

Primary Care Commissioning Committee

22 March 2017

Details	Part 1	X	Part 2		Agenda Item No.	9
Title of Paper:	Greater Manchester response to the GP Forward View					
Board Member:	Dr Jeffrey Schryer, Clinical Director for Primary Care					
Author:	Amy Lepiorz, Deputy Director of Primary Care					
Presenter:	Amy Lepiorz, Deputy Director of Primary Care					
Please indicate:	For Decision		For Information		For Discussion	X

Executive Summary

Summary	This paper is to share the report presented to the Greater Manchester Health and Social Care Strategic Partnership Board. The report describes the Greater Manchester response to the national GP Forward View.					
Risk	High		Medium		Low	X
	At this stage there are no particular risks with this paper, though it is noted that effective engagement with the membership will be required in ensuring successful implementation of the reports content.					
Recommendations	The Board is asked to: <ul style="list-style-type: none"> Note the content of the report To begin the local considerations around the reports content 					

Strategic themes

To deliver improved outcomes and reduce health inequalities for patients through better preventative strategies	
To deliver service re-design in priority areas through innovation	
To develop primary care to become excellent and high performing commissioners	X
To develop the CCG leadership to work with the Local Authority to be excellent integrated commissioners	
To develop robust and effective working relationships with all stakeholders and partners to drive integrated commissioning	
To deliver long term financial sustainability through effective commissioning and innovative investment across the wider system	
To develop and influence the provider landscape through development of a Locality Care Organisation (LCO)	
Equality Analysis Assessed?	Supports NHS Bury CCG Governance arrangements X

Greater Manchester response to the GP Forward View

1. Introduction and background

- 1.1 Enclosed is a copy of the report presented to the Greater Manchester Health and Social Care Strategic Partnership Board describing the Greater Manchester response to the GP Forward View.
- 1.2 The report describes how a total investment of circa £41m will be spent on increasing resilience in General Practice over the next 4 years. The key areas for funding are:
 - Training Care Navigators and Medical Assistants
 - Online consultation software
 - GM General Practice Resilience Programme
 - Improving Access
 - Expansion of the Clinical Pharmacist Programme

2. Recommendations

The Primary Care Commissioning Committee is asked to:

- Note the content of the report
- To begin the local considerations around the reports content

Amy Lepiorz

Deputy Director of Primary Care
amy.lepiorz@nhs.net

**GREATER MANCHESTER HEALTH AND SOCIAL CARE
STRATEGIC PARTNERSHIP BOARD**

#

Date: 14 February 2017
Subject: Transformation Theme 2 – Primary Care Reform Delivery
Report of: Tracey Vell

PURPOSE OF REPORT:

The purpose of this report is to outline a GM programme for primary care reform which will provide a firm foundation on which to transform primary care. This plan does not represent the totality of the primary care transformation programme and is the GM approach to the delivery of the national GP Forward View (GPFV). This implementation plan for the general practice contribution to the GM strategy for primary care, accompanied by transformation plans for Dental, Pharmacy and Optometry, will comprise the entirety of the programme across GM.

The GPFV commits to making significant investment in to General Practice and for GM this funding is contained within the GM Transformation Fund. This paper outlines our GM approach to the delivery of the GPFV but is also aligned to our wider ambitions in GM as set out in Taking Charge Together and the GM Primary Care Strategy, published in October last year.

To fund the initiatives set out in this paper will require investment of up to circa £41m, phased over the next four years. This will enable a resilient workforce whilst providing additional capacity via additional access to General Practice; the expansion of the Clinical Pharmacist programme as well as a new workforce of Care Navigators and Medical Assistants. The combination of this additional capacity and improved skills, combined with instilling a culture of best practice and excellence through our resilience programme, will yield benefits across the system.

We will ensure that this investment is aligned to Locality Plans and the emerging new models of care. The investment will support 24/7 provision as part of our urgent care system, facilitate more focussed routine capacity in-hours where needed, i.e. provide longer appointments to treat more complex patients who are at risk of admission; support vulnerable groups and reduce health inequalities. A review of 24/7 urgent primary care provision will also seek to rationalise services, avoid duplication and offer a more seamless, integrated service delivered within neighbourhoods of 30,000 – 50,000 population.

RECOMMENDATIONS:

The Strategic Partnership Board is asked to:

- Support the GM programme for primary care reform
- Approve the request for funding to fulfil the commitments of our GM Primary Care Strategy and the requirements of our devolution agreement with NHS England in respect of General Practice as outlined in the GPFV
- Support the requirement for localities to demonstrate how they will embed these initiatives into the emerging models of care to maximise the impact

CONTACT OFFICERS:

Laura Browse

laura.browse@nhs.net

Sara Roscoe

sara.roscoe@nhs.net

1.0 INTRODUCTION

- 1.1. This report provides an update on progress to deliver a transformation plan for Primary Care in Greater Manchester and seeks agreement for resourcing the programme once endorsed by the Strategic Partnership Board in February 2017.
- 1.2. This plan does not represent the totality of the primary care transformation programme but rather is the GM approach to the delivery of the GP Forward View (GPFV). This implementation plan for the general practice contribution to the GM strategy for primary care, accompanied by transformation plans for Dental, Pharmacy and Optometry, will constitute the entirety of the programme across GM.
- 1.3. The transformation plan for primary care aims to provide a stable and sustainable foundation on which to develop new models of care and Local Care Organisations in line with our ambition for GM. Our GM primary care strategy sets the direction of travel for primary care transformation going forward and is aligned to the 10 Locality Plans.
- 1.4. The strategy describes our ambition for primary care and its contribution to Greater Manchester Health and Social Care Devolution. By 2021 we want everyone in Greater Manchester to have the opportunity to proactively manage their own physical and mental health and wellbeing. And to do this, they will have access to high-quality, integrated care, underpinned by the best possible technology, a sustainable workforce and an estate that is fit for purpose.
- 1.5. Our plans aim to deliver the best outcomes for our population as well as our workforce which we recognise is fragile in places and under increasing strain. We therefore look to solutions which offer the benefits to individual practices and their teams but which are delivered by more feasible methods. We believe that by working in such a collaborative and integrated manner, ensuring a population based offer to neighbourhoods of 30,000-50,000 population will provide patients with access to consistently high quality services whilst not destabilising individual practices and their teams.

2.0 BACKGROUND

- 2.1. Primary care is critical to the successful delivery of Taking Charge, the achievement of clinical and financial sustainability and the transformation of health outcomes for Greater Manchester's residents. We are committing to an increase in the primary care investment.
- 2.2. The GM Primary Care Strategy 'Delivering Integrated Care across Greater Manchester – The Primary Care Contribution' sets out a renewed sense of ambition across Greater Manchester to truly deliver a place based population model of care with primary care at the heart.
- 2.3. These models are being designed to ensure there are effective alternatives to hospital based care, and will support GM in achieving its objective of treating the

estimated 2,500 patients in an acute bed on any given day when their needs could be met more effectively and appropriately closer to home. Thousands of people are treated in hospital when their needs could be better met in the community; care is not always joined up between teams and not always of a consistent high quality. In Greater Manchester, people diagnosed with an 'ambulatory care sensitive' condition such as diabetes, asthma and hypertension, which can be actively managed, are more likely to be admitted to hospital as an emergency case when this could have been avoided.

- 2.4. However, there is real pressure on primary care resulting in increased workload. According to one survey, nine in 10 GPs feel their heavy workload has a negative impact on the quality of care they give their patients. Problems recruiting and retaining GPs create further workforce difficulties. Between 2002 and 2013, GP numbers only increased by 14%, compared with a 48% rise in hospital consultants. A third of GPs hope to retire within the next five years, and a fifth of current GP trainees plan to move abroad.
- 2.5. The Transformation Plan for Primary Care will identify GM wide solutions (with local implementation where appropriate) that will contribute to the delivery of Taking Charge. The emerging work streams and the architecture and governance that are required to support their delivery will be firmly located in Transformation Theme 2 and the emerging Locality Care Organisations.
- 2.6. The national GP Forward View, (GPFV) published in April 2016 also acknowledges the pressures faced by General Practice and sets out a programme of investment to address the rising pressures. It contains specific, practical and funded steps to respond to the challenges in respect of workforce, workload and infrastructure. It also seeks to facilitate care redesign by providing investment and support to individual practices and federations.

3.0 GM PRIMARY CARE TRANSFORMATION PROGRAMME

- 3.1. In order to deliver on the GPFV and on our commitment and ambition within the GM Primary Care Strategy, we must support our primary care workforce to ensure we have a stable and sustainable foundation on which to transform. We are therefore embarking on a programme of reform over the next 5 years which seeks to support our primary care workforce, ensure a system of resilience and develop primary care and its infrastructure. We commit to develop a GM support package for primary care reform which includes:

3.2. A GM approach to delivery of improved access to routine GP care

- 3.2.1. We want to design a service model which will improve patient outcomes and achieve optimum benefits to the system. We want to develop a sustainable model embedded within Local Care Organisations (LCOs) and rooted within the neighbourhood delivery model and therefore more responsive to the needs of the

population and the foundation on which to build, to respond to the challenges we face in GM.

- 3.2.2. Our GM strategy is not to extend access at every practice which will add to the frailty of the individual practice and its workforce, but to plan and organise enhanced access at the neighbourhood level through clusters of practices working together, supported by a designated hub. This will benefit individual practices and aid their resilience. We envisage that each primary care hub will form part of wider neighbourhood hubs, with a broader range of services, serving populations of 30k – 50k in each of our 10 localities. The hubs, which could also provide urgent care, would offer a full range of general medical services with access to routine diagnostics and full access to clinical records. We already know this operating model is successful in some parts of Greater Manchester; however, we intend to build on this model as part of a much wider place, based integrated offer to our patients and as a foundation of the urgent primary care system.
- 3.2.3. Integrated into the neighbourhood delivery models, our enhanced seven day services will target vulnerable and hard-to-reach groups that may need a special approach to access. This approach can prevent avoidable admissions and facilitate discharge from hospital, including over the weekend, as well as contributing to wider system resilience. This additional capacity will also act as an enabler to proactively support and manage more complex patients, both in hours and out of hours and provide the means to:
- Flex consultations and provision of longer consultations in core hours
 - Involve a wider multidisciplinary team and wider skill mix
 - Proactively case finding and connecting with those people with unmet needs, for example, carers, those in deprived communities, LGBT, etc.
 - Manage patient flow and demand across 7 days, for example, booking more acute activity in to the 7 day access hubs to provide an alternative community emergency service taking pressure from Emergency Departments
- 3.2.4. This allows core general medical services to manage LTCs, chronic conditions and those patients with complex needs where continuity of care is important.
- 3.2.5. In order to generate capacity in hours, there will need to be a systematic approach to shifting the activity out of core general medical services into the seven day access hubs. Such activity could include health checks, immunisations and vaccinations, cervical screening etc. where there is no requirement for continuity of care. This would help to free up capacity in-hours to proactively support and manage more complex patients and provide continuity of care. We will also ensure we align the primary care programme for reform with the Adult Social Care Transformation Plan, recognising the interdependencies. An example would be the potential for this additional capacity to provide support to nursing and residential homes and form part of the wider reform of social care.

- 3.2.6. The seven day access hubs could also provide an opportunity for workforce development across GM and to test new roles such as Care Co-ordinators, Nurse Practitioners and Clinical Pharmacists at scale. It is often difficult for individual practices to afford such roles and there is often a reluctance to introduce new roles without the demonstrable evidence of their impact. Operating on a wider scale, the seven day hubs could offer this opportunity.
- 3.2.7. A framework outlining the GM approach for additional access over 7 days is appended.

3.3. 24/7 Urgent Primary Care Provision

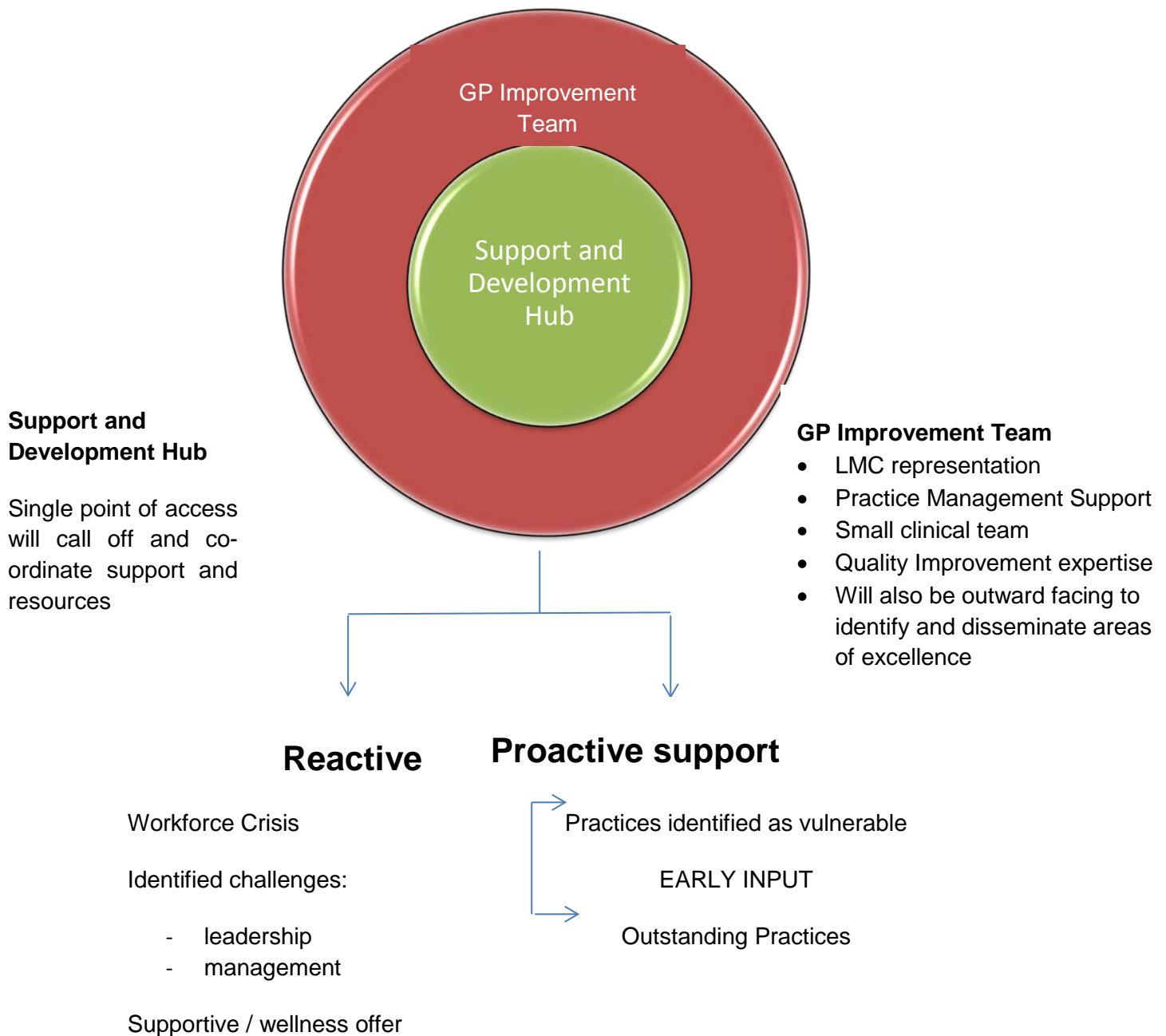
- 3.3.1. We know that there is a great deal of duplication in the system with the introduction of demand management initiatives, provision of additional capacity via walk in centres, out of hours' services and now seven day additional routine access. This not only presents a degree of confusion for patients in terms of navigating the numerous options but also evidence shows we are not necessarily seeing any correlation in reduction in activity in emergency departments. Working in collaboration with urgent care leads within localities, we will undertake a review of all out of hours' provision across Greater Manchester to understand CCG plans and commissioning intentions for an integrated service model. The outputs of the review will also explore the options to develop a GM framework which can be applied locally as well as discuss any benefits of a GM wide commissioned service.
- 3.3.2. The basis of this review is aligned to the commitment made in the NHS Five Year Forward View (FYFV) that across the NHS, urgent and emergency care services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services. As such, this piece will form part of the GM urgent care plan.
- 3.3.3. The draft specification for the review of 24/7 urgent primary care provision is appended.

3.4. GM Resilience Programme

- 3.4.1. In order to ensure that primary care can deliver on the ambitious reform programme across Greater Manchester, we will be establishing a GM resilience programme.
- 3.4.2. The GM resilience programme will:
- Become a single world class hub which will support General Practice and act as a programme for improvement.
 - Identify best practice and areas of excellence from elsewhere, supporting practices to develop these models locally.
 - Offer a coherent and consistent offer in terms of rescue, resilience and improvement

- Provide a systematic response at a locality level however must also be responsive to individual practice requirements and crisis response.
- Embrace the excellent practice which is taking place across Greater Manchester, ensuring mechanisms to share best practice
- Adopt a proactive approach to identifying improvements earlier rather than in the reactive sense, e.g. following CQC inspection
- Have an understanding of the needs of practices in order to be able to respond
- Support practices in undertaking the diagnostic tool to identify improvements
- Foster a sharing and learning environment across GM which will include a repository or portal of best practice, case studies, standard documentation etc, which practices and commissioners can access
- Adopt quality improvement methodologies in order to sustain change whilst developing capability
- Develop our clinical leaders to enable them to offer peer support or more formal arrangements to support general practice

3.4.3. A Greater Manchester Programme for General Practice Resilience



3.4.4. Support and Development Hub

3.4.4.1. This will serve as the single point of access whereby practices will contact for support. It is imperative that the Co-ordination Hub is accessible to practices. Not only will practices need to have clear avenues to contact and engage with the Hub (additionally supported by referral by CCG teams, LMC offices and GM Contracts Team) it is necessary to avoid unintended obstacles, such as any perception of

performance management. It will therefore be clearly identified as being separate to any commissioning performance and contractual compliance function.

3.4.4.2. Clinical leadership will further support this accessibility of the hub, and as such it is proposed to identify an appropriate lead.

3.4.4.3. While ensuring 'clear-blue water' between contractual compliance and support functions, there will be clear lines of communication across functions. The teams providing practice support and contractual compliance will be required to communicate in order to ensure consistency of expectation and understanding.

3.4.4.4. The development of an online access portal to information, best practice, will further accelerate the accessibility for General Practice.

3.4.5. Facilitating Practice Capacity

3.4.5.1. Key to practices being in a position to benefit from the support of the Resilience Programme will be their capacity to be able to engage and implement change within their situation, while continuing to be accountable and deliver their contracted services.

3.4.5.2. Clarity of terms of engagement in facilitating this practice capacity is therefore necessary.

3.4.5.3. The GP Career Plus project, part of the GPFV proposals, presents a potential workforce supply for practices to draw on for clinical backfill. Also, in some localities it may be that practices may be able to realign current appointment capacity working with the additional access service in order to create some practice 'head-space'.

3.4.5.4. Those practices rated as being 'Outstanding' by the Care Quality Commission, provide a significant local resource. These practice teams (clinical and administrative) are proposed to be engaged to provide mentorship and support. These practices are identified in the Appendix.

3.4.6. Securing External Support Provision

3.4.6.1. In order to draw on national and international best practice, discussions are taking place with a number of external, expert support providers, such as the Royal College of General Practice. It is recognised that these providers have access to a significant repository of evidence-based practice to deliver successful improvement in general practice. This will supplement local intelligence held by the Partnership, CCGs and LMCs, for example the Appendix table which shows CQC themes identified as requiring improvement.

3.4.6.2. It is recognised that a centralised engagement of support on behalf of Greater Manchester is likely to present certain practical considerations in regard to procurement and governance. It was initially intended that national framework of

support provision would be established for local call-off. However, this position has not progressed, and it will be necessary to consider appropriate business case proposals for the resilience products. However, for those matters targeting direct individual practice support, funding arrangements under Section 96 of the GMS contract can enable a practice to directly engage a support provider.

- 3.4.6.3. Our ambition is to establish a centre of excellence by the creation of a learning hub which will be created and sustained by our own workforce. We will continue to work in collaboration with our universities to provide learning and development across Greater Manchester.

3.5. Developing our primary care estate

- 3.5.1. In order to deliver our vision for a population based model of care with integrated neighbourhood teams delivering care and support to populations of circa 30,000-50,000 we need an estate which is fit for purpose and can incorporate the range of services required to truly deliver place based integrated care out of hospital. We want to develop an estate which is embedded in the local community and one which holds a range of services from across health, social care and the voluntary sector. We need to utilise all our public sector estate including General Practice and other existing premises where possible. We know that a significant number of our GP practices are no longer fit for purpose and this often presents a predicament for GPs who have invested in these premises and issues to release the equity. We are therefore exploring what is the 'art of the possible' in terms of our estates which includes:

- Consideration of how we streamline this process and overcome barriers.
- To plot the Primary care hubs in each GM locality to understand the coverage across GM.
- To review all premises including NHSPS, LIFT, GP owned and leased premises to understand how we can better utilise public sector estate and support GPs in this process.
- Assisting GPs to relocate out of existing premises they own if this fits with the Strategic direction of the Locality
- Enabling GM to achieve integrated hubs across all localities
- Develop a toolkit for practices so that they can consider all the options available to them to support them in this process

- 3.5.2. We are in the process of developing a virtual, interactive map which will show all our general practices, existing hubs and planned hubs. This will help to inform our plans around our future estate ensuring we have fit for purposes premises and facilities to deliver our ambition.

- 3.5.3. GM, like other areas, receives a finite amount of capital funding for primary care to improve, transform and build new estate. We have clear governance processes in place within each of our 10 localities and at a GM level who oversee our capital pipeline. This ensures investment decisions are aligned to individual Locality Plans but are also support business as usual. The interactive map will provide an illustrative view of our primary care estate and where we have significant challenges or gaps in the necessary facilities and infrastructure, including the neighbourhood hubs. The interactive map should be available February/March 2017.

3.6. Workforce

- 3.6.1. We value our primary care workforce and their significant contribution to the transformation of out of hospital care. GM like other areas however faces significant workforce challenges and we continue our endeavour to recruit and retain our primary care workforce. This alone however will not achieve our ambition and so within GM we want to optimise wider primary care provision, creating a system which enables patients to directly access the most appropriate professional while maximising professionals to operate to the full extent of their license.
- 3.6.2. We therefore want to expand on the traditional concept of primary care to foster a much wider primary care system including, for example; physiotherapy, midwifery, podiatry, social care along with voluntary organisations to enable people to access the most appropriate professional and service directly.
- 3.6.3. We have already started to make strides in order to support localities in respect of their workforce plans by:

3.6.4. Development of a GM Primary Care Workforce Framework

- 3.6.4.1. We will develop a GM framework for workforce planning and support to localities in order to understand their capacity and demand and to model their workforce in order to respond to the needs of their population. This work has been informed by 3 workshops to explore the 'art of the possible' which has showcased some of the excellent practice already taking place across GM and starting to think about a population based workforce for the future. The workshops have also provided an opportunity to:
- Share tools and techniques and other support available from HEE such as the Workforce Repository and Planning Tool, (WrAPT), population centric modelling along with other bespoke tools to measure and understand demand within general practice.
 - Share the GP capacity and demand tool currently being piloted in Salford which provides an understanding at practice level of actual demand and can then model workforce requirements
 - Highlight the significant role of Practice Nurses, Clinical Pharmacists, Care Navigators and Medical Assistants, etc.

3.6.5. Expansion of the Clinical Pharmacy programme

3.6.5.1. Three areas, Bury, Oldham and South Manchester have now rolled out clinical pharmacists in General Practice under phase 1 of the national programme and we are committed to expand to all parts of GM. Phase 2 of the national programme is now live with applications from most areas across GM.

3.6.6. Group Consultations

3.6.6.1. We are working with HEE North to pilot group consultations in 50 practices. Group consultations is one of the transformational interventions recommended in the GPFV '10 high impact changes' to make time in general practice. This alternative way of seeing patients offers a consultation model that also delivers peer support and a way of supporting a group of people who have a similar condition. We are delighted with the response from practices to participate in this initial pilot.

3.6.7. Care Navigators and Medical Assistants

3.6.7.1. We will embark on the roll out of a training programme for care navigators and medical assistants from 2017/18. We are working with HEE North to procure a training provider and aim to commence the programme early 2017/18. There are many examples of care navigators, some are already working in GM as well as some excellent models from elsewhere. These roles can support and signpost those patients who do not require a GP or Practice Nurse appointment however would benefit from accessing, other public services such as housing, debt management, benefits advice, the voluntary sector, or those who feel isolated and require support from their community assets. We will therefore will explore the different roles, models and disseminate the learning so as to maximise the opportunities of these new roles.

3.7. GM Digital Collaborative

3.7.1. Enabling advances in technology will enable us to deliver primary care in new ways. Digital technology will also mean records can be shared across providers. We continue to work with the Academic Health Sciences Network (AHSN) for the continued development and roll out of the 'Datawell' platform which will enable integrated shared records across health and social care.

3.7.2. Greater Manchester responded to the national requirement for Local Digital Roadmaps by developing a single roadmap covering the whole of Greater Manchester. This built on the individual locality level understanding of digital maturity through the self-assessment process and fed into the development of the Greater Manchester IM&T strategy. The strategy, signed off by the Strategic Partnership Board in June will be implemented through the establishment of a Digital Collaborative. The governance group responsible for the development of the strategy has representation from GPs and is supported by a wide ranging clinical reference group. As part of the implementation we are strengthening these links

through increased representation and involvement with key governance groups including GPAG and PCAG.

- 3.7.3. We are currently working with GM Connect to establish a legal indemnity contract for GM for data controllers which is critical for us to work in an integrated way to provide better care for our population.

3.8. Funding

- 3.8.1. We know that general practice is under increased pressure and we commit to supporting the workforce and in respect of their resilience, capacity and ability to work collaboratively in order to deliver the optimum benefits. The GPFV outlines the additional investment into general practice alongside additional physical resource, networks and tools. A number of these initiatives are within our Transformation Fund which we intend to fulfil. A list of GPFV commitments are detailed in appendix 4 outlining those which will be funded through GM Transformation Fund, (box a) and those which will be nationally funded, (box b). This does present us with the opportunity to ensure that primary care is fully embedded in the new models of care and LCOs and responsive to the local needs. Whilst we are managing this process at GM in respect of outlining a GM programme of reform, we fully expect localities to demonstrate how this investment will contribute to the delivery of their locality plans to ensure clinical and financial sustainability.

3.8.2. GM 'Ask' of GM Transformation Fund

- 3.8.2.1. Using the national funding formula and list size projections for the 'GM share' of the national funding available, **the maximum funding required to deliver the programme of reform outlined in this paper is £41,235,587 over the next four years.** A breakdown is provided in table one.
- 3.8.2.2. We do expect the overall cost in respect of additional access will reduce over the period as localities review their service model for all primary care provision and seek to rationalise costs and duplication. It is also anticipated that by optimising this additional capacity to target vulnerable groups as described earlier should alleviate pressures on other parts of the system including A&E attendances, non-elective admissions and ambulatory care attendances therefore providing a return on investment.
- 3.8.2.3. Additional capacity and skills will also alleviate some of the pressures facing general practice, for example, the introduction of care navigators to pro-actively signpost patients to right parts of the system, embracing the community assets as well as supporting people to self-care will relieve the demand placed on GPs. This will free up GP time allowing for longer consultations with those complex, vulnerable patients who are more at risk of admission and benefit from continuity of care.
- 3.8.2.4. As with any submission to the Transformation Fund, localities will be required to sign an investment agreement which will stipulate key requirements surrounding

this funding. Fundamentally, whilst this investment is to support general practice and the workforce and is embedded within locality plans and contributes to the bridging the gap in terms of improving clinical outcomes, reducing health inequalities, meeting the financial gap and improving patient experience. We will agree some common metrics across GM so as to measure the impact of this investment in respect of our workforce, our population and financial plans.

3.8.2.5. This is not representative of the totality of our primary care transformation programme but will provide a strong foundation on which to deliver our ambition.

Table one GM ‘ask’ of the Transformation Fund to deliver primary care reform programme

Year	Training Care Navigators and Medical Assistants	Online consultation software	GM General Practice Resilience Programme	Improving access	Expansion of clinical pharmacist programme	Total
2017/18	£ 771,000	£ 770,175	£ 1,232,845	£ 9,738,071	£ 1,394,715	£ 13,906,806
2018/19	£ 514,000	£ 1,025,640	£ 410,400	£ 10,261,658	£ 1,394,715	£ 13,606,412
2019/20	£ 514,000	£ 512,212	£ 409,600	£ 10,377,842	£ 1,394,715	£ 13,208,369
2020/21	£ 514,000		£ -	£ -		£ 514,000
Total	£ 2,313,000	£ 2,308,027	£ 2,052,845	£ 30,377,571	£ 4,184,144	£ 41,235,587

Notes:

1. The above calculations are based on the GM share of the national funding and include list size projections until 2020/21.
2. Funding has been phased in line with the national phasing outlined in the NHS Operational Planning and Contracting Guidance for 2017-19. We have rolled forward the planned investment for 2016/17 into 2017/18 in respect of training care navigators and medical assistants and the GM Practice Resilience Programme.
3. Further work is required in conjunction with localities to realign the investment over the four years in accordance with locality plans, local implementation and recruitment of clinical pharmacists.
4. Improving access funding is calculated on the basis of weighted list size and at the national rate of £6ph – GM has already made a recurrent investment of £9.4m per annum and so the calculations in table one reflect the balance of total funding required.
5. The increase in CCG growth funding in 2020/21 is almost entirely driven by the feeding of funding for seven day services and so will no longer be an ask of the Transformation Fund.

4.0 RECOMMENDATIONS

4.1. The Strategic Partnership Board is asked to:

- Support the GM programme for primary care reform
- Approve the request for funding request to meet the commitments of the GM Primary Care Strategy and to honour the levels of investment to General Practice as outlined in the GPFV
- Support the requirement for localities to demonstrate how they will embed these initiatives into the emerging models of care to maximise the impact

5.0 APPENDICES

- Appendix 1 GM approach to 7 day access
- Appendix 2 Specification 24/7 review of primary care provision
- Appendix 3 GM Resilience Model
- Appendix 4 GPFV commitments

A GM approach to delivery of enhanced access to general practice

Introduction

The national mandate as prescribed in the NHS Operational Planning and Contracting Guidance, 2017-2019 signals the requirement for CCGs to “*commission and fund extra capacity to ensure that everyone has access to GP services, including sufficient routine and same day appointments at evenings and weekends to meet locally determined demand, alongside effective access to other primary care and general practice services such as urgent care services.*” Additional funding has been allocated in addition to CCG allocations to meet this requirement. For GM, this funding is within our Transformation Fund and so has provided some opportunity for GM to determine how we wish to deliver this requirement although there is a requirement to fulfil the planning guidance.

Delivery of a 7 day, additional access to General Practice has been a priority for Greater Manchester in recent years. We made the commitment as part of the Healthier Together Consultation that “***everyone living in Greater Manchester, who needs medical help, will have same day access to primary care, supported by diagnostic tests, seven days a week***”. We were the first to implement and deliver 7 day access to primary care across a number of Demonstrator sites in 2013 in advance of the national NHS England programme. Several areas in GM were successful in being awarded the Prime Minister’s Challenge Fund which provided us with a significant test bed to implement 7 day services to 1.1m population across the three PMCF areas. These sites have not only provided additional access and more accessible capacity to patients but have also allowed us to understand demand and utilisation for additional access over 7 days. They have identified solutions to key enablers, such as IT and workforce and have continued to refine their model in response to patient need and are now working with their local commissioners to design the future service model.

Evidence base

The evidence base for 7 day access to primary care is still emerging. Locally however, there is some evidence that provision of additional availability in primary care over 7 days does yield benefits to the wider system. The findings of the independent review ¹of the GM Demonstrator programme showed:

- ↓ 3% in total A&E activity compared to the rest of Greater Manchester.
- ↓ 8% in minor A&E activity across the 4 Demonstrator sites when compared to the rest of Greater Manchester.
- ↓ Out-of-hours and walk in centre activity of 38% and 14% respectively in one of the Demonstrators.

¹ CLAHRC Demonstrator Evaluation (<http://clahrc-gm.nihr.ac.uk/cms/wp-content/uploads/PCDE-final-operational-summary-final.pdf>)

The recent publication of the NHS England independent evaluation² of the 20 wave one PMCF sites has shown a reduction of 42,000 minor self-presenting attendances at A&E across the pilot schemes compared with the same period across previous years, representing a 14% reduction. The national evaluation highlights that there has been no demonstrable impact on non-elective admissions to hospital or out of hours service overall. It does however report that the Bury pilot has seen a marginal reduction in non-elective admissions compared to the previous year.

The national evaluation reports little change in in patients' levels of satisfaction and experience since the introduction of the Challenge Fund initiatives however this is based on the results of the national GP Patient Survey which do not specifically focus on the PMCF. Anecdotal feedback from the PMCF sites does indicate levels of patient satisfaction and experience of the services.

Softer intelligence from the Challenge Fund sites indicates that by integrating with other service providers has shown an appetite to collaborate and offers a more holistic package of primary care.

Some examples include:

- Incorporation of specialist nurses or Advanced Nurse Practitioners (ANPs) have been successful in reducing pressures on GP time, adding more capacity in core and extended hours.
- Integrating pharmacy into delivery of primary care services has helped to release GP time.
- Targeted work with nursing and care homes to provide more proactive care to these patients has reduced the number of care home visits by GPs as well as delivering other benefits such as releasing GP time and achieving patient satisfaction.
- Engaging with the voluntary sector to offer a wider package of patient support and direct patients to community resources which can support them has worked well, releasing GP time and proving popular with patients.

Our GM approach

We want to design a service model which will improve patient outcomes and achieve optimum benefits to the system. We therefore need to utilise this additional capacity in order to respond to the challenges which we face in Greater Manchester. We therefore want to develop a sustainable model personifies our ambition and is aligned to Locality Plans; one which is embedded within Local Care Organisations (LCOs) and rooted within the neighbourhood delivery model and therefore more responsive to the needs of the population.

² Prime Ministers Challenge Fund: Improving access to General Practice. Second Evaluation Report to September 2015. <https://www.england.nhs.uk/wp-content/uploads/2016/10/gp-access-fund-nat-eval-wave1-sml.pdf>

Our GM strategy is not to extend access at every practice which will add to the frailty of the individual practice and its workforce but to vision all additional and urgent access to be investing in additionally as a HUB. This will benefit individual practices and aid their resilience. The hub will form part of the neighbourhood hubs, serving populations of 30k – 50k in each of our 10 localities, offering a full range of general medical services with access to routine diagnostics and full access to their clinical records. We already know this operating model is successful in Greater Manchester; however, we intend to build on this as part of a much wider place, based integrated offer to our patients and as a foundation to the urgent primary care system

Integrated into the neighbourhood delivery models, our 7 day services will target vulnerable groups, prevent avoidable admissions and facilitate discharge from hospital over the weekend as well as contributing to wider system resilience. This additional capacity will also act as an enabler to proactively support and manage more complex patients, both in hours and out of hours and provide the means to:

- Flex consultations and provision of longer consultations in core hours
- Involve a wider multidisciplinary team and wider skill mix
- Proactively case finding and connecting with those people with unmet needs
- Manage patient flow and demand across 7 days, for example, booking more acute activity in to the 7 day access hubs to allow core general medical services to manage LTCs, chronic conditions etc where continuity of care is important

In order to generate capacity in hours, there will need to be a systematic approach to shifting the activity out of core general medical services into the 7 day access hubs. Such activity could include health checks, immunisations and vaccinations, cervical screening, etc where there is no requirement for continuity of care. This would help to free up capacity in hours to proactively support and manage more complex patients and provide continuity of care.

The 7 day access hubs could also provide an opportunity for workforce development across GM and to test new roles such as Physician Associates, Nurse Practitioners and Clinical Pharmacists at scale. It is often difficult for individual practices to afford such roles and there is often a reluctance to introduce new roles without the demonstrable evidence of their impact. Operating on a wider scale, the 7 day hubs could offer this opportunity.

Risks and mitigations

There are challenges however in respect of delivery of 7 day access, mainly in respect of the workforce implications. Some challenge fund sites have encountered difficulties in recruitment of GPs and Practice Nurses; there is a finite pool of clinicians working across the system and there have been some reports of providers competing for the same workforce and offering differential rates of pay. The pay and conditions for locum work has made this a more attractive offer to some GPs and therefore presents recruitment and retention issues across the system. There is also concern that 7 day access hubs will have a detrimental impact on the 'in-hours' workforce with the hubs providing a more attractive offer for GPs

who prefer sessional or salaried working arrangements therefore exacerbating the current workforce challenges which GM is currently facing.

We strive to mitigate against this by making general practice a more attractive place to work in GM. The work we are doing at a GM level and within the respective localities aims to offer more flexible ways of working for GPs and the wider workforce. For example, we are seeing an increase in Salaried GPs in parts of the system, larger partnerships, practice mergers and a greater sense of collaboration amongst practices. Workforce is a critical enabler to our plans and we acknowledge this continues to be a challenge, as part of a wider workforce strategy for GM, we want to expand the role of primary care to incorporate much broader, multidisciplinary teams. We also need to reform the contractual systems to enable flexibility across the system.

Other areas within GM are looking at more innovative ways to recruit and retain newly qualified GPs, for example, in Wigan, practices have come together to consolidate their part-time vacancies and can therefore advertise a number of whole time equivalent posts. This not only offers more substantial roles but also provides the opportunity to work across practices, gaining greater experience.

Creating a sustainable model

The economic case for 7 day access is also unproven with the evidence indicating that the cost to deliver the service outweighs the return on investment. We therefore need to ensure that this service is embedded within wider health and care reform and plans for transforming primary and community care. In particular, commissioners need to consider the impact of 7 day services in the context of the wider urgent care agenda, the reformed out of hours service, GP streaming in ED and walk in centres (WiCs).

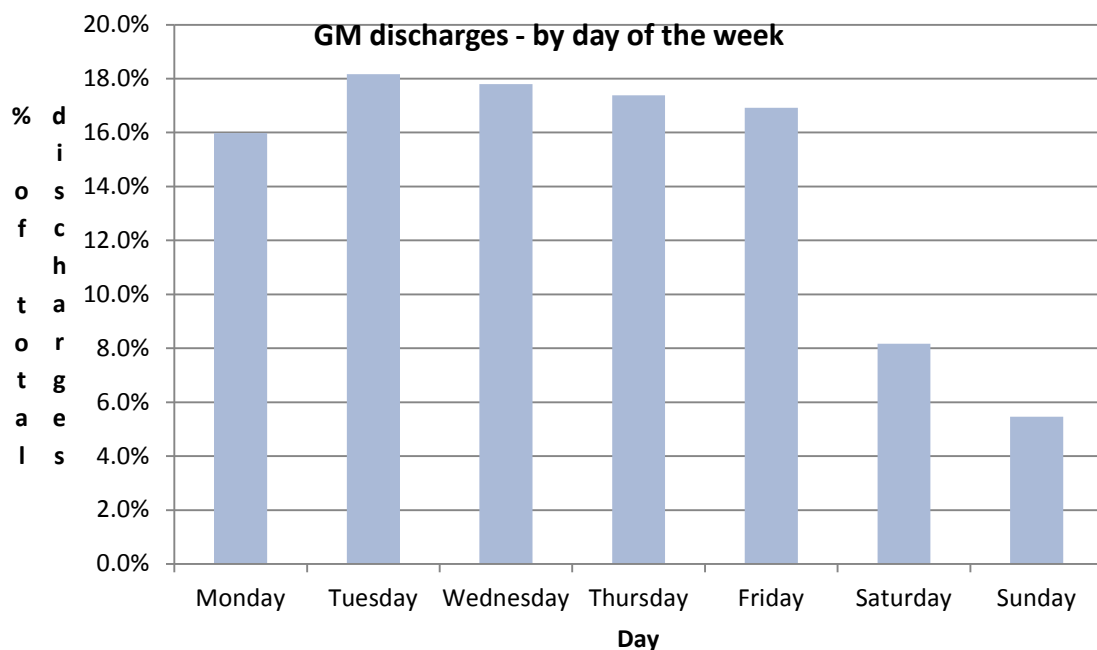
We know that there is a great deal of duplication in the system with the introduction of demand management initiatives, provision of additional capacity via walk in centres, out of hours' services and now 7 day additional access. This not only presents a degree of confusion for patients in terms of navigating the numerous options but also evidence shows we are not necessarily seeing any correlation in activity in emergency departments. Working in collaboration with urgent care leads within localities, we will undertake a review of all out of hours' provision across Greater Manchester to understand CCG plans and commissioning intentions for an integrated service model. The outputs of the review will also explore the options to develop a GM framework which can be applied locally as well as discuss any benefits of a GM wide commissioned service.

The basis of this hours review is aligned to the commitment made in the NHS Five Year Forward View (FYFV) that across the NHS, urgent and emergency care services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services.

Some CCGs have already started to review their out of hours provision, for example, in Heywood, Middleton and Rochdale, evening and weekend appointments will be available via the redesigned out of hours service. This will incorporate 7 day access, an acute visiting

scheme and the traditional out of hours service. Wigan Borough CCG are also in the process of undertaking a whole systems review of their urgent care system with a view to commissioning an integrated service model delivering primary care additional access at scale. This integrated service will incorporate out of hours, 7 day services, NWS pathfinder and the WiC, the aim of which is to eradicate duplication in the system whilst providing equity of service for the population and making it much easier for a patient to navigate. We need to learn from those areas who are already embarking on this process of redesign.

We must also realise the opportunities that this additional capacity provides to support admission avoidance, to facilitate discharge at the weekend and offer a pro-active approach to supporting more vulnerable patients over the weekend. Our 7 day access hubs have access to shared records and so could provide the necessary medical input into admissions avoidance teams or hospital discharge teams as they will have access to patient information. We know that discharges from hospital reduce significantly over the weekend and whilst not all relate to a lack of primary care support, there must be an opportunity to facilitate further discharges. The graph below illustrates the total number of discharges (excluding maternity) for the population of GM, over a 12 month period. The graph reflects the number of discharges per day as a % of the total number of discharges; we can see the significant reduction at the weekend.



This capacity could also prevent emergency readmissions over the weekend by offering a pro-active follow up to those most vulnerable or those who have recently been discharged from hospital. Bury CCG are incorporating their vulnerable patient scheme into their 7 day service which will involve the service providing a 'comfort call' to patients who have been identified as vulnerable, i.e. at risk of admission. The PMCF 'Manchester Access' scheme operating across the three Manchester CCGs have also targeted some of their capacity to

vulnerable patient groups. The service has ring fenced dedicated appointments for carers at the weekend, working in collaboration with the Carers Centre in order to raise awareness of the service and for the Carers Centre to be able to refer into the service. This has provided much needed capacity for carers who we know struggle to access primary medical services during core hours due to their commitments of caring for a loved one. Carers often end up in crisis themselves, resulting in a hospital admission and potentially, the cared for requiring emergency respite care.

Key components

Whilst there needs to be some consistency in the core offer, it is imperative that the service is designed locally and is relevant to the needs of the population and workforce. This must form part of a Locality's wider plans to reform primary care services in order to deliver an integrated, out of hospital model of care and is a core feature of the Local Care Organisation.

It will also be the foundation of primary care urgent care services.

The model will incorporate the national requirements which are detailed below in *italics* for ease of reference:

Timing of appointments

Weekday provision of access to pre-bookable and same day appointments to general practice services to provide an additional 1.5 hours per day. We recommend however that across GM, this additional capacity is deployed flexibly in order to meet the needs of the population, for example early morning appointments in commuter belt areas.

Weekend provision of access to pre-bookable and same day appointments on both Saturdays and Sundays to meet local population needs. Learning from the GM Demonstrator programme and our PMCF sites suggests that the service needs to operate for a minimum of 4 hours on a Saturday and Sunday in order to offer a viable offer to patients and the workforce.

Service provision and disposition supported by evidence of needs of population

Capacity

To provide a minimum additional 30 minutes consultation capacity per 1000 population, rising to 45 minutes per 1000 population. This is on a weekly basis and can be delivered by a multidisciplinary team. We recommend that we aspire to 45 minute per 1000 population based on the needs of the population, a wider review of other services and the emerging new models of care which will evolve over the next 3-5 years.

Measurement

Use of nationally commissioned tool to automatically measure appointment activity by all participating practices, both in-hours and during the additional hours. This will enable improvements in matching capacity to times of high demand.

The Development of minimum data set to illustrate impact and the outcomes achieved as a result of this additional funding.

Advertising and ease of access

Ensure services are advertised to patients, including notification on practice websites, notices in local urgent care services and publicity into the community, so that it is clear to patients how they can access these appointments in the associated service. We will need an approach to communications which is sensitive to individual localities however and provides a narrative which clearly articulates the local service model to patients. This will not be a homogenous service as we know that across each of our localities, the needs of the population are different and we want a service which is responsive to the needs of that particular population. Localities therefore will need to define a clear narrative for patients which articulates the nature of the service.

Ensure ease of access for patients including:

- *All practice receptionists able to direct patients to the service and offer appointments to the additional hours service on the same basis as appointments to non-additional hours services*
- *Patients should be offered a choice of evening or weekend appointments on an equal footing to core hours appointments*

We want to ensure that this additional capacity facilitates a more pro-active approach to provide support and interventions to our most vulnerable and at risk population. This could include, for example:

- Provision of routine appointments over 7 days to proactively find and treat the missing 1000s with undiagnosed disease and close the prevalence gap;
- The offer of immunisations, vaccinations and screening
- To provide a step up / step down facility to support admission avoidance and facilitated discharge over the weekend as we committed under Healthier Together
- To treat to target in line with evidence base guidance
- Targeted appointments for carers
- By extending services across 7 days, this will enable capacity in hours to manage those patients with complex needs who benefit from continuity for example, providing longer consultations, enable a more pro-active rather than reactive approach to care and support

Digital

Use of digital approaches to support new models of care in general practices.

We will embrace advantages in technology to deliver primary care in new ways. There are many pockets of innovation already taking place across GM and we need to learn from these and scale up where appropriate. Initiatives such as online consultations, increased utilisation of patient online as well as wider use of telehealth and telemedicine are to name but a few.

Inequalities

Addressing issues of inequalities in patients' experience of accessing general practice identified by local evidence and actions

Effective access to wider whole system services

There is effective connection to other system services enabling patients to receive the right care from the right professional, including access from and to other primary care and general practice services such as urgent care services.

We intend to adopt a phased approach to implementation in order to ensure alignment and connectivity to all parts of the system which will be informed by the outputs of the review of out of hours' services across Greater Manchester including 111.

Across GM we have been testing additional access over 7 days for a number of years and so have established significant learning and development. It is recommended that the following components are also considered to enhance the service model as part of the wider transformation of primary care in line with our ambitions in the GM Health and Social Care Strategic Plan, the GM Strategy for Primary Care and Locality Plans:

Additional components to be determined locally:

- Provision of urgent appointments including referrals from ED and NWS dispositions
- Provision of routine diagnostics as per the GM commitment made under Healthier Together
- Support admission avoidance, e.g. provision of medical advice into integrated health and social care teams; provision of pro-active telephone follow up for vulnerable patients
- Facilitate discharge at weekends either as part of an integrated service or establish links with hospital discharge team and community providers
- Have access to shared records
- A hub based model serving geographical neighbourhoods*
- Provide pro-active support and follow up over the weekend for those recently discharged from hospital or complex patients
- Support for Care Homes**
- Dedicated appointments for carers
- Promotes people powered health, self-care, asset based approaches
- Domiciliary care to frail elderly/housebound
- Ambulatory style clinics with provision of patient transport
- Provision of x-ray and diagnostics in 'super hubs'

A hub based model serving geographical neighbourhoods*

Our population across Greater Manchester and even within localities is diverse and so localities should be able to define a service model which is flexible to meet the needs of the population down to a neighbourhood level. We already have some innovative examples of how the service is designed to meet the needs of a geographic population, for example:

Across the City of Manchester, the 7 day service has worked with the Carers Forum and has set up dedicated appointments for carers on a Sunday. A member from the Carers Forum is also co-located within the hub during this time to provide additional support and signpost to wider support services. This has worked particularly well in North Manchester.

Other developments in North Manchester intend to target paediatric asthma and children and are exploring the possibility to integrate the Children's Paediatric Nurse within the service. This team are currently under-utilised yet North Manchester has particularly poor outcomes for childhood asthma and higher rates of attendances at A&E and the Walk in Centre for paediatrics.

In parts of Stockport, they have responded to the needs of the commuter belt population and so have extended their opening hours to early mornings so as people can access the service on their way to work.

Ensuring support to care homes over the weekend**

We know that medical input to residential and nursing homes is variable, even more so at evenings and weekends and so a baseline review is currently underway across GM is currently to understand existing arrangements for primary care medical input to residential and nursing homes in each of our 10 localities. Locality leads have also been requested to outline their commissioning intentions in light of the development of their LCOs. The outputs of this will feed into the GM Care Homes work stream, led by Richard Jones to ensure that the primary care element is part of the overall review.

Review of 24/7 urgent primary care provision across Greater Manchester

1. INTRODUCTION

- 1.1 The NHS Five Year Forward View (FYFV) makes the commitment that across the NHS, urgent and emergency care services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services. Furthermore, over the next five years, the NHS will do far better at organising and simplifying the system. This will mean helping patients get the right care, at the right time, in the right place and making more appropriate use of primary care, community mental health teams, ambulance services and community pharmacies, as well as urgent care centres. The FYFV highlights that this will partly be achieved by evening and weekend access to GPs or nurses working from community bases equipped to provide a much greater range of tests and treatments.
- 1.2 Every year the NHS in England deals with 438m visits to a pharmacy for health related reasons, 340m GP consultations, 24m calls to NHS urgent and emergency care telephone services, 7m emergency ambulance journeys, 21m attendances at A&E, minor injury units and emergency care centres and 5.2m emergency admissions to hospitals. Demand for these services continues to rise.
- 1.3 We also know that there is a great deal of duplication in the system with the introduction of demand management initiatives, provision of additional capacity via walk in centres, out of hours (OoH) services and now 7 day additional access. All of which are delivering primary medical services to some degree, at the same time. This not only presents a degree of confusion for patients (and health professionals) in terms of navigating the numerous options but also evidence shows we are not necessarily seeing any correlation in activity in emergency.

2. PROPOSAL

It is therefore proposed to undertake a review of all primary care out of hours provision across Greater Manchester (GM); to understand CCG plans and commissioning intentions to meet the requirements of the FYFV and to develop a GM approach or framework to support commissioners. This not only prevents localities doing things 10 times over but also offers some level of clarity, consistency and equity to the 2.8m population of GM.

This review needs to be captured as part of the wider system reform in GM including the development of new models of integrated urgent care including NHS 111 and the Clinical Advice Service (Clinical Advice Service) to identify current services and future plans for the delivery of a 24/7 model of integrated urgent care assessment, advice and treatment.

2.1 Proposed principles of a 24/7 urgent primary care service

Some areas in GM are already considering consolidation of services; HMR, Bury and Wigan have already commenced a review. Some initial thinking of what overarching principles could include are detailed below:

- Provides highly responsive urgent care services outside of hospital so people no longer choose to queue at A&E
- Provides a consistent urgent primary care offer across a 24 hour period within the hub structure
- Offers access to primary care in every A&E
- Meets urgent care needs as close to home as possible
- Provides better triage support for self-care
- Ensure that access to health information and symptoms checker is maximised so that most patients do not have to be referred anywhere but manage their own illness, with advice
- Offers a simplified service for patients to navigate, i.e. single point of access, direct referral from NHS 111, A&E
- Offers patient engagement and awareness regarding community based urgent primary care provision as an alternative to A&E
- Offers a triage service to define the most appropriate response for the patient, i.e. domiciliary, face to face, location
- Is aligned with 7 day services and so has the ability to book planned appointments and provide same day access, walk in and accept referrals from A&E and NWS 'green' ambulance response
- Manages workflow in a more productive way, i.e. generates a worklist for domiciliary care
- Is an integrated service, connecting urgent care and emergency care services together
- Involves multidisciplinary teams including nursing
- Incorporates wider primary care, i.e. community pharmacy, dental services and optometry etc.
- Supports delivery of the Integrated Urgent Care Key Performance Indicators
- Is integrated with the emerging model for the Clinical Assessment Service (CAS)
- Supports the clinically and financially sustainability of GM
- Utilises the wider primary care workforce in a consistent way
- *Future ambition - one 'super hub' per locality with X-ray, diagnostics and near patient testing

3.0 SCOPE

3.1 In scope:

The following provides an overview of the scope of the review:

Provision:

- A comprehensive review of 24/7 urgent primary care provision across Greater Manchester (from both a commissioning and provision perspective) including:
 - GP out of hours providers
 - NWS NHS 111 and NWS Paramedic Emergency Services (PES),

- Community pharmacy, optometry services, dental services
- Walk in centres
- Urgent Care Centres
- GPs in A&E
- *7 day additional access
- GP practices with APMS contracts (offering extended access/Walk in centres)
- Local admissions avoidance schemes
- Alternative to treatment (ATT)
- Including:
 - Scope of services offered
 - Criteria for use of service (e.g. frail/elderly only, location etc.)
 - Access to same day services
 - Times/availability of services
 - Utilisation of services
 - Gaps in service provision
 - Duplication/overlap of services
 - How services are accessed (referral, self-referral, walk in etc.)
- CCG commissioning intentions, contract values and dates of contract renewal
- Explore relationship between Clinical Assessment Service and primary care out of hours provision
- Presentation at A&E for minor conditions

Infrastructure and enablers:

- A review of existing infrastructure and enablers including:
 - Understanding of IT systems including:
 - System providers
 - IG requirements/compliance
 - Interoperability across the urgent primary care system and wider
 - Workforce and estates
 - Where services are located (physical and virtual)
 - How services are manned/who is staffing them
 - Understanding the relationship with community health provision and diagnostics available
 - Understand the relationship with other urgent and emergency community services such as mental health, social care, district nursing, etc. – determine the interaction across the system

**Although included in the overall scope of this review, 7 day additional access has been subject to a separate review*

Outputs:

- Development of final report including:
 - Summary of current 'as is' state
 - Identification of opportunities for improvement
 - Options appraisal for a GM urgent primary care offer
 - Recommendations for next steps

3.2 Out of scope

The following is out of scope of the review:

- A review of urgent and emergency secondary care activity
- A review of community care
- *In hours primary care provision

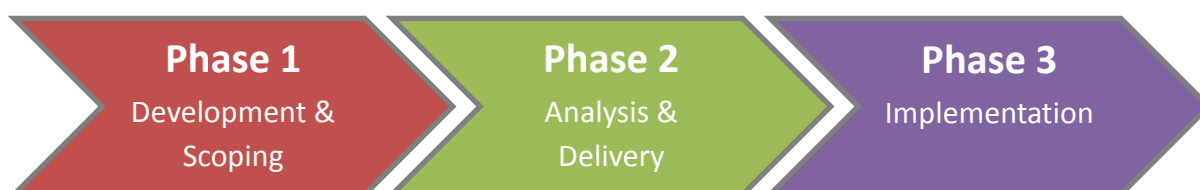
**Although the above is out of scope, it will provide an indication of how the system is working overall*

3.3 Interdependencies

- The information collated as a result of the baseline assessment will inform/input into the GM proposals be used to inform/refine existing triage processes e.g. NHS 111
- The review of urgent primary care will feed into the wider urgent care review
- The relationship between local hubs/neighbourhood teams (including Locality Care Organisations) and urgent primary care provision

4. APPROACH

The review of out of hours provision in GM will be delivered across 3 phases (see section 8.1 for timescales), as detailed below:



4.1 Phase 1: Development and scoping

This initial phase will focus on gaining system buy in and agreeing the scope of work to be undertaken:

Scoping

A task & finish group has been established to inform the review of 24/7 urgent primary care provision across Greater Manchester. The group comprises of a cross section of representatives from across GM and a range of disciplines. The group will refine the specification for the review including the overall purpose, scope of the review, process to be taken and next steps.

Stakeholder engagement

There will be continuous stakeholder engagement throughout the process including:

- Urgent Care Leads (UCLs)
- Chief Operating Officers (COOs)
- The Association of CCGs (AGG)
- Primary Care Advisory Group (PCAG)
- GP Advisory Group (GPAG)
- Primary care commissioners for dental, optometry and pharmacy
- GM Provider Board and A&E departments

- Patients and elected members
- A&E delivery board
- Comms & engagement teams
- The GM IM&T enabler and external IT providers

The refined proposal (based on outputs of stakeholder engagement) will be presented to the Strategic Partnership Board Executive.

Baseline assessment

Information will be collated to inform the review and options appraisal. This will be co-ordinated through the Urgent Care Leads and Primary Care Commissioners. The information gathered will include:

- Stocktake of current urgent primary care (detailed in section 3) - including value, commissioning intentions and date of renewal of contract
- Alignment with 7 day access to additional primary care
- How provision links to other parts of the system e.g. 111, emergency dental and eye health and community pharmacy, NWAS pathway, GPs in emergency departments etc.
- Details of dental, eye health and community pharmacy out of hours provision
- Mapping all urgent primary care provision to understand location (physical and virtual), gaps in provision and duplication
- Analysis of the utilisation of urgent primary care services
- As referenced in section 2, a number of localities have already commenced reviews into their out of hours provision. There are also opportunities to learn from the Urgent and Emergency Care Vanguard, local, national and international examples of good practice to inform the thinking in GM.

4.2 Phase 2: Analysis and Delivery

There will be an external review of the baseline information to determine the 'as is' state of urgent primary care across Greater Manchester. The external analysis will:

- Provide analysis of the baseline information
- Provide an objective diagnostic of local plans and ambitions
- Compare local plans with 'what good looks like'

The information gathered for the baseline and the external diagnostic will form the basis of the options appraisal and recommendations. The outputs from this phase will be as follows:

- Formal report summarising the main findings
- Workshop with GM urgent primary care system to review the results of the baseline assessment and external diagnostic to inform the development of a GM approach
- Further development of GM principles and/or a GM framework which will aim to move towards a more streamlined, responsive and integrated service - enabling GM to do things once and implement locally
- Options appraisal to determine how future services will be delivered e.g. GM level, sector level, by locality etc.
- Engagement with stakeholders regarding the options appraisal

- Presentation of options appraisal and recommendations to Joint Commissioning Board and Strategic Partnership Board

4.3 Phase 3: Implementation

Following the presentation of options appraisal to the Joint Commissioning Board and Strategic Partnership Board, this phase will focus on establishing a delivery mechanism to deliver the principles detailed in section 2.1 and the recommendations of both boards. This stage would be shaped by the recommendations from the Strategic Partnership Board and will include timescales and detailed plans for implementation.

5. RESOURCE

5.1 Although the review will be undertaken at a GM level, it needs to be fully aligned to the GM Urgent Care Leads and the A&E Delivery Board. The following resource is therefore proposed:

- Dedicated project management support for 4-5 months to lead the review
- A nominated GM Urgent Care Lead to sponsor the programme of work
- Additional project support - to support collation of information
- A clinical lead to lead the review and options appraisal
- External support to provide an analysis of the baseline and an objective review of local plans/ambitions

It is proposed that Project Management and Project Support will be drawn from the Primary Care Transformation team within the Population Health and Commissioning Directorate of the GM Health and Social Care Partnership.

5.2 24/7 urgent primary care review task & finish group

The task and finish group will oversee the review of urgent primary care provision and options appraisal. The group will comprise of GM representation as follows:

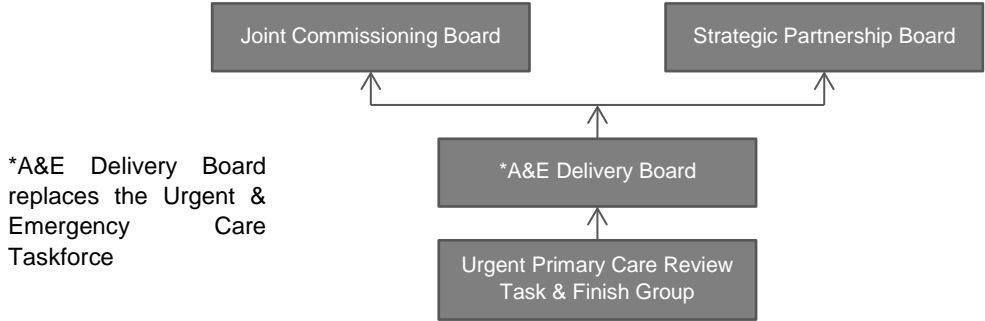
- CCG urgent care leads
- CCG clinical leads
- CCG commissioner
- GMHSCP Head of Primary Care
- GMHSCP Head of Primary Care Operations (for dental, pharmacy, optometry)
- GMHSCP Project Manager
- NWAS NHS 111 / NWAS Paramedic Emergency Service
- Out of hours provider
- GP for in hours provision
- GP for 7 day additional access
- Clinical lead for the Task & Finish group

6. GOVERNANCE AND REPORTING

The review of out of hours provision will form part of the 'GM Programme of Primary Care Reform' and is part of a larger piece of work to improve urgent and emergency

care across GM. As such, the outputs of this review will feed into the A&E Delivery Board.

The options appraisal is likely to present commissioning implications. As such, the final report will be presented to the Joint Commissioning Board as well as the Strategic Partnership Board. A proposed governance structure is as follows:



7. NEXT STEPS

The first task and finish group has taken place. Subject to approval of this draft outline, the group will refine the proposal and commence with phase one. Section 8.1 provides an overview of the proposed timescales

8. Timescales

Phase	Activity	By whom	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17
Phase 1	Finalise proposal including purpose, scope & process and agree timelines								
	Establishment of task and finish group								
	Engagement with key stakeholders (UCLs, COOs, AGG, PCAG, AGG) to present scope of review/review proposal								
	Development of proforma/template to capture data								
	Presentation of proposal to JCB Executive & SPB Executive								
	Collation of baseline information: <ul style="list-style-type: none"> - Stocktake of <u>all</u> urgent care provision including availability, and utilisation - Understanding of contract values, expiry and commissioning intentions - Alignment with other parts of the system (e.g. mental health) - Alignment with the Clinical Assessment Service 								
Phase 2	External review of baseline information								
	Analysis of data								
	Diagnostic of local plans/ambitions								
	Workshop to review findings								
	Develop GM principles / framework for the GM urgent primary care offer with a view to moving to a streamlined, integrated service								
	Develop options appraisal and recommendations								
	Engagement with stakeholders								
	Present outcome of the review, options appraisal and recommendation to JCB and SPB								
Phase 3	Commence development/agreement of implementation approach								

GM Resilience Programme

Resilience Programme Model:



A) GM Practices rated OUTSTANDING by the CQC (Dec 2016)

Deane Medical Centre	NHS Bolton CCG
The Olive Family Practice Ltd	NHS Bolton CCG
Rock Healthcare Limited	NHS Bury CCG
The Doc's Surgery	NHS Central Manchester CCG
Middleton Health Centre	NHS Heywood, Middleton and Rochdale CCG
Stonefield Street Surgery	NHS Heywood, Middleton and Rochdale CCG
Urban Village Medical Practice	NHS North Manchester CCG
Five Oaks Family Practice	NHS North Manchester CCG
Hill Top Surgery	NHS Oldham CCG
Salford Health Matters, Eccles	NHS Salford CCG
Irlam Medical Practice 2	NHS Salford CCG
Marple Cottage Surgery	NHS Stockport CCG
Brinnington Surgery	NHS Stockport CCG
Lockside Medical Centre	NHS Tameside and Glossop CCG
Dr Mahendra Patel	NHS Trafford CCG
Boundary House Medical Centre	NHS Trafford CCG
Marus Bridge Practice	NHS Wigan Borough CCG

B) CQC Themes identified as requiring improvement across GM (Dec 2016)

CQC THEME	Practices inadequate or requiring improvement
Clinical Governance	55
Persons who Perform Services - Training	49
Infection Control	39
Persons who Perform Services - Recruitment	35
Legislation & Guidance	26
Provision of drugs, medicines and appliances for immediate treatment or personal administration	26
Complaints	24
Patient Participation Group	18
Provision of services - Premises	17
Storage of Vaccines	15
Patient Online Services	3
Additional Services - equipment	2
Patient Records	2
Insurance	1
Friends and family	1
Consent of treatment	1
Confidentiality of personal data	1

GPFV Commitments

GM has been notified that the funding for the following GPFV initiatives are within the GM Transformation Fund:

Box A

<p>7 day services/GP access-related costs:</p> <p>GP access initiatives</p>
<p>GPFV commitments:</p> <p>Extended clinical pharmacists programme (including training and practice development)</p> <p>Training care navigators and medical assistants for all practices</p> <p>Online consultation software systems</p> <p>Practice resilience programme / Vulnerable practices programme</p> <p>Estates and Technology Transformation Programme, including “hard commitments” brought forward from 2015/16 – this relates to the revenue elements</p>

Box B

Programmes which will be managed/funded nationally:

<p>7 day services/GP access-related costs:</p> <p>HEE costs for training 5000 GPs</p> <p>Provision for rollout of appointment data tool</p> <p>Start-up costs for Transformation Areas</p>
<p>Other primary care transformation programmes:</p> <p>Accelerating the development of ETPP local estates plans</p> <p>Regional programme management office support for ETPP implementation</p> <p>NHS PS and CHP lease incentive payments</p> <p>National development programme for general practice</p>

Practice nurse measures

International recruitment

Practice manager development

Other workforce 2020 initiatives e.g. GP retainer/returner

Automated task software

Leadership coaching for experienced GPs

OOH winter indemnity scheme

Engagement events for GPFV

Pharmacy Summary Care Records

Secondary/primary care interface work

Digital primary care