Wolverhampton CCG
Practices as Providers Task and Finish Group updated 12 06 2017

## Terms of Reference

1. Introduction

The aim of Practices as Providers Task and Finish Group is to develop GP Clinical Networks in line with GPs to encourage working relationships to strengthen boundaries across Primary and Community Care services in order to develop a Primary Care Model of Care. This is one of the key work streams within the Primary Care Strategy to ensure the Wolverhampton have a Primary Care Model that is resilient to future changes. The Task and Finish Groups role is to define and develop an understanding of infrastructure requirements to support the practices delivery including back office functions in order to support the approach of implementing the Primary Care Model of Care.

It has the responsibility to establish working relationships with practices to devise an approach of bringing practices together to support the movement of specialist care out of hospitals into the community, which is in line with the National Multi-specialty Community Provider (MCP) models of care.

The Task and Finish Group need to ensure information sharing and appropriate links with other Task and Finish Groups and the Better Care Wolverhampton Programme to ensure these interdependencies are aligned and working collaboratively to reduce the risk of duplication.

Its role is to achieve the transition from present way of working to the one set out by Strategy and then to ensure the new way of working becomes business as usual. Once this has been achieved the Task and Finish Group will be disbanded, unless there are on-going activities which exist beyond the transformation delivery duration.

Task and Finish Group Structure
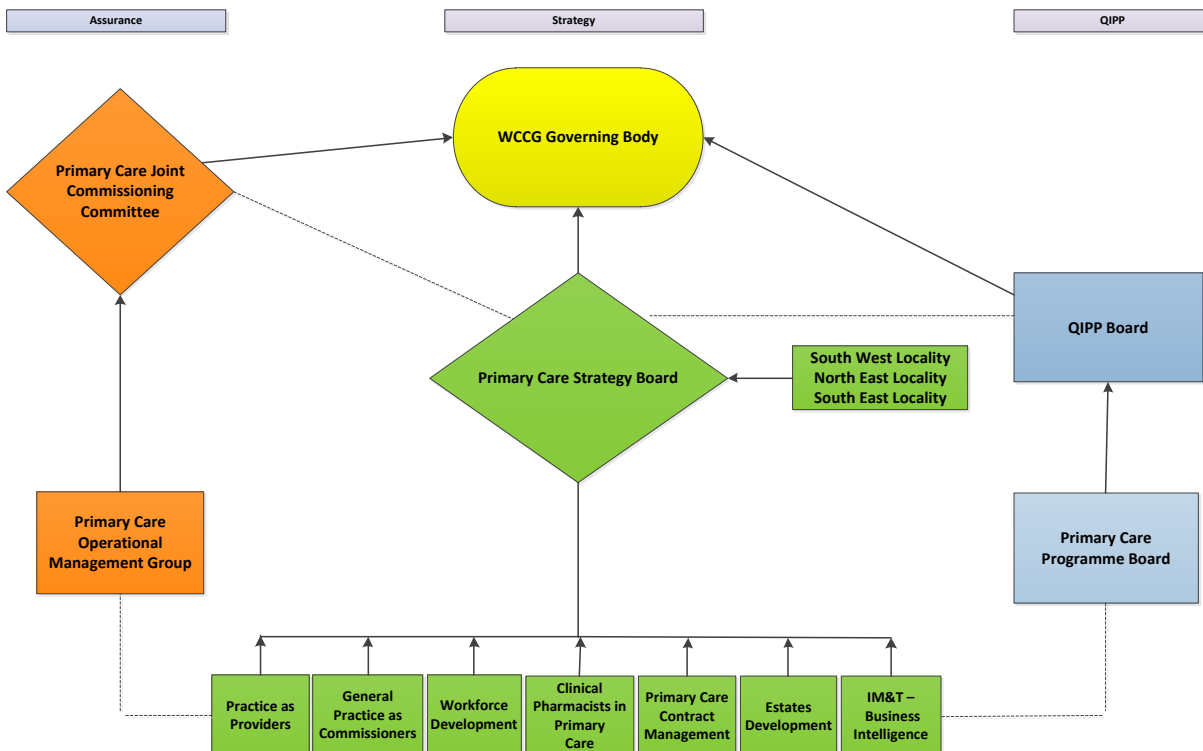
2. Membership

Core membership will comprise of the following personnel:-

Primary Care Transformation Manager (Chair)
GP Locality Leads
New models of care representative
Head of Integrated Commissioning
LMC Representative
Solutions and Development Manager -Community Services

There may be occasions when other representatives are co-opted or invited to attend these meetings.

3. Meeting administration

3.1 The Chair, with the support of their Admin support, will be responsible for ensuring circulation of the agenda and papers of the Task & Finish Group at least three working days before the meeting.

3.2 Circulation of the minutes/action notes will be completed by the chair/admin support within five working days of the meeting to all members.

3.3 The action log will be maintained, monitored and chased by the Business and Performance Primary Care PMO Administrator and they will send reminders to all the T&F Group members prompting updates at least three working days before the meeting.

3.4 Following the meetings, the Chair will provide a highlight report based on key discussion points/ actions, to the Business and Performance Primary Care PMO Administrator within 3 working days, for presentation at the next Primary Care Strategy Committee.

4. Quoracy
4.1 Meetings of the group will be quorate if the chair and 2 other members are present. In the event of members being unable to attend meetings they must ensure they identify a nominated deputy to aid continuity of the program and discussions at the meeting. Where it is possible, the group will also conduct business 'virtually' to ensure that all members have the opportunity to comment on proposals.

5. Voting

5.1 The Task & Finish Group is expected to operate by consensus wherever possible. In circumstance where a decision cannot be reached, the chair will escalate the issue to the Primary Care Strategy Committee.

6. Frequency
Meetings will be held at monthly intervals.

7. Remit, duties and responsibilities

7.1   In light of the General Practice 5 Year Forward View the vision is to work with Localities/Clinical Networks to explore and test general practice models, which are fit for the future and demonstrate sufficient resilience to future challenges inclusive of:-

Practices collaborating to improve access
- Shared access to records
- Seven day services
- Practices coming together collaboratively to deliver out of hospital services
- Overseeing the implementation of initiatives aligned with the 10 High Impact Actions to release time to care:
  1. Active signposting
  2. New consultation types
  3. Develop the team
  4. Reduce DNAs
  5. Productive Workflows
  6. Personal Productivity
  7. Partnership Working
  8. Use Social Prescribing
  9. Self Care
  10. Build QI Expertise
- Practices undertaking GP Peer Review and referral management to reduce unwarranted variation

Integrating primary and community services
Development of Integrated Primary Care Model of care, place and population based approach, geographically coherent across localities, consisting of the following characteristics;

- Best Practice models
- MCP approach in line with national MCP framework
- Wider primary care team, with wrapped around community teams across Locality Hubs incorporating both health and social care provision as aligned with the Better Care Wolverhampton programme
- Risk Stratification and admissions avoidance for high risk individuals

Sharing of Back Office functions to enable practices working at scale including:
- Legal Advice
- Payroll
- Interpreting Services
- Supplies and Ordering
- Human Resource support
- IT, information sharing and clinical templates
- Standard set of policies and procedures
- Business intelligence and Data
- Medicine Optimisation and Prescribing Support
- Contract Management

8. Reporting

8.1   The Task & Finish Group will report to the Primary Care Strategy Committee on a monthly basis. The Primary Care Strategy Committee will oversee the programme of work for this, and all other Task and Finish Groups.

8.2   Workstream leads will need to ensure they alert each other if implications for another workstream are identified (which will be reflected in the highlight report).

9.   Review of Terms of Reference

9.1   These terms of reference will be reviewed by the T&F group and Primary Care Strategy Committee annually to ensure the group is achieving its objectives and to ensure that key changes are being incorporated as required.

10.   TOR agreed at: