or sign off the data prior to the collection end date. Practices should therefore ensure the content submitted is accurate.

7.3 The PCWT module is designed to minimise data quality issues. Most questions are multiple choice with only certain responses available for selection; for example 'Yes' or 'No'. Practices will not be able to submit the survey until all mandatory questions are answered.

8 Questions

8.1 For any queries about obtaining access to be able to view/edit and submit the return please contact your NHS England local office.

8.2. For any questions about the collection itself, for example clarification of the survey questions, please contact england.gpaccess@nhs.net or your NHS England local team.

8.2 For any other general enquiries regarding other areas of the Primary Care Web Tool please email info.primarycareweb@nhs.net

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WOLVERHAMPTON CCG

PRIMARY CARE JOINT COMMISSIONING COMMITTEE
4th October 2016

Title of Report:	**Update Report on Primary Care Programme Board Activity September 2016 (PCPB)**
Report of:	Manjeet Garcha Chair PCPB
Contact:	Manjeet Garcha
Primary Care Joint Commissioning Committee Action Required:	☐ **Decision** ☒ **Information**
Purpose of Report:	To update the PCJCC on PCPB activity for September 2016
Public or Private:	Public
Relevance to CCG Priority:	1,2a,2b,3,4 &5
Relevance to Board Assurance Framework (BAF):	Outline which Domain(s) the report is relevant to and why – See Notes for further information
• **Domain 5:** Delegated Functions	**Domain 5: Delegated functions**: When approved this will include primary care and may, in time, include other services. This is in addition to the assurances needed for out-of-hours Primary Medical Services, given this is a directed rather than delegated function.

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1. BACKGROUND AND CURRENT SITUATION

1.1. The Primary Care Programme Board meets monthly and it was agreed that there will be a monthly summary report presented to the PCJCC.

2. MAIN BODY OF REPORT

Summary of activity discussed on September 2016.

2.1.1 All currently active work streams are being progressed well with dates for reviews and benefit realisation analysis planned on the key planner.

2.1.2 The revised contract review register was presented and agreed to turn into a 3 year planner. Discussion took place regarding the Sickle Cell project. This will be part of the wider project review which is commencing in line with the refreshed efficiency reviews.

2.1.3 Interpreting Procurement update presented. The procurement closing end date was extended until 30th Aug 2016; following this a review of the bidders is being be made in September with a new contract start date of 1st Dec 2016. The existing provider's contract will be extend until this date.

2.1.4 Community Equipment Procurement
Update provided; the lead gave an update to confirm that the city council had reached an agreement on the 20th July 2016, regarding the procurement (Council will lead with CCG support). The CCG is to ensure that the service commissioned is appropriate for the CCG requirements and work will be undertaken closely with the City Council to ensure that this is completed. A paper was presented to the Commissioning Committee in August and further information was requested as to the different models that could be considered. The discussion at PCPB included the CC request and clarification from the LA as to what they mean by 'like for like'.

2.1.5 Choose and Book, Advice and Guidance
Paper presented to the Board. The lead confirmed that A&G services not available for Neurology and Geriatric Medicine and that after various escalations the reason behind this is that there are vacant posts for these specialties. The Board agreed that due to the low levels of GPs using the service overall, the project details should go to the clinical reference group for a more in depth clinical view to the benefit of pursuing. In addition another issue was raised re the availability of secondary and primary appointments. This is being investigated. CRG met on the 22nd September. GPs are currently calling consultants on telephone directly rather using the system, this was deemed to be inappropriate and time consuming. Action agreed to look into having a central email address where requests could be sent to. This is being considered by the CCG.

2.1.6 Atrial Fibrillation, a new proposal for QIPP presented by Dr D De Rosa. Board agreed to put forward option b (Introduce scheme as pilot in one locality for 12 months) to the Commissioning Committee in September; an updated report is to be presented to the PCPB in September for reference only. The proposal was presented to CRG on 22nd September, no changes were made to the proposal therefore the preferred option of a 12 month pilot will be presented to the Commissioning Committee in September.

2.1.6 Primary Care Review (Basket and Minor Injuries)
Update provided by VM and timeline for consideration will be:
July F&P meeting – sign off of costing template
August CRG – further review of specs with revised tariffs
Sept LMC Officers meeting – support for proposal
Sept CRG – LMC response meant that the costing model has not yet been agreed; therefore this is currently being explored further.
Oct PCPB - Spec to be presented (however, this may be delayed).

2.1.7 A&E Chest Pain
Audit finding provided, which showed that 21 patients were reviewed and one patient was deemed suitable for CDU based on clinical need.
The results will now be challenged with RWT via contract discussions for CI, with the request that a change of practice is made as the facility is being utilised inappropriately. A scheduled Quality Visit is being undertaken on Monday 27th September of ED & UCC. The visiting team will endeavour to review the situation in using CDU capacity.

2.1.8 The Risk Register was discussed, all risks are to be kept updated and leads will ensure this is maintained. No risks were escalated

2.1.9 The QIPP Plan for the PCDB was discussed and the need to continue to address the QIPP unallocated deficit reiterated.

2.1.10 No exceptions or risks to the Primary Care Delivery Board work were identified.

2.1.11 Contract Register, Commissioning Intentions, Commissioning Intentions and Engagement Documents to support the contract discussions were presented to the board. The contract register is to be presented as a standing item

2.2 CLINICAL VIEW

Clinical view is afforded by the Director of Nursing and Quality and also Dr Dan De Rosa, CCG Chair. Dr DeRosa has recently requested to attend meetings if his diary will allow and also to be sent papers and minutes etc. so there is opportunity to provide comment. Dr De Rosa was present at this meeting.

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3. PATIENT AND PUBLIC VIEW

3.1 The PCPB ensures that all schemes have an EIA completed and patient and public views are sought as per requirement. Where this is not evident, there is a requirement made to have in place before further work is commenced or the project is moved to the next stage.

4. RISKS AND IMPLICATIONS

Key Risks

4.1 The PCPB has reviewed its risk register and it is in line with the CCG requirement.

5.0 **Financial and Resource Implications**

5.1 All exceptions are reported to the QIPP Board and full discussion held re risk and mitigation.

6.0 **Quality and Safety Implications**

6.1 Quality and Risk Team are fully sighted on all activity and the EIAs include a Quality Impact Assessment which is signed off by the CCG Head of Quality and Risk

7.0 Equality Implications

7.1 A robust system has been put in place whereby all schemes have a full EIA undertaken at the scoping stage.

8.0 Medicines Management Implications

8.1 There are no implications in this report regarding medicines management; however, full consultation is sought with Head of Medicines Management for all schemes presented.

9.0 Legal and Policy Implications

9.1 There are no legal implications.

10.0 RECOMMENDATIONS

10.1 To **RECEIVE** and **Note** the actions being taken.

Name: Manjeet Garcha
Job Title: Director of Nursing and Quality
Date: 23rd September 2016

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REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View	MGarcha Dr De Rosa	23 Sept 16
Public/ Patient View		
Finance Implications discussed with Finance Team	QIPP BOARD	Sept 16
Quality Implications discussed with Quality and Risk Team	M Garcha	23 Sept 2016
Medicines Management Implications discussed with Medicines Management team	nil	Sept 2016
Equality Implications discussed with CSU Equality and Inclusion Service	J Herbert	NA
Information Governance implications discussed with IG Support Officer		
Legal/ Policy implications discussed with Corporate Operations Manager		
Signed off by Report Owner (Must be completed)	M Garcha	23rd Sept 2016

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Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

PRIMARY CARE JOINT COMMISSIONING COMMITTEE
Tuesday 4 October 2016

Title of Report:	**Primary Care Operational Management Group Update**
Report of:	Mike Hastings – Associate Director of Operations, Wolverhampton CCG
Contact:	Mike Hastings – Associate Director of Operations, Wolverhampton CCG
Primary Care Joint Commissioning Committee Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To provide an update on the Primary Care Operational Management Group
Public or Private:	The report is suitable for the Public meeting.
Relevance to CCG Priority:	
• **Domain 4:** Planning (Long Term and Short Term)	Planning for the CCG Primary Care provision to be fit for purpose in line with NHSE recommendations.
• **Domain 5:** Delegated Functions	Fulfilling the delegated responsibility of jointly managing primary care.

NHS
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1. BACKGROUND AND CURRENT SITUATION

1.1. The Primary Care Operational Management Group met on Tuesday 20 September 2016 – this report is a summation of the discussions which took place.

2. MAIN BODY OF REPORT

PRIMARY CARE ASSURANCE

2.1 Collaborative Working Model – Practice Issues and Communication Log

An issue had been highlighted at a Wolverhampton practice relating to an out of date vaccine being stored in a fridge and staff being unsure of the disposal process. It was noted that the vaccine had now been disposed of in accordance with Policy and internal re-training had taken place.

2.2 Review of Primary Care Matrix

An overview of the Primary Care Matrix was presented to the Group. Discussion took place around the merge of 2 Wolverhampton practices and a potential practice closure.

2.3 Primary Care Quality Update

Discussions took place regarding Friends and Family testing and how to manage practices which regularly fail to submit data. It was noted that going forward, Quality Matters would be used to identify any themes within practice reporting.

ESTATES

2.4 Estates and Technology Transformation Fund (ETTF)

The Group were informed that nationally, the ETTF initially had funds of £1 billion and it has now been reduced to £750 million and now stands at £404 million. In relation to cohort 1 all projects have to be completed by the end of the financial year, the majority of the bids are IT related with a couple of smaller estates bids. The CCG have a deadline of 23 September 2016 to submit for cohort 1 and state cohorts 1 and 3. We are speaking to other CCGs within the Sustainability and Transformation Plan footprint to agree what bids are being taken forward in readiness for a meeting on 26 September 2016.

SERVICE LEVEL AGREEMENT AND SPECIFICATION FOR ZERO TOLERANCE SCHEME

2.5 The Group were updated that the current service providers for the Zero Tolerance Scheme had confirmed that they were happy to continue until the end of March 2016 when a new provider will be appointed.

2.6 A number of changes to the specification had been highlighted by the Primary Care Joint Commissioning Committee and it was noted that they would be incorporated. Discussion also took place regarding the Review Panel and a suggestion was made around taking this forward on a larger STP footprint basis.

PHARMACEUITICAL INVOLVEMENT IN PRIMARY CARE

2.7 The Group were updated on a new model called Healthy Living Pharmacies which is driven by NHS England and Public Health England. An overview was provided on the model and its approach which is being driven locally in Wolverhampton and it was noted that a project group was in the process of being established.

3. RECOMMENDATIONS

3.1 The Committee is asked to note the progress made by the Primary Care Operational Management Group.

Name: Mike Hastings
Job Title: Associate Director of Operations
Date: 26 September 2016

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NHS
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WOLVERHAMPTON CCG
Commissioning Committee
Wednesday 28th September 2016

Title of Report:	**Social Prescribing Proposal**
Report of:	Andrea Smith
Contact:	Andrea Smith
Commissioning Committee Action Required:	☒ **Decision** ☐ **Assurance**
Purpose of Report:	To present a proposal of Social Prescribing to be delivered as a 12 month pilot
Public or Private:	This Report is intended for the public domain
Relevance to CCG Priority:	
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	N/A
• **Domain 2a:** Performance – delivery of commitments and improved outcomes	**Developing a social prescribing model will support care closer to home and improved patients wellbeing**
• **Domain 2b:** Quality (Improved Outcomes)	**Developing a social prescribing model will support care closer to home and improved patients wellbeing**
• **Domain 3:** Financial Management	**N/A**
• **Domain 4:** Planning (Long Term and Short Term)	Developing a social prescribing will improve patients wellbeing and reduce social isolation leading to a longer term impact of reduction on health and social care services]
• **Domain 5:** Delegated Functions	**N/A**

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Clinical Commissioning Group

1. BACKGROUND AND CURRENT SITUATION

1.1. The CCG previously explored a model of Social Prescribing through a Social Impact Bond financial model. The financial model proposed was deemed to result in a level of risk to the CCG that meant the proposal was not viable. The operational model of Social Prescribing however is a model that we would wish to pilot as evidence shows that it improves patients well being and reduces social isolation.

2. MAIN BODY OF REPORT

2.1. The Proposal describes a model for a 12 month pilot for Social prescribing, delivered during the pilot by Wolverhampton Voluntary Sector Council.

2.2. Social prescribing is described as:

*"**Social Prescribing** is about linking people up to social or physical activities in their community with a wide range of benefits" (North Tyneside)*

*"**Social prescribing** is a means of enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services, often provided by the voluntary and community sector. (Age Concern, Yorkshire and Humber)*

2.3 The model proposed would see 3 trained "link workers" across the City working with and supporting individuals that require low level, non-clinical support but whom access Health and Social Care services regularly.

2.4 The outcomes of Social Prescribing are expected to be:-

- Reduction in social isolation
- Improved health and well being
- Reduction in demand on primary care
- Reduction in secondary care activity

3. CLINICAL VIEW

3.1. The business case has been shared with Dr DeRosa and with the three locality leads. They were also involved in previous discussions when the Social Impact Bond model was being developed and were supportive of the principles of Social Prescribing

4. PATIENT AND PUBLIC VIEW

4.1. Patient feedback will be collected and analysed and acted upon during the pilot.

5. RISKS AND IMPLICATIONS

Key Risks

5.1. No risks identified to date

Financial and Resource Implications

5.2. There is a financial investment required as outlined in the business case.

Option 2 – cost of WVSC delivering model as a 12 month pilot

Service Element	**Cost year 1**
Project Manager @ 30K + 16% on –costs 0.5WTE	17,400
Community Development Officers @ 25K x 3 + 16% on costs	87,000
Administration @17K + 16% on costs 0.5WTE	9,860
Staff Training	1,500
Desk space at community location (assuming employment and management by accountable body) 2000 x 3	6,000
Staff Travel @ 45p x200 pm x 4	4,320
Central and management costs: Management, reception, payroll, rent, Insurance, IT maintenance, utilities, payroll, reception, photocopying, finance . HR etc.. @15% of hosted staff salary costs and 10% outreach.	8,178 8,700
Marketing/publicity	500
Telephone @ £35 x 3 x 12	1,260
Laptop/ipad x 3 PC x 1	2,952 646
Totals	**£148,316**

For Financial Year 2016/17 there is a part year effect equivalent to (148.316/12) x3 = £37,079.

Whilst it is difficult to demonstrate the impact from this specific project, other areas report that a reduction of demand on Primary Care is a key impact, in both telephone calls from the patient to the practice and in GP consulting time for patients who currently present high demand due to underlying social factors.

It is anticipated that each Link worker would hold a patient on their caseload for approximately 3-6 months. The contact time for each patient would be variable but as an estimate we would model an initial 1 hour meeting with fortnightly telephone calls (approx. 20 mins) thereafter.

Taking into account travel time, for each average 7.5 hour day the Link Worker could undertake 3 New referrals (I hour face – face meetings) and up to 6 follow up (20 minute calls), with an hour for admin each day.

Based on a rolling programme of patient discharge/drop out and new referrals each Link Worker could hold a caseload of approximately 442 patients per annum - Total for 3 Link Workers 1326 patients.

This proposal is very much for a qualitative project which will reduce demand on Primary Care releasing capacity to more appropriate interventions, reducing social isolation and improving the wellbeing of patients referred to the service. This in turn, however, may have an impact on secondary care activity and the table below depicts scenarios through estimating a reduction of 1 A&E attendance and 1 emergency admission for a percentage of the patient cohort. (Assuming A&E attendance of £81 and emergency admission of £2,000).

Table 2

	No. of patients	A&E	Emergency Admission	Total
Reduction of Activity for 10% cohort	132	10692	264000	274692
Reduction of Activity for 30% cohort	398	32238	796000	828238
Reduction of Activity for 50% cohort	663	53703	1326000	1379703
Reduction of Activity 100% cohort	1326	107406	2652000	2759406

Quality and Safety Implications

5.3. If the business case is approved quality and safety implications will be identified and risk assessed. As an example we would need to identify where link workers meet with patients ensuring a safe environment in line with the lone worker policy.

There would also need to be a clear escalation route if a clinical need was identified.

Equality Implications

5.4. If the business case is approved an EIA will be completed upon development of the service specification.

Medicines Management Implications

5.5. No medicines management implications have been identified

Legal and Policy Implications

5.6. None identified

6. RECOMMENDATIONS

Members of the Commissioning Committee are asked to f the policy

- **Receive** and **discuss** this report.
- **Approve funding for the pilot**.

Name Andrea Smith
Job Title Head of Integrated Commissioning
Date: 09.09.16

ATTACHED:

Social Prescribing Business Case

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Wolverhampton City
Clinical Commissioning Group

PROJECT DOCUMENTATION

BUSINESS CASE

Project: Social Prescribing Link Workers

Release:

Date: 24.06.16

PRINCE2

Author: Andrea Smith

Owner: Andrea Smith

Client:

Document Ref:

Version No:

1 Business Case History

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Business Case

3 Purpose

This business case describes a model of delivering Social Prescribing across Wolverhampton, to enable patients in finding appropriate support for their individualised needs.

Social Prescribing is described as:

***"Social Prescribing** is about linking people up to social or physical activities in their community with a wide range of benefits" (North Tyneside)*

*"**Social prescribing** is a means of enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services, often provided by the voluntary and community sector. (Age Concern, Yorkshire and Humber)*

Referrals would be made into the service by:-

- GPs
- Practice nurses
- Community nursing teams
- Social workers
- West Midlands Ambulance Service
- A&E

Referral Criteria

The referral criteria for Social Prescribing can be very broad as often it is a need that is identified from an understanding of the individuals situation or by something that the patients says or behaviours they display. Whilst social isolation is more prevalent in older adults who live alone, it is not exclusively this group of patients who would benefit from social prescribing. Therefore it is recommended to keep the referral criteria broad at this time with scheduled reviews (quarterly) once the project has commenced to manage demand and capacity. The service would

- Patients who frequently access NHS services
- Patients who are lonely
- Patients who show mild symptoms of anxiety and/or depression
- Patients with long term conditions that could benefit from individualised support
- Where a medical solution or intervention is unlikely to be successful or satisfactory

A similar project has been running in Dudley (Integrated Plus) for the past 12 months and whilst slow to start is now beginning to demonstrate positive results. Not least, feedback is showing a significant reduction in the demand on Primary Care.

Based loosely on the Dudley model, the proposed service will consist of 3 Link Workers, one based in each of the three localities in Wolverhampton. A Project Manager will co-

ordinate the service and it will be supported by Admin. The service will provide the following support to the patient:

- Initial one-one assessment of individualised need
  Upon referral the Link Workers will arrange to meet with the patient to determine their situation and their needs.

- Well Being assessment using approved tool (i.e. Well Being Star)
  During the initial assessment a Well Being Assessment will be undertaken using an approved tool. The level and areas of support required will be determined and base lined against the score that the tool generates

- Development and agreement of a management plan
  The Link Workers will agree with the patient a plan of action to improve their wellbeing and reduce social isolation. Further contact will be scheduled at regular points in time and will likely be telephone contact.

- Appropriate Signposting/Referral
  Depending upon the outcome of the initial assessment the patient will be signposted or referred to appropriate service. This may be for education and lifestyle advice (i.e. Healthy Lifestyles) or to community or voluntary sector services such as exercise classes, book clubs, smoking cessation, lunch clubs, improved self-management of their condition etc. depending upon the need and preference of the patient.

- Regular contact and monitoring of patient
  The Link worker will maintain contact and support with the patient as agreed in the management plan and assess any further or differing needs.

- Updated Well Being Assessment and data analysis
  At the end of the agreed period of support a further Well Being Assessment will be undertaken and the results recorded. The outcome of this will determine whether indeed the support has made an impact. Data analysis will also be undertaken to determine any reduction in the patient accessing services i.e. GP appointments, A&E attendances, emergency admissions etc.

The Project Manager and Link workers will work closely with GP practices within their locality to build relationships and promote the service. They will be an integral part of the Community Neighbourhood Teams (CNTs) attending the monthly MDT meetings and being based with the teams when they are co-located. They will also work with staff in A&E and at West Midlands Ambulance to raise awareness of referral criteria and pathways. Being employed by Wolverhampton Voluntary Sector Council (WVSC), they will continually update and maintain their knowledge of organisations that can offer support to patients.

During the process where a more medical need is identified by the Link Worker, they will be enabled to refer back to the CNT or to the patients GP.

The effectiveness of the project will be monitored in a number of ways:-

- The evaluation of the well-being tool will demonstrate where an improvement in a patients' well-being has been made.
- Patients activity both in Primary and Secondary Care will be monitored prior to and following the intervention.
- Feedback from service users
- Feedback from health professionals

4 Reasons

Often a need is identified, particularly in Primary Care but GPs do not have the time to undertake the in depth discussions with patients about their lower level social needs and just deal with the immediate medical need. This Social Prescribing model enables sufficient time to be allocated to the patient for them to discuss their likes, dislikes, needs and challenges.

Reduced resources and growing demand across both Health and Social Care means that there is a need to shift the focus from managing symptoms to prevention and resolving underlying causes. Whilst it is difficult to attribute a reduction in activity to this low level intervention, evidence shows that by improving peoples wellbeing and reducing social isolation, patients general health improves and they access fewer health services.

In view of the Better Care Fund Programme the development of Social Prescribing takes another step towards holistic management of individuals, providing that lower level intervention to support the proactive and rapid response approach across all of the works streams (Adult Community, Dementia, Mental Health) and also demonstrates the desire to work more closely with voluntary sector organisations.

There is growing evidence (*Self Care - A Real Choice, DH, January 2005*) to show that supporting self-care leads to:

- Improved health and quality of life
- Increased patient satisfaction
- Significant impact on the use of services, with fewer primary care consultations, reduction in visits to outpatients and A&E, and decrease in use of hospital resources

5 Options

Option 1 – Do Nothing

Option 2 – Deploy Social Prescribing model working with the Voluntary Sector Council to deliver the model as a 12 month pilot

This model is a familiar model across the country. Neighbouring Dudley has also adopted this approach. Here the Voluntary Sector Council employ Link Workers for their 5 localities who then work closely with GPs and Multi-Disciplinary teams to provide support, advice and guidance to people referred into the service. Utilising the Voluntary Sector Council reduces influence from if the Link Workers were from specific voluntary organisations. The service is supported by a Project Manager and an Admin officer. Feedback is that by having Project management support the Link Workers have more capacity to deliver the front line service.

Working with the Voluntary Sector Council optimises the knowledge of community and voluntary services that are available to support patients' wellbeing as the Council has a wealth of information and established links with voluntary sector organisations.

6 Benefits Expected

There are many benefits to be realised from adopting a Social Prescribing model.

Benefits for the patient include:-

- Improved fitness
- Improved mobility
- Reduced social isolation and loneliness
- Lower levels of anxiety and depression
- Improved well being
- Learning new skills
- Developing friendships and networks
- Awareness of available services
- Medicines intake is regulated or reduced

Benefits for Primary Care:-

- Allocated time for patients who are identified as needing additional, non-medical support
- Improved well-being of the practice population
- Patients require less GP time as their needs are being managed
- Less demand on surgery time (phone calls, appointments)

Benefits to the CCG:-

- Improved health and well-being of the population of Wolverhampton
- Increased working with community and voluntary sector organisations
- Reduced secondary care activity (A&E attendances and Emergency admissions), therefore potential QIPP savings

Benefits to the Community and Voluntary Sector

- Increased knowledge of voluntary and community organisations
- Closer working with other agencies i.e. Health and Social Care

7 Risks

A research project is about to be launched in the City using Health Navigator's Proactive Health Coaching. This is a very similar model to the one proposed here but as a research project is only focussing on a small number of patients using a Random Controlled Trial. There will be 100 patients in the Intervention Group and 50 patients in the Control Group (no intervention). In order not to skew the results of this research it will be essential to ensure that members of the Control Group do not receive any intervention from the CCG Social Prescribing model.

As experienced with other projects it is extremely difficult to attribute a reduction in activity and subsequent savings to one specific project when so many other factors are in play. This is even more difficult when looking at low level, non-medical intervention; therefore it will be difficult to evidence that savings are solely attributable to this model.

The modelling for the service has been done purely based on capacity of 3 Link Workers not on demand for the service as this is as yet unknown. Should the service be successful it may generate more referrals than the team can manage resulting in waiting lists for patients to be seen.

8 Cost

Option 1 – no cost

Option 2 – cost of WVSC delivering model as a 12 month pilot

Service Element	**Cost year 1**
Project Manager @ 30K + 16% on – costs 0.5WTE	17,400
Community Development Officers @ 25K x 3 + 16% on costs	87,000
Administration @17K + 16% on costs 0.5WTE	9,860
Staff Training	1,500
Desk space at community location (assuming employment and management by accountable body) 2000 x 3	6,000
Staff Travel @ 45p x200 pm x 4	4,320
Central and management costs: Management, reception, payroll, rent, Insurance, IT maintenance, utilities,	

payroll, reception, photocopying, finance . HR etc.. @15% of hosted staff salary costs and 10% outreach.	8,178 8,700
Marketing/publicity	500
Telephone @ £35 x 3 x 12	1,260
Laptop/ipad x 3 PC x 1	2,952 646
Totals	**£148,316**

9 Timescales

If the proposal is successful, upon receipt of approval recruitment will commence. Please see timeline below

Table 1

				Timescales (weeks) from approval					
	wk 2	wk 4	wk 6	wk 8	wk 10	wk 12	wk 14	wk 16	wk 18
Development of Job Desciption/Service specification									
recruitment of Link Wokers									
Notice Period									
Communicaitons									
Service Commencement									

10 Investment Appraisal

Whilst it is difficult to demonstrate the impact from this specific project, other areas report that a reduction of demand on Primary Care is a key impact, in both telephone calls from the patient to the practice and in GP consulting time for patients who currently present high demand due to underlying social factors.

It is anticipated that each Link worker would hold a patient on their caseload for approximately 3-6 months. The contact time for each patient would be variable but as an estimate we would model an initial 1 hour meeting with fortnightly telephone calls (approx. 20 mins) thereafter.

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11 Equality – Appraisal

12 Quality Impact Analysis (QIA)

13 Privacy Impact Assessment (PIA)

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