Report to:	**HEALTH AND WELLBEING BOARD**
Date:	19 January 2017
Board Member / Reporting Officer:	Clare Watson, Director of Commissioning
Subject:	**PRIMARY CARE BRIEFING – PRIORITIES AND SCOPE 2017-2021**
Report Summary:	This report provides a briefing on the priorities and scope for primary care over the next two to five year based on the national and regional strategies set out through the Five Year Forward View, General Practice Forward View, New Models of Care: The new models of care and contract framework, NHS Operational Planning and Contracting Guidance 2017-19 and Delivering Integrated Care Across Greater Manchester: The Primary Care Contribution. Our Primary Care Strategy 2016-2021.
Recommendations:	1. Note the scale of the ambition for Primary Care nationally. 2. Support the delivery of this ambition through our local implementation, development of neighbourhoods and progression of new models of working and through the refresh of the Primary Care Quality Scheme. 3. Acknowledge the competing priorities on scarce financial resource and the CCG investment already in place as part of the Primary Care Quality Scheme, noting the refresh of this aligned to national policy and GM standards, and the investment in respect of neighbourhoods through Transformation Fund.
Links to Health and Wellbeing Strategy:	Improved care and outcomes, a focus on early intervention and prevention for all patients are priorities of the H&W Strategy.
Policy Implications:	Mets the legal policy framework.
Financial Implications: **(Authorised by the Section 151 Officer)**	Primary Care expenditure can fall into all three elements of the Integrated Commissioning Fund but this is predominantly in the Aligned and In Collaboration Budget areas. Although this briefing identifies potential funding streams for primary care collated from various operational planning guidance, this must be treated with caution. Clarity is required but it would be prudent to expect little, if any, additional resource and assume this resource inherent within CCG Baselines or Transformation Funds which are already significantly over subscribed with other clinical priorities. The CCG has committed £1.5m to the Primary Care Quality Scheme which will be refreshed with alignment to the priorities of the GP Forward View, planning guidance and GM standards to deliver optimum use of this resource.

Legal Implications: **(Authorised by the Borough Solicitor)**	The statutory requirements for submission of CCG plans and GP Forward View plans are detailed.
Risk Management :	None, this is a briefing report only as any specific issues will be addressed in subsequent detail.
Access to Information :	The background papers relating to this report can be inspected by contacting Janna Rigby, Head of Primary Care Telephone: 07342 056001 e-mail: janna.rigby@nhs.net

1. INTRODUCTION

1.1. The strategy for Primary Care over the next two to five years is outlined throughout a number of national and regional documents, with links to each included at **Appendix 1**;

- The Five Year Forward View, published October 2014.
- The General Practice Forward View, published April 2016.
- New Care Models: The multispecialty community provider emerging care model and contract framework, published July 2016.
- NHS Operational Planning and Contracting Guidance 2017-2019, published September 2016.
- Greater Manchester Primary Care Strategy (Delivering Integrated Care Across Greater Manchester: The Primary Care Contribution. Our Primary Care Strategy 2016-2021), published September 2016.

1.2. These documents are closely aligned and interlinked and all outline the need for system wide changes to ensure the NHS can deliver the right care, in the right place, with optimal value. The framework was first outlined in the Five Year Forward View with the clear task to "drive improvements in health and care; restore and maintain financial balance; and deliver core access and quality standards". This is translated to describe localities position in their Sustainability and Transformation Plans.

2. CONTEXT

2.2. Primary Care – whether provided by doctors, dentists, optometrists, pharmacists or other health and care practitioners who support people outside hospital – already benefits our local population. It offers easy access, high quality care from professionals who know their patients and can make a big difference to health outcomes.

2.3. There are many health and care related issues that could be addressed by improvements both to primary care generally and to specific services, in particular by ensuring we all work together and make the most of every opportunity to give people the right support close to where they live. How people use, or do not use, primary care is an indication of the scale of the challenge; this is alongside an ageing population, an increasing number of people with more than one long term condition and health inequalities.

2.4. Tameside & Glossop has 41 practices working across 5 neighbourhoods. All 3 of the current nationally recognised GP contracts are in place within the economy: general medical services, personal medical services and alternative provider medical services.

Locality	Population (TBC)	General medical services contract	Personal medical services contract	Alternative provider medical services contract
Ashton	56,481	7	1	1* registered and WIC
Glossop	31,912	6	1	0
Stalybridge	43,545	9	0	1
Denton	49,594	5	0	2
Hyde	62,392	6	2	0
Total	243,624	33	4	4

2.5 We have a mixed economy of contracts, although the majority are general medical services.

- General medical services contract is the standard national general practice contract.
- Personal medical services contracts are locally contracted, specified and priced.
- Alternative provider medical services contracts locally were for the new practices that were commissioned to increase the number of GPs in an under-doctored locality.

This was a national initiative, with the make-up of the contracts determined locally based on the needs of the population served.

- General medical services contracts are nationally negotiated and run in perpetuity (subject to quality, performance etc.).
- Personal medical services contracts, although locally specified and priced, have recently undergone a nationally imposed review to bring the contract value more in line with general medical services.
- Alternative provider medical services contracts are for a 7 year term, and we are about to start a consultation and engagement exercise with the practice populations before we go through a formal procurement exercise and re-let the contracts. This is a national requirement for all alternative provider medical services contracts

Through its contract, a practice income is made up of Core, Additional and Enhanced elements. The majority of which are nationally prescribed. The Primary Care Trust/Clinical Commissioning Group has invested in locally commissioned services which have allowed practices to develop and deliver enhanced care services for our practice population.

2.6 This can be summarised by the two key principles of the GM Primary Care Strategy:

- **People-powered change** – making sure people receive the right support to take more control of their own health and behaviours;
- **Care delivered by population based models** – making the best possible use of resources available within localities and neighbourhoods.

2.7 Strengthening and transforming general practice will play a crucial role in the delivery of Sustainability and Transformation Plans and in integrating the aims of the GP Forward View into these plans. CCGs will need to document the aims and key local elements of the GP Forward Plan into more detailed local operational plans and submit one GP Forward Plan to NHS England on 23 December 2016; plans need to reflect local circumstances but must, as a minimum, set out:

- How access to general practice will be improved;
- How funds for practice transformational support will be created and deployed to support general practice;
- How ring fenced funding being devolved to CCGs to support the training of care navigators and medical assistants, and stimulate the use of online consultations, will be deployed.

3 OPERATIONAL PLANNING GUIDANCE 'MUST DOS' AMD THE GOVERNMENT'S MANDATE TO NHSE

3.1. The operational planning guidance identifies 9 key 'must dos' for 2017-19, and primary care is a running theme throughout a number these. Primary care is also specified as a 'must do' under its own heading in the form of:

- Ensure the sustainability of general practice in your area by implementing the GP Forward View, including the plans for Practice Transformational Support, and the ten high impact changes.
- Ensure local investment meets or exceeds minimum required levels.
- Tackle workforce and workload issues, including interim milestones that contribute towards increasing the number of doctors working in general practice by 5,000 in 2020, co-funding an extra 1,500 pharmacists to work in general practice by 2020, the expansion of Improving Access to Psychological Therapies in general practice with 3,000 more therapists in primary care, and investment in training practice staff and stimulating the use of online consultation systems.
- By no later than March 2019, extend and improve access in line with requirements for new national funding.

- Support general practice at scale, the expansion of Multi-speciality Community Provider or Primary and Acute Care System, and enable and fund primary care to play its part in fully implementing the forthcoming framework for improving health in care homes.

3.2 Alongside the documents outlined above NHS England are publishing a revised NHS Standard Contract for consultation. This refresh addresses ambition set out in the GP Forward View to enable more seamless care for patients, this includes the requirement for transmitting letter to GPs following clinic attendance in a progressively reducing timescale and also mandates, from April 2017, use of the e-Referral system with acknowledgement of the need to resolve practical issues which currently hinders the use and uptake of e-Referral system in general practice.

3.3 The planning guidance details the government's mandate to NHS England setting the 2020 goals, as with the 'must dos', primary care is a theme through these and is also specifically referenced in the following:

- Patient Experience – measured by the Friends and Family Test, alongside other sources of feedback to improve services.
- New Models of Care – including 100% of population having access to weekend/evening routine GP appointments and 5,000 extra doctors in general practice nationally.
- Technology – 95% of GP patients being offered e-consultation and other digital services and 95% of tests to be digitally transferred between organisations.

3.4 Primary Care, across the whole workforce within General Practice, Pharmacy, Optometry and Dental, has a key role in preventative intervention and signposting to support in the delivery of, for example but not limited to, cancer, obesity and diabetes, dementia, health and social care integration and mental health, learning development and autism targets.

4. NEW MODELS OF CARE

4.1. The theme throughout all the documentation is around system wide changes and transformation of services to change the way patients access care, self-care and benefit from population based care models. This place based approach of new models of care will break down the boundaries between different types of provider and foster stronger collaboration across services. This starts with Primary Care at Scale and grows to centre around a Multi-specialty Community Provider. This is not a new form of practice based commissioning or the recreation of a Primary Care Trust but is the delivery of primary and community based health and care services – not just planning and budgets.

4.2. The local view is that a new model of care would provide the required form in order to formalise and be an enabler for the desired function. Elements of the Multi-speciality Community Provider and/ or Primary and Acute Care System model may be used to ensure local arrangements align to the national principles of these models, however the presence of the Integrated Care Foundation Trust means that a different approach is needed in Tameside and Glossop to ensure the commissioning and provision of health and social care services is cohesive. Any new contract will be outcomes-based and the delivery model of this contract will be designed by the provider(s) alongside the Commissioner.

4.3. The building blocks of a Multi-speciality Community Provider or equivalent are the 'care hubs' of integrated teams, each typically serving a community of around 30-50,000 people. A Multi-speciality Community Provider is a place based model of care, it serves the whole population and covers the sum of the registered lists of the participating practices. It is designed to strengthen wider primary care provision and deliver transformed care provision out of hospital to pro-actively manage patients in the community and see a shift in people attending hospital who could be better supported in the community.

4.4. The work of the five Integrated Neighbourhoods across Tameside and Glossop will continue to implement areas of work for their populations. Details of this are included within **Appendix 2.**

4.5. The development of the Integrated Neighbourhoods will be led by Tameside and Glossop Integrated Care Foundation Trust, along with the Commissioning Business Managers and the Neighbourhood Clinical Leads from the CCG, to ensure that this model of care is fully integrated and embedded within the health and social care within Tameside and Glossop.

5. ENHANCED PRIMARY CARE AND EXTENSIVIST MODELS

5.1. A Multi-speciality Community Provider offers an enhanced primary care model which provides a broader range of services in the community integrating primary, community, social and acute care services and aims to improve the physical, mental and social health and wellbeing of the local population. They encourage diverse communities to look after themselves by supporting self-care and connecting people to community assets and resources. They support staff to work in different ways with a focus on team based care and harness digital technology to achieve their goals.

5.2. The extensivist model provides additional support for a small group of patients with high needs and high cost. This model uses risk stratification supported by trigger tools and case finding to identify patients which would benefit and works to provide targeted out of hospital care, fewer unplanned admissions, shorter lengths of stay and few unplanned readmissions.

6. TECHNOLOGY

6.1. The mandate for technology is for 95% of GP patients to be offered e- consultation and digital services and that 95% of tests be digitally transferred between organisations. The GM strategy takes forward the innovative practice taking place across localities and provides links to the new Health Innovation Manchester partnership to accelerate the discovery, development and implementation of new treatments and approaches with a focus on improving health outcomes. This includes the use of digital technology to improve how people access care, how records are shared with the ambition of becoming paper free at the point of care to strengthen primary care to create easier access to services that fit around the patient’s family and work life. In line with the self-care culture of people powered change this also offers opportunities to improve access to advice and treatment through technology such as online, real-time video consultation.

7. PRIMARY CARE QUALITY

7.1. The Five Year Forward View, NHS Planning Guidance and Sustainability and Transformation Plans are all driven by the pursuit of the “triple aim”:

- Improving the health and wellbeing of the whole population;
- Better quality for all patients through care redesign; and
- Better value for taxpayers in a financially sustainable system.

7.2. To this aim NHS England have introduced a new Improvement and Assessment Framework for CCGs and NHS Improvement have published the Single Oversight Framework. The key themes of the latter include quality of care; assessing whether a provider’s care is safe, effective, caring and responsive.

8. GREATER MANCHESTER PRIMARY CARE MEDICAL STANDARDS

8.1. A suite of standards have been co-designed and agreed with the aim of transforming the delivery of primary care to reduce unwarranted variation, adopt a more pro-active approach to health improvement and early detection in order to improve health outcomes for the patient population. These standards are to be implemented by 2017, with similar standards also being developed in dental, optometry and pharmacy, all of which will contribute to the earlier detection of disease, proactive management within the community and supporting patients to self-care. The nine GM medical standards are:

1) Improving access to general practice;
2) Improving health outcomes for patients with mental illness;
3) Improving cancer survival rates and earlier diagnosis;
4) Ensuring a proactive approach to health improvement and early detection;
5) Improving the health and wellbeing of carers;
6) Improving outcomes for people with long term conditions;
7) Embedding a culture of medication safety;
8) Improving outcomes in childhood asthma;
9) Proactive disease management to improve outcomes.

8.2. Locally, proactive engagement around quality and assurance, aligned to the Care Quality Commission work programme will dovetail the delivery of national and regional directives. Utilisation of risk stratification data to understand the needs of specific cohorts of patients and how services and care models can be used to better support these patients is also in place, linked also to the enhanced primary care and extensivist models outlined above.

9. WORKLOAD

9.1. There is pressure on primary care from other parts of the health system resulting in increased workload, problems recruiting and retaining GPs therefore creates further workforce difficulties. The GM strategy illustrates that 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. Other parts of the primary care workforce face similar challenges, for example in practice nursing over 64% of nurses are over 50 and only 3% are under 40. A baseline collection of the current workforce, workload demands will form one element of our GP Forward View plan.

9.2. The potential for clinical pharmacists to reduce the burden on GPs and increase capacity within primary care is already being demonstrated. Locally there are success stories and feedback on the benefits being realised in our practices, resolving day to day medicine issues and requests from pharmacies, providing extra help for patients to manage long term conditions, advice to those on multiple medication and better access to health checks.

9.3. In GP Forward View plans CCGs will want to include a general practice workforce strategy that links to their service redesign plans. These should be clear about the current position, areas of greatest stress, examples of innovative workforce practices, the planned future model and actions to get there, building on the 10 high impact actions to release capacity described in the GP Forward View.

9.4. Improving the way different health and care professionals work together to get the most from what each profession brings to primary care services and individual patient care will help embed best practice in all services and will contribution to delivering the GM vision focusing on place and people rather than specific organisations and professional groups.

10. PRIMARY CARE ESTATES

10.1. The primary care estate varies significantly in terms of quality, condition and suitability and needs to cope with increasing patient activity as more services are developed out of hospital. Vision and direction for primary care estate needs to enable the delivery of place based services across neighbourhoods and make full use of buildings currently available, including patients' own homes, local community services, traditional primary care facilities and other public sector premises. Locally this agenda is being taken forward in a separate workstream.

11. FINANCE

11.1. Under delegated commissioning arrangements the CCG receives an allocation for core primary care commitments; the value of this for 16/17 to 20/21 is detailed below:

• 2016/17	• £30.922m
• 2017/18	• £32.075m
• 2018/19	• £33.041m
• 2019/20	• £34.108m
• 2020/21	• £35.485m

11.2. Although this outlines increases in allocation year on year, this must be measured against unknowns around increased in global sum, changes to the quality and outcomes framework and premises reimbursement regulations and changes in list size, though an element of list size growth is incorporated in allocation uplifts. It would be therefore be prudent to assume these allocation fully committed and any slippage be dealt with on an in year basis.

11.3. In addition to this allocation other primary care funding is potentially available as part of the £500m plus sustainability and transformation package announced in the GP Forward View including potential funding to support improvements. in access to general practice and improvements in estates and technology. As yet, GM Health and Social Care Partnership are seeking clarity on these resources, with particular reference to whether these are genuinely additional resources which GM can access, or whether these are either inherent in the GM Transformation Fund or already in CCG Primary Care baselines. Experience leads us to believe the latter two scenarios are the more likely and if so these resources are already significantly over-subscribed with other "must do" clinical priorities. It is therefore crucial that the whole health and social care economy work collaboratively to achieve optimal outcomes with the scare resources we have.

11.4. The different funding streams reported in various publications have been collated and are summarised in the table below. The third column reports the perceived reality of whether this is genuinely new funding and how this compares to CCG investment:

Operational Planning Guidance Headline	Policy Description	Detail/Tameside and Glossop translation
Transformational support 17/18 and 18/19 from CCG allocations	"CCGs should plan to spend a total of £3 per head of population as a one off non recurrent investment commencing in 2017/18 for practice transformation support as set out in the GP Forward View and can take place over two years, £3 per head in 17/18 or 18/19 or split over the two years. This	This funding is included within CCG core allocations. For Tameside and Glossop, based on list size information at 1 July 2016 this would equate £735,750. The CCG has already committed £1.5m to the Primary Care Quality Scheme which more than

	investment is designed to stimulate development of at scale providers for improved access, stimulate implementation of the 10 high impact actions to free up GP time and secure sustainability of general practice.”	adequately addresses this requirement and others noted below. In addition there may be a possibility to address this requirement with links to the Primary Care investment via the GM Transformation Fund.
Online General Practice consultation software systems	This was announced in the GP Forward View with £45m funding for this programme with £15m to be deployed in 2017/18 along with the rules, specification and monitoring arrangements and a further £20m in 2018/19.	For Tameside and Glossop, based on nationally estimated registered populations this will equate to £63,595 in 2017/18 and £84,672 in 2018/19. GM Health and Social Care Partnership are seeking clarity on whether this is genuinely new funding and not already included in the GM Transformation Fund, or the CCG baseline.
Training Care Navigators and Medical Assistants	The £45m, over five years, announced in the GP Forward View for the Training Care Navigators and Medical Assistants programme totals £10m in each of 2017/18 and 2018/19 with £5m allocated in 2016/17.	Locally this allocation equates to, based on estimated registered populations, £21,229 in the current year, £42,402 in 2017/18 and £42,336 in 2018/19. GM Health and Social Care Partnership are seeking clarity on whether this is genuinely new funding and not already included in the GM Transformation Fund, or the CCG baseline.
General Practice Resilience Programme	The £40m non recurrent funding announced in the GP Forward View to be deployed over four years; £16m of which is being allocated in 2016/17. This resource will be delegated to NHS England local area teams on a fair share basis with a number of elements of the package being held centrally pending further information.	This resource will be held by the GM Partnership, detail of how this is to be allocated, including whether or not (and how) practices can self-refer is still unknown and requires confirmation.
Funding to improve access to general practice services	This funding stream allocates £6 per head to those CCGs who had Prime Minister’s Challenge Fund pilot sites. The programme expands and includes £3.34 per head of population for remaining CCGs to provide access to pre-bookable and same day appointments to general practice services in evenings, 1.5 hours per day and provision of weekend provision on both Saturday and Sunday to meet local population need.	This should total a minimum additional 30 minutes capacity per 1000 population, rising to 45 minutes per 1000 population. For Tameside and Glossop this equates to £807k of which a recurrent allocation has been received in 16/17 are is therefore now within the CCG baseline with other competing priorities.
Estates and	CCGs were invited to bid for funding	Tameside and Glossop are

Technology Transformation Fund (ETTF)	from 2016/17 onwards.	understood to have been successful in securing capital funding for Union Street Hyde and Hattersley integrated Hub. The details have yet to be verified and account taken of the the additional revenue costs associated with capital funding.

11.5 There is also the potential for some non-recurrent funding which is being held nationally to support GPFV commitments in a number of areas including growing the general practice workforce, premises and the national development programme. In addition there will be potential increases in a number of national lines to support the promised increase in investment for general practice, this includes:

- Increases in funding for GP trainees funded by Health Education England;
- Increases in funding for nationally procured GP IT systems;
- Increases in the section 7A funding for public health services, which support payments to GPs for screening and immunisation services; and
- 3000 new fully funded practice-based mental health therapist to help transform the way mental health services are delivered.

11.6 NHS England has retained some national funds to support workforce developments including international recruitment and clinical pharmacists and Health Education England and NHS England will produce frameworks and models to support the expansion of physician associates, medical assistants and physiotherapists.

11.7 Primary Care is a significant partner in the neighbourhoods for which Transformation Funding has been received of circa £8m and plans are being developed collaboratively with primary care colleagues to deliver holistic services in neighbourhoods.

12. LOCAL IMPLEMENTATION

12.1. Although the neighbourhood model of peer support has been in place for a number of years more recently this has developed and expanded to promote new ways of working across, and by, neighbourhoods. The ambition of this is to improve efficiency and achieve the care delivered by population based models approach. Further alignment of commissioning staff to neighbourhoods has strengthened the support offer and work programme with practices. The review of risk stratification patients, as outlined in the description of the extensivist model, is being implemented locally through this extended support and it is anticipated that this will become embedded in practice culture.

12.2. Following the GM New Models of Care event in early October, a local session was held on 20 October. The national direction of new models of care described through national strategy, although in its infancy in Tameside and Glossop, is moving forward and will further develop through the coming years. We have already seen a change in the way practices are working together; this has further been reflected in the alignment of practices, both formally and informally.

12.3. Neighbourhoods are designing care models for their populations based on local need, fostering relationships between providers to deliver the best outcomes. These Integrated Neighbourhoods have been formed across all neighbourhoods bringing together providers to work in collaboration.

12.4. Different models of working and widening the range of professionals within the primary care workforce is a key strand throughout all the national documentation and this is being taken forward locally. This expansion of the primary care workforce, could comprise models such as for example: the use of community paramedics and pharmacists. These are currently in operation and may continue through 2017/18 and inform the further development of integrated neighbourhoods.

12.5. New models of care and the direction of the GP Forward View and GM strategy has been fully reflected in the documentation for the Alternative Provider Medical Services re-procurement. Although a new contract model is not yet available, the context in which the contracts are being re-procured and the future vision for these practices has been outlined and will form part of the assessment of bids.

12.6. The Greater Manchester Health and Social Care Partnership have recently been able to access to the national GP Development Programme and invited practices, through their CCG, to express interest in the Productive General Practice Programme. This programme offers dedicated support to practices to help them plan and implement rapid changes to release time, remove waste and create headspace to work through current and future pressures and implement a means to approach and manage these. We have been able to secure funding to support cohorts of practices through this programme and will communicate this to practices in the coming weeks ahead of the programme launch mid December. Alongside this a Quality Improvement champion workshop session is being held in December. This is the first session of a two part programme which is being facilitated locally as part of the learning from year one of the Primary Care Quality Scheme and will further support practices to understand their own practice and population need and how changes can be implemented to address both the direction of national and regional strategy but also to ensure sustainable general practice locally.

12.7. The Primary Care Quality Scheme refresh required for 2017/18 must reflect the current landscape, both financially and policy. This is best summarised as the Primary Care Quality Scheme refresh must deliver the primary care quality “triple aim”. This redesign must therefore address the direction for primary care outlined through the documentation to support the formation of new models of care and deliver people powered care and place based, population based models. This redesign will address the ‘must do’s’ and mandates from the planning guidance outlined above as well as ensure Tameside and Glossop fulfils its commitment to the delivery of the GM standards. The drive to improve use of technology and change the way people access services will also be reflected, ensuring people powered change can be achieved. This refresh is underway and will go through a period of patient and practice consultation.

13. RECOMMENDATIONS

13.1. As set out on the front of the report.

APPENDIX 1

Five Year Forward View

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

General Practice Forward View

https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

New Care Models: The multispecialty community provider (MCP) emerging care model and contract framework

https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmwrk.pdf

NHS Operational Planning and Contracting Guidance 2017-2019

https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

Greater Manchester Primary Care Strategy (Delivering Integrated Care Across Greater Manchester: The Primary Care Contribution. Our Primary Care Strategy 2016-2021)

http://www.gmhsc.org.uk/assets/GMHSC-Partnership-Primary-Care-Strategy.pdf

APPENDIX 2

INTEGRATED NEIGHBOURHOOD ACTIVITIES - UPDATE

1. BACKGROUND

1.1. The Integrated Neighbourhood model has been developed with significant input from a range of stakeholders, and the implementation of the model is now being led by Tameside & Glossop Integrated Care NHS Foundation Trust.

1.2. The CCG Commissioning Business Managers and Neighbourhood Clinical Leads continue to support the further development and implementation of the IN model with a number of activities and projects across the neighbourhoods. This briefing paper has been produced with the intention (in the first instance) of sharing (informally) the work which is ongoing and which has been initiated and led by the Single Commissioning Function.

2. STANDARD ACTIVITIES ACROSS THE LOCALITY

2.1. Each of the neighbourhoods offer the following as standard:

2.2. Neighbourhood Business Meetings: These are held monthly, chaired by the clinical lead, and involve a range of General Practice staff (GPs, Practice Managers and Practice Nurses). The monthly Neighbourhood business meetings discuss and address any locality based issues and challenges. Also a platform to share key messages that will impact on Primary Care services within the Neighbourhood.

2.3. Practice Monthly Packs: facilitate monthly lock-in sessions (with Medicines Management, Business Intelligence, Finance colleagues) to review Practice data packs. Identify key trends and themes that the Practice may wish to focus on to reduce overspend and or deliver their referral Pathways differently so they fall in line with identified Good Practice.

2.4. Risk Strat data – Support Practices to review their cohort of 'Risk' clients identified through the monthly Risk Stratification report. Encourage Practices to link in with the LTC colleagues to undertake reviews of their patients with a view to ensuring all appropriate patients are on the right pathways and receive the best interventions at the right time.

2.5. Practice Visits – Undertaken Practice Visits with Clinical leads. Following the Visits, facilitated the sharing the granular breakdowns of activity as discussed/identified during conversation with the Practice staff. Maintain follow up conversations with Practices once breakdowns have been shared with the offer of continuous support to identify and resolve any concerning trends/themes as well as sharing with Peers any identified Best Practice.

2.6. Integrated Neighbourhood Meetings – CCG organise and facilitate / support Monthly Integrated Neighbourhood Team meetings attended by Adult Care, Social Services, Young People Services, Community Nursing (Tameside and Glossop Integrated Care Foundation Trust), 3rd Sector/Voluntary services, mental health and Primary Care colleagues. Key aim of the Group is to bring together all major departments to develop and deliver a system that will support the robust and integrated management of peoples Health and Social Care needs. This is building on the development phase of the Integrated Neighbourhood model, which for Glossopdale was supplemented with separate discussions to ensure the Derbyshire County Council stakeholders were involved.

2.7. Input to ongoing development, design and implementation of Integrated Neighbourhoods – the Single Commissioning Fund continue to engage at every opportunity in the development

and implementation of Integrated Neighbourhoods, with the Deputy Director of Transformation and the Heads of Primary Care meeting on a regular basis with the Director of Strategy from the Integrated Care Foundation Trust.

2.8. Pharmacy Support - The Single Commissioning Fund are currently leading the design of the integrated neighbourhood pharmacy model and are looking to take this through the required Integrated Care Foundation Trust governance, with support from the Trust to confirm the details required to enable this.

3. ASHTON – NORTH NEIGHBOURHOOD: Clinical Lead – Dr Nav Riyaz, Commissioning Business Manager – Christopher Martin

3.1. In addition to the monthly Neighbourhood Business Meetings, to take forward the Integrated Neighbourhood model, Ashton is holding the following meetings:

- An additional evening meeting for the neighbourhood to further discuss development of an integrated neighbourhood – this is proposed for 17 December (venue permitting).
- A meeting to discuss the children and young families area with primary care staff, school nurses, safeguarding, paediatricians and paediatrics community nursing – this will be in March 2017 after the children multi-disciplinary team model has been established by the children's commissioner.
- A meeting to discuss vulnerable / heavy acute system users with police, fire service, social care, third sector, mental health and the North West Ambulance Service.
- A "market" event where third sector and social prescribing providers can introduce themselves to the Ashton neighbourhood so GPs have a more robust idea of what is available, which will take place in the New Year. This has been discussed with Action Together, as best placed to provide support. Pete Forrester, one of the patient representatives attending the Ashton Neighbourhood will also support as it links in to work he is already undertaking for Ashton patient groups.
- Paediatrics advice and guidance pilot scheme, with Bedford House participating during the pilot.

3.2. Priority Projects - To look at over-referring areas as a neighbourhood, compare with other neighbourhoods and consider what can be done to reduce those areas of over-referral.

4. DENTON – WEST NEIGHBOURHOOD: Clinical Lead – Dr Asad Ali, Commissioning Business Manager – Heather Palmer

4.1. All practices are well engaged in the neighbourhood discussions and are willing to take part in integrated working. Examples of work to date includes:

- Denton Huddle – practices/social/community healthcare etc. met twice with really good attendance – another meeting arranged for January to take forward integrated agenda.
- Denton HRV (High Risk Vulnerable) – meetings on a quarterly basis – practices/social/community health/Pennine care/police to discuss individual cases again really well attended.
- Denton GSF (Gold Standards Framework) Meeting – held 1 integrated GSF meeting which was very well attended by social/community health/district nurses/police etc. but it was felt to take forward this forum as a HRV meeting and continue with GSF on a practice based approach.
- Practice based GSF meetings at all practices attended by social/district nurses.
- We have exchanged contact numbers practices AUA by pass numbers/social care/DNs/LTC on call as following discussions they had previously been issues contacting the teams.

4.2. Pilot projects in the Denton / East Neighbourhood include:

- 3 practices Nasal High Flow pilot with Catharine Thomas at Tameside Hospital NHS Foundation Trust to reduce Chronic Obstructive Pulmonary Disease re-admissions commencing December 2017;
- 3 practices paediatric outreach pilot commencing January 2017;
- 6 separate practices involved in the pilots out of 7 in the neighbourhood;
- The other practice has taken on 24 hr ECGs for the neighbourhood.

4.3. Priority areas for the further development of the Integrated Neighbourhood in Denton / East are:

- Practices are doing a retrospective peer review of 1 month's referrals to generate areas to focus on and identify trends and organise some consultant teaching sessions in these areas.
- Looking at the possibility of piloting a neighbourhood wide afternoon visiting service.
- Neighbourhood awaiting Transformation funds to run a Neighbourhood-wide telehealth project.
- Holding separate Multi-speciality Community Provider evening meetings to take forward as a neighbourhood.
- All practices taking part in Restricted Pharmacy ordering and looking at care home alignment.

5. HYDE – SOUTH NEIGHBOURHOOD: Clinical Lead – Dr Andy Hershon (to 31 December 2016 then Drs Jane Harvey and Lisa Gutteridge), Commissioning Business Manager – Louise Roberts

5.1. The Hyde Integrated Neighbourhood Team Steering group meet on a monthly basis and will continue to do so however but will from January take on a more operational role and we now also hold twice monthly strategic meetings. Ongoing work includes:

- The Hyde neighbourhood utilise the 'Clean Room' for a multi-disciplinary team assessment of medium/high risk patients and the intention is to utilise the operational INT meetings to discuss other cases (that fall outside the criteria for the clean room).
- Hyde Neighbourhood are involved in the Paediatric pilot project with Tameside and Glossop Integrated Care Foundation Trust, initially this will involve access to advice and guidance with a named consultant.
- Hyde practices have multi-disciplinary team /gold standard framework meeting in house to include a range of professionals i.e. Macmillan nurses, LTC team, district nurses and health visitors.
- Last year as part of the Commissioning Improvement Scheme (CIS) practices started to internally review / peer review referrals (and the more difficult cases were reviewed at the neighbourhood meeting).
- Hyde Practice Managers meet up on a regular basis and I am aware of several other meetings/inductions etc that take place to progress INT development.

5.2. Asset based Training: The Hyde neighbourhood was one of only 5 areas in Greater Manchester that was successful in securing this training, which forms part of the Greater Manchester Health and Social Care Devolution programme and refresh of the Greater Manchester Primary Care Strategy. It was decided that Hyde would be best placed as they already had experience in asset based approaches via their over 75s work. It was an opportunity to spread the message to other parts of the Primary Care system in Hyde.

The training has been developed in association with Skills for Health and Skills for Care and complements the Tameside Health & Wellbeing Strategy as well as the Tameside & Glossop Care Together programme, Locality Plan and work streams. The training was funded by NHS England.

5.3. Social support for practices: Developed with the support of Tameside MBC Adult Social Care teams, the worker will link into the Hyde Healthy Living workers and support patients across the neighbourhood.

5.4. Lifeline: Thornley House Medical Practice (along with Mossley) are currently piloting the redesign of the Drugs and alcohol primary care model of working within the community.

6. STALYBRIDGE – EAST NEIGHBOURHOOD: Clinical Lead – Dr Saif Ahmed, Commissioning Business Manager – Heather Palmer

6.1. All practices are engaged and willing to be involved in integrated working in the neighbourhood:

- Practice based GSF meetings held and increasing the numbers of social/community health care representatives at these meetings.
- We have exchanged contact numbers, practices' AUA by pass numbers/social care/district nurses/LTC on call as following discussions there had previously been issues contacting the teams.

6.2. Pilot projects in Stalybridge / East Neighbourhood:

- 1 practice paediatric outreach pilot commencing January 2017
- 2 practices long term conditions/mental health pilot – awaiting commencement date from Pennine Care

6.3. Priority areas for the Neighbourhood are:

- Established Stalybridge Peer Review Group to reduce inappropriate referrals for 2 outlying practices with an educational element for the GPs – starting w/c 5th December 2016.
- Care Homes – Task and Finish group met (practices/DN representatives) and putting together pilot of Integrated Care Home Ward Round led by Dr J Shilhan (Staveleigh) hoping to involve social care and community physio input to these ward rounds – hope to commence January 2017 for 3 months. Group to meet again during January 2017.
- Children's' and Families – Task and Finish Group led by Dr Tina Greenhough – met with practices/public health early years/social care – to include on all the Neighbourhood agendas each month 'what's new section relating to children's and families'. Number of actions as a result of first meeting including pulling together list of 'what's available in Stalybridge neighbourhood for children and families'.
- Meeting with Live Active on 13 December to organise a childrens' and families 'fun run/walk' with input from local practices/Live Active and Stalybridge schools in the New Year.
- Neighbourhood encouraging NMPs, and 3 new NMPs enrolled for training in the New Year
- All practices taking part in restricted pharmacy ordering and also now looking at care home alignment taken forward by the Care Home Task and Finish Group.

7. GLOSSOPDALE: Clinical Lead – Dr Alan Dow, Commissioning Business Manager – Wassiem Rafique

7.1. The Glossop Neighbourhood are all engaged in integrated working, with the following activities currently being undertaken:

- Link between Derbyshire County Council and Tameside MBC: liaise with Derbyshire CC and Tameside MBC to ensure parity between services offered to Glossop residents that are being offered to both Derbyshire and Tameside residents. Examples of recent work include agreements made around Sharp Bins collections, Larcs and IUDs, NHS Health Checks and Enuresis services.

- Community Specialist Paramedic – work closely with the Glossop CSP in the development of their role to support Glossop Practices. Ensure all identified Good/Best Practice is shared with all Primary Care colleagues.
- Re-zoning of Care Homes – due to the opening of Regency House, undertaking an exercise to re-zone all Glossop Care Homes to ensure process of management is as efficient as possible and no Practice has too much pressure on it in the management of this cohort of patients.
- Over 75 Schemes - Glossop Practices have been successfully running a range of Over 75 schemes that have made a positive impact in a range of areas. Such schemes include an Elderly Care Engagement Champion and a Practice Based Pharmacist.
- Minor Injuries Clinic - Glossop Practices undertook a pilot to deliver a Minor Injuries clinic from the Neighbourhood and has been working successfully to deflect potential attendances/admission in to hospital.
- Glossop MDT/GSF meetings - All meetings take place monthly All Glossop practices hold MDT/GSF meeting with a range of professionals i.e. Macmillan nurses, LTC team, DNs and HVs in attendance.

7.2. Potential pilots to be considered in Glossop include:

- Improved E-referral use - Peer led training to Practices to encourage/improve use of the E-referral system.
- Care Home Zoning (i) – Group of staff to work up the model i.e. GP, nursing expertise practice and community, Community Specialist Paramedic, social care, Care home rep. To ensure any offer covers preventative, proactive and urgent support which reduces demand on all partners and keeps more people in the homes rather than hospital.
- Care Home Zoning (ii) – following completion of the re-zoning exercise, a representative group (i.e. GP, Nurse, PM) visiting all Care Homes and Patients to hold information sessions and alleviate concerns related to the potential changes.
- Bridging the Gap – Young People Mental Health Service to be delivered locally in Glossop.