AGENDA
PRIMARY CARE COMMISSIONING COMMITTEE

Date: 14th June 2018

Time: 12.00pm to 13.25pm

Venue: Bevan Room, 2nd Floor, St Peters House

Item No.	Time	Duration	Subject	Paper/Verbal for Approval, Discussion or information	By Whom
1.	12.00pm		Apologies for absence.	Verbal	All
2.	12.00pm		Declarations of Interest.	Verbal	All
3.	12.00pm	5 mins	Minutes from the last meeting of the Primary Care Commissioning Committee held on 12th April 2018.	Paper – for approval.	All
4.	12.05pm	5 mins	Report from the Primary Care Operational Group meeting held on 10th May 2018.	Paper – for information	Lynda Helsby
5.	12.10pm	15 mins	Bolton Quality Contract:- • Options for Year 4 Payments under the Bolton Quality Contract (2018/19). • Proposal for the development of an acute visiting service.	Paper – for information Paper – for discussion.	Lynda Helsby Lynda Helsby
6.	12.25pm	10 mins	Special Allocation Scheme (previously the Violent Patient Scheme) – further detail on the local process and appeal panel representation.	Paper – for discussion	Kath Oddi
7.	12.35pm	10 mins	Primary Care Investment Agreement – May 2018 Update.	Paper	Lynda Helsby
8.	12.45pm	10 mins	Update on the Practice Relocation application.	Verbal – for discussion	Kath Oddi
9.	12.55pm	10 mins	Health Check Programme Update.	Verbal – for discussions	Lynda Helsby
10.	13.05pm	5 mins	Estates Update.	Verbal – for discussion	Kath Oddi
11.	13.10pm	5 mins	Any Other Business:- • Access Audit.	Paper	Lynda Helsby
12.	13.15pm	5 mins	Chair reflection on significant decisions/actions/risks that may need reporting to the Board through these minutes.	Verbal	All
13.	13.20pm	5 mins	Time & Date of Next Meeting: 16th August 2018 at 12pm in the Bevan Room, St Peters House.	Verbal	All
14.	13.25pm		Dates/times in 2017 – bi-monthly - 2nd Thursday of the month from 12pm to 2pm in the Bevan Room, SPH: • 11th October 2018 • 13th December 2018		
15.	13.25pm		Exclusion of the Public:- *"That publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, and that the public be excluded".*		

MINUTES

Primary Care Commissioning Committee

Date: 12th April 2018

Time: 12.00pm

Venue: The Bevan Room, 2nd Floor, St Peters House

Present:

Alan Stephenson (AS)	**CCG Lay Member (Chair of Committee)**
Stephen Liversedge (SLiv)	**CCG Clinical Director, Primary Care & Health Improvement**
Su Long (SL)	**CCG Chief Officer**
Stacey Walsh(SW)	**Local Practice Manager representative**
Kathryn Oddi (KO)	**CCG Head of Primary Care Contracting**
Lynda Helsby (LH)	**Associate Director, Primary Care & Health Improvement**
Ian Boyle (IB)	**CCG Chief Finance Officer**
Ann Gough (AG)	**GM Health & Social Care Partnership, Primary Care Team representative**
Jack Firth (JF)	**Health Watch Representative**

Minutes by:

Joanne Taylor (JT)	**Board Secretary**

Minute No.	Topic
17/18	**<u>Apologies for Absence</u>** Apologies for absence were received from:- • Steven Whittaker, Local GP representative. • Jackie Murray, CCG Deputy Chief Finance Officer. • Sara Roscoe, GMH&SCP Primary Care Team representative.
18/18	**<u>Declarations of Interest</u>** **Stephen Liversedge and Stacey Walsh declared an interest in all the items on the agenda due to potential financial conflicts of interest.** **The Chair agreed that for each item, views would be taken on the potential conflicts of interest to confirm if these members could take part in any voting or decisions taken.** It was noted that declarations declared by members of the Primary Care Commissioning Committee are listed in the CCG's Register of Interest.
19/18	**<u>Minutes from the last meeting held on 8th February 2018</u>** Members were informed that the CCG Board has agreed to change the terms of reference of the Committee to include 2 elected members from Bolton Council plus one council officer. The Committee Chair has contacted the Council Leader and is currently awaiting confirmation on the Council membership. **The minutes were approved as a correct record.**

20/18	**<u>Report of the Primary Care Operational Group meeting held on 8th March 2018</u>** The last meeting of the Operational Group was cancelled, however an informal discussion was held with GMH&SCP colleagues. The Committee was informed there were no specific items to raise that were not already on the agenda.
21/18	**<u>Bolton Quality Contract (BQC):-</u>** **<u>Update on the funding for the BQC for 2018/19</u>** The announcement on the national uplift to the global sum rate was still awaited. It was noted that the CCG now has the information on the % uplift but how this applies to the global sum is not yet known until further information is received. **A report will be presented to the Committee on options available once further information was received.** **<u>Proposals for the development of an acute visiting service</u>** Further to discussions held at the last meeting, it was agreed that the proposals on the development of an acute visiting service be presented to the Committee at a future meeting. Members were informed that work has developed to review how acute visiting services are provided across the country, this includes a review of the number of home visits currently being carried out in Bolton. The primary care team is also looking at national figures, which is showing that 75% of home visits are for patients over 65. The CCG is also commencing a pilot around ambulance deflections and alternatives to transfer to scope out this proposal further. **The Committee noted the update and agreed to receive the proposal at the next meeting.**
22/18	**<u>Special Allocation Scheme (previously Violent Patient Scheme) – Further Detail on the Local Process</u>** Further to the previous update received, the Committee was informed of the local process under development to bring consistency of provision to the service previously known as the violent patient scheme. To ensure the process is aligned with the regulations and policy, NHS England has directed PCSE, with effect from Monday 5th February 2018, to action immediately i.e. on the same day, all requests from GP Practices for removals under these regulations. This will require each CCG to establish an SAS Team to review all referrals onto the scheme as well as an SAS Panel which would hear any appeals from patients. Kathryn Oddi is the CCG's link for the scheme and will support the process for appeals as and when this is required. **The Committee noted the update and agreed a further report on the process and appeal panel representatives would be presented to the next meeting.**
23/18	**<u>Primary Care Investment Agreement – March 2018 Update</u>** The Committee received an update on the report as at March 2018. The report detailed progress on each project in the primary care investment agreement and the Committee reviewed each project in detail.

	Members discussed the remaining five nursing homes that still require a GP link and agreed to review options to ensure these nursing homes were covered. Ann Gough also highlighted the GM offer available with regard to the GM excellence programme and supporting CCGs locally to move towards a sustainable model. External facilitation and input from RCGP and a training provider of choice was made available to the CCG. **The Committee noted the update and agreed to receive a further update at the next meeting.**
24/18	**<u>Update on the Practice Relocation Application</u>** An update was received, further to previous discussions held by the Committee on the practice relocation application. The Committee has previously approved the application in principle, with the caveat that there is no increase in revenue and full patient consultation is undertaken. Members were informed that a full patient consultation has now been undertaken. However, there is further work to be finalised on current market rental and financial options before the final application can be approved. **A further update will be reported to the Committee at the next meeting.**
25/18	**<u>Access Audit Update</u>** The report details the outcome of the access audit undertaken in November 2017. The report details the expectations from this standard. The access audit has highlighted:- • On average practices have provided 25,746 contacts per week; this is 83.43 per 1000 population. • 3.6% of appointments are DNA'd. • 7.7% of appointment slots are empty. • Of the 49 practices, 10 practices have not achieved the target of 75 contacts per 1000 population. The Committee considered whether the penalty be applied to the 10 practices that have not achieved the target to provide 75 contacts per 1000 population and noted the next step is to write to practices informing them of the decision and the right to appeal. The CCG primary care, however, is intending to recount the contacts in these 10 practices for data quality to mitigate any appeals due to data issues. It was noted that one practice refused the access audit in practice due to concerns around patient confidentiality. The practice provided a list of contacts. However the list did not include DNA's. **The Committee agreed with principle of maintaining the integrity of the Contract and agreed to give notification of a penalty and that an appeals process would be put in place if practices appeal.**
26/18	**<u>Estates Update</u>** Members were informed that in March three schemes under the ETTF scheme have now been approved. The schemes will now be progressed further. There are also two enhanced PIDs progressing for two health centres, which are now at the design stage. The Committee also received an update on the Horwich development. **The Committee noted the update.**

27/18	**Any Other Business** There was no further business discussed.
28/18	**Chair Reflection on significant decisions/actions/risks that may need reporting to the Board through these Minutes** The main areas to be highlighted to the Board through these minutes were noted as:- • Proposal for an acute visiting scheme. • Outcome of the Access audit.
29/18	**Time and Date of Next Meeting** Agreed as 14th June 2018 at 12pm in the Bevan Room, St Peters House.
30/18	**Proposed dates/times for meetings in 2018** Agreed to hold bi-monthly on the 2nd Thursday of the month from 12pm to 2pm in the Bevan Room, SPH (with the exception of August): • 16th August (at 12.30pm) • 11th October 2018 • 13th December 2018
31/18	**Exclusion of the Public** "That publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, and that the public be excluded".

Bolton Clinical Commissioning Group

Primary Care Commissioning Committee

AGENDA ITEM NO: ………4………………

Date of Meeting: ……14th June 2018………………………

TITLE OF REPORT:	Report from the Primary Care Operational Group meeting – 10th May 2018
AUTHOR:	Joanne Taylor, Board Secretary
PRESENTED BY:	Lynda Helsby, Associate Director Primary Care and Health Improvement
PURPOSE OF PAPER: **(Linking to Strategic Objectives)**	To update the Primary Care Commissioning Committee on discussions held at the last Primary Care Operational Group.
RECOMMENDATION TO THE COMMITTEE: **(Please be clear if decision required, or for noting)**	To note the discussions held and comment further on any of the items discussed.

Report from the Primary Care Operational Group meeting – 10th May 2018

1 Executive Summary

This report provides a summary of the discussions held at the last meeting of the Primary Care Operational Group meeting held on 10th May 2018.

2 Attendees

- Kathryn Oddi, CCG Head of Primary Care Contracting (KO).
- Claire Donovan, CCG Head of Management Accounting (CD).
- Andrea Ferguson, GMH&SCP Primary Care representative (AF).
- Andrea Thomas, CCG Primary Care Contract Manager (AT).
- Irfan Uddin, CCG Primary Care Finance Team (IU).

3 Items Discussed

Minutes from the last meeting held on 11th January 2018
The minutes were agreed as a correct record.

It was noted that the last meeting held on 8th March was an informal discussion and no formal minutes were recorded.

The matters arising that were discussed were:-

- AUA DES – IU updated members on the notification received from NHS England that the budget and funding for this was for the end of the financial year 2016/17 and no further funding will be available going forward. This relates to the reconciliation of final payments and it was noted that Lynda Helsby has taken appropriate action on the appeals received and processes in place to make the required payments. No further outstanding action required.

  AF agreed to forward to CD an email confirming actions taken and costs involved.

- Patient access to online services – Members discussed the need to differentiate between the two types of online services available. One relates to a consultation developing on online access via skype etc., whilst the other relates to online ordering of prescriptions etc. The CCG liaising with GMH&SCP on developments around practices promoting and engaging services available with their patients. The group discussed any links required with GDPR requirements.

  AF agreed to seek further information on GDPR requirements.

- Child Health Surveillance – AF confirmed that an update on the issue previously reported regarding a Bolton practice is still awaited.

  AF to raise the issue further.

- Clinical Waste – the update received at the recent GM Primary Care Leads meeting confirming the financial increase with the provider was reported. It was noted that there will be an overall increase for CCGs of around 2.5%.

Feedback from the last PCCC Meeting:-

BQC Contract Changes
The Group was updated on the changes to the BQC contract. The PCCC and CCG Board have now approved a 3 year commitment to the contract and 20 standards have been agreed for 2018/19.

Members noted that notification of the global sum rate was still awaited. The CCG continue to work on an indicative rate until the information is received. When this is received, a review of options available will be presented to the PCCC. It was noted that current payments to practices will continue until a reconciliation can be undertaken.

Acute Visiting Service Proposal
It was noted that, from early discussions with practices, there is an appetite from the majority to sign up to this service. Further work continues to develop the proposal further.

Branch Surgery Opening Hours
Members were updated on the work continuing in the primary care team to review branch surgery opening hours across Bolton. The team know only of one practice with a branch surgery that opens within core hours. Members noted it is not within the core contract to open branch surgeries within core hours but is in the BQC contract.

Part of the review by the primary care team is to identify if any differentials need to be applied, ie., because a branch surgery may be the main surgery in one area.

Special Allocation Scheme
AF updated on the GM network meeting held that week to review the scheme and how this is progressing. KO requested clarification around the review and appeal panel processes, in particular which organisation is responsible for which parts.

AF agreed to check and confirm process.

Access Audit Update
The group noted the report reviewed by the PCCC.

Primary Care Performance:
Quarterly Performance Dashboard
The performance update would be circulated with the minutes from this meeting.

GMH&SCP Report on Contractual Changes
A copy of the current briefing was tabled and reviewed by the group. The briefing included an update on contractual changes, PMS and APMS update, remedial breach notices, CQC update, QoF update and minor surgery claims and PCV for babies.

A copy would also be circulated with the minutes from this meeting.

Individual Performer Affairs/Issues from CCG Reference Group
KO updated the group on current performer issues in particular:

- GP Partner Dispute – Members were informed that the CQC is visiting the practice again this week, this is further to lack of response from the enforcement notices issued and no improvement seen. It was noted that the CCG is liaising with solicitors on the contractual options available to the CCG, acknowledging that patient safety remains the main priority.

- Update on GP Concerns – The group was informed that the outcome from the formal desk top review undertaken by NHS England's Practice Advisory Group was awaited and would be reviewed and discussed further at the next CCG GP Reference Group.

Contracting:

Application from practice to relocate practice premises

KO updated the group on the application by a practice to move premises and the agreement in principle by the PCCC to develop this proposal further with the caveat that there is no increase in revenue and full patient consultation is undertaken.

KO is reviewing likely rental costs with GMH&SCP. It was reported that, at this stage, some patient engagement and EIA has been undertaken.

AF agreed to review district valuation processes and the best option to move this application forward.

Update on application to close practice list

KO has chased up the practice regarding their application. A response is awaited.

Review of Practice Boundary – AF highlighted a query received from a GP practice to review their practice boundary. KO and AT were aware of the request and AT was working up a review of boundary options to take to the PCCC.

AUA Enhanced (2%) DES Appeals Update

Previously discussed earlier on the agenda.

Primary Care Investment Agreement

An update on the developments with the GP Excellence Scheme was presented. Members discussed other options and possible additional funding available for use by practices requiring areas of support. The group discussed possible support in the areas such as business resilience, continuity planning etc.

It was agreed to discuss these options further through the CCG GP Reference Group.

Estates Update

KO updated the group on the 3 ETTF funding applications that have been approved from slippage last year, namely Kearsley Medical Centre, Peter House and Beehive Surgery.

The other applications developing for Avondale and Farnworth were also highlighted.

Finance Update

CD updated on the current financial position. It was reported that the co-commissioning budget is £450k underspent, mainly due to APMS and contract reserves which the CCG is required to hold. It was also noted that prescribing spend has been significantly underspent towards year end. Therefore a general underspend on primary care budgets at month 12.

The CCG has discussed with NHSE colleagues to agree what funding can be carried forward into next year's budgets.

Other Primary Care Contractors:

Pharmacy – EPS

AF has requested information on pharmacies across Greater Manchester who use EPS.

AF to update the group on information received.

Optometry
Nothing to report.

Dental
Nothing to report.

Any Other Business
Clinical Waste – IU also confirmed that he is undertaking an audit check to ensure all practices are using the same provider, as it has come to light that one practice is using a different provider.

4 Recommendations

The Committee is asked to note the discussions held and comment further on any of the items discussed.

Name of person presenting the paper: Lynda Helsby
Title: Associate Director, Primary Care and Health Improvement
Date: June 2018

Bolton Clinical Commissioning Group

Primary Care Commissioning Committee

AGENDA ITEM NO: ………5………………

Date of Meeting: ……14th June 2018………………………

TITLE OF REPORT:	Options for Year 4 Payments under the Bolton Quality Contract (2018/19)
AUTHOR:	Lynda Helsby / Jackie Murray
PRESENTED BY:	Lynda Helsby / Jackie Murray

PURPOSE OF PAPER: (Please be clear e.g. decision(s) required, a discussion, for noting)

This paper offers a number of options for consideration in relation to the level that the price per patient should be set at during the Bolton Quality Contract's fourth year in light of the **proposed indicative uplift** to the Global Sum Rate (the national price per patient for 'core primary medical services) for 2018/19

FINANCIAL IMPLICATIONS [discussed with Chief Financial Officer]:

Deputy CFO

COMMITTEES/GROUPS PREVIOUSLY CONSULTED:

N/A

RECOMMENDATION(s)

The Primary Care Commissioning Committee is recommended to choose Option 2, with Standard 20 continuing to be paid separately as an additional £3 per weighted patient for 2018/19.

In the event that the proposed indicative uplift is different to the final uplift, then it is recommended that the same principle is adopted.

OPTIONS FOR YEAR 4 PAYMENTS UNDER BOLTON QUALITY CONTRACT

1.0 Summary and Purpose of Report

The Primary Care Commissioning Committee (PCCC) has recommended to NHS Bolton Clinical Commissioning Group (CCG) Board the continuation of the Bolton Quality Contract (BQC) as a 3 year contract.

In the first year of the BQC, each practice that signed up to the Contract received a minimum of £95 per weighted patient to deliver 'core' primary medical services plus the nineteen standards included in the BQC itself.

In the second year, the CCG PCCC recommended to the CCG board continued investment in primary care with funding to support an additional standard and the national uplifts, resulting in practices receiving a minimum of £102.45 to deliver 'core' services and twenty standards.

In the third year, the CCG PCCC recommended to the CCG board the continuance of the BQC and to include the national uplifts to the Global Sum rate, bringing the value to £107.21 to deliver 'core' services and twenty standards.

This paper offers a number of options for consideration in relation to the level that the price per patient should be set at during the Contract's fourth year in light of the **proposed indicative uplift** to the Global Sum Rate (the national price per patient for 'core primary medical services) for 2018/19

2.0 Context

From the 1st April 2016, under Level 3 Joint Commissioning arrangements with NHS England, the CCG has been responsible for the commissioning of 'core' primary medical services and their associated payments. Core primary medical services include the provision of:

- 'essential' services (management of patients who are ill, terminally ill or living with a chronic disease), and
- 'additional' services (e.g cervical screening, maternity services etc)

The CCG is also now responsible for payments relating to the delivery of Directed Enhanced Services (DESs) and the Quality and Outcomes Framework (QOF).

Under these arrangements, NHS England still retains ultimate accountability and control in relation to how much national resource is allocated to primary care, and for core GMS/PMS/APMS contractual terms and conditions. However, responsibility for all decisions concerning the commissioning of the core GP contract and the enhanced services commissioned by NHS England, as well as the associated risks arising from in year pressures on the delegated budget, sits fully with the CCG. This latter point being an important factor when considering the options detailed later in this paper.

3.0 Brief summary of previous funding allocations

3.1 Calculation of Payments under BQC for 2015/16 – Year 1

Nineteen standards
During the first year of the BQC, all 50 Bolton practices signed up to deliver the 19 standards and the CCG 'leveled up' each practice's contract payment to **£95** per weighted patient.

3.2 Calculation of Payments under BQC for 2016/17 - Year 2

Addition of Standard 20 – Working in Integrated Neighbourhood Teams
The CCG Board has agreed that, from 1st April 2016, **all** practices will receive an additional **£3.00** per weighted patient for delivery of this new standard, regardless of how much they currently receive for delivery of core services. This funding reflects the time practices will need to review patients regularly, particularly on discharge from hosptial, and to meet with the integrated neighbourhood team. It is a discrete payment, over and above the price per patient funding for standards 1-19 of the BQC. Following the national increase to the global sum rate (£4.45) this resulted in an increase BQC payment of £7.45 (£4.45 + £3), increasing the minimum payment to **£102.45** per weighted patient.

3.3 Calculation of payments under BQC for 2017/18 – Year 3

There were minimal changes to the BQC in 2017/18 and it was agreed that standard 20 would continue.

GMS Contract negotiations resulted in a £238.7m investment in the GP contract for 2017/18. The investment took into account increasing expenses covering:

- A pay uplift on pay of 1%
- An increase in the value of a QOF point to £171.20
- The payment fee for the Learning Disability DES from £116 to £140
- Changes and increased payments to the GP retention scheme
- Funding to cover expenses related to additional CQC business improvement district (BID) levies costs
- Costs and other increased business expenses

There has been a transfer of £157m from the avoiding unplanned admissions enhanced service into core funding.

This resulted in an increase to the Global Sum rate of £4.76, bringing the BQC payment to £107.21.

4.0 Options for BQC Price per Patient 2018/19 - Year 4

The table below outlines the three possible options for setting the price per weighted patient 'tariff' in relation to standards in the BQC for 2018/19

The PCCC is also asked to consider the £3 funding for Standard 20. For the last 2 years this was kept as a separate payment from the BQC funding for standards 1-19 as it was felt this funding was key to engage practices in Standard 20 and this funding is dependent on the agreement of the commissioning partnership board to continue with this additional standard/

Therefore the options can be further broken down to include / exclude the £3 from the core funding.

Options range from:
1. No change from the tariff agreed for 2017/18,
2. Application of the full £2.57 increase to the global sum for 2018/19.
3. Application of the 3.4% uplift to BQC in line with the % uplift to Global Sum.

	Options	Amount Per Weighted Patient	CCG Investment required (£5,833k in 2017/18 incl Std 20)	Description
1a. **1b.**	**'No Change'**	£107.21 £104.21 + £3.00 separate	£5,843k £4,878k + £945k	No increase – payment per weighted patient in relation to standards 1-20 remains the same previous year.
2a. **2b.**	**Total Global Sum Uplift (£2.57)**	£109.78 £106.78 + £3.00 separate	£6,015k £5,070k + £945k	This increase reflects the total increase to global sum rate for 2018/19.
3a. **3b.**	**Total Global Sum uplift + 3.4% applied to BQC element**	£110.42 £107.42 + £3.00 separate	£6,187k £5,242k + £945k	This increase reflects the 3.4% increase to global sum rate for 2018/19.

The financial impact of the 3 options are:-

- Option 1 - increase in the 2017/18 level of investment by £10k,*
- Option 2 - increase in the 2017/18 level of investment by £182k,
- Option 3 - increase in the 2017/18 level of investment by £354k.

*This is due to an increase in list sizes

6. Recommendation

The CCG has not planned for the level of increase for Option 3 and would need to increase its QIPP target to cover these costs.

Option 2 is recommended as this ensures practices receive the benefit of the Global sum increase of additional £2.57.

In light of the CCG's commitment to invest in primary care, and to ensure continued commitment sign-up to BQC from general practice, Primary Care Commissioning Committee is asked to consider Option 2 as the preferred option. This recommendation will be ratified at the CCG Board meeting in July.

L Helsby / Jackie Murray
June 2018

CCG Primary Care Commissioning Committee

AGENDA ITEM NO: ………5…………

Date of Meeting: ………14th June 2018………………..

TITLE OF REPORT:	Proposal for the development of an Acute Visiting Service
AUTHOR:	Lynda Helsby, Associate Director Primary Care & Health Improvement
PRESENTED BY:	Lynda Helsby, Associate Director Primary Care & Health Improvement
PURPOSE OF PAPER: (Please be clear e.g. decision(s) required, a discussion, for noting) The Committee is asked to review the proposal attached for the development of an acute visiting service.	
COMMITTEES/GROUPS PREVIOUSLY CONSULTED: Primary Care Commissioning Committee. CCG Executive.	
RECOMMENDATION(s) The PCCC is asked to discuss the contents of this paper and the merits of a ‘pilot’ AVS over the winter months.	

Acute Visiting Service - Overview of proposal

1. Background

It has been demonstrated that early home visits lead to a greater chance of avoiding hospital admission. A patient safety alert, March 2016, states that there is *"risk of death from failure to prioritise home visits in general practice"* and *"when a request for a home visit is made, it is vital that general practice have a system in place to assess:*

- *Whether a home visit is clinically necessary: and*
- *The urgency of need for medical attention*

Acute visiting services (AVS) have been set up across the country in order to reduce unscheduled hospital admissions. The aim is to provide rapid access doctors for acute care at home for patients who, if they are not visited rapidly are at risk of admissions. Areas that implemented such schemes have seen significant reductions in hospital attendances.

The normal work pattern of GPs can results in waits of over 2 hours and sometimes up to 6 hours for many patients requiring a home visit. If a patient or carer is anxious they will often not wait to see the GP and, instead go straight to A&E. In this setting, due to a potential lack of knowledge about the patient, they are quite often being admitted unnecessarily.

Once a GP does visit, if it is deemed that the patient requires urgent admission then the GP organises this with the hospital and this results in a large number of admissions in the afternoon, particularly for those patients needing hospital transport. Hospitals do experience a large proportion of emergency admissions during the period of 3-7pm, creating pressure on admissions units and the emergency department.

GP recruitment, retention and workload are ongoing issues, and should be a key consideration for Primary Care (GP Forward View).

It is also expected that requests for home visits will rise due to an ageing population, who make up significant proportion of home visit requests, leading to additional pressures on GP practices to provide equitable, high quality care.

Acute Visiting Services are challenging traditional models of working in General Practice. Successful delivery across the country has persuaded patients, GPs and commissioners that innovative methods of delivering traditional care can have benefits at multiple levels. Traditionally there has been a rigid definition of core GMS work. 'The AVS' demonstrates that it is possible to work across these barriers and integrate core GMS services with new care pathways to deliver an enhanced service which provides outstanding patient care.

Much has been written about the reasons which lead to an emergency admission. It is suggested that many patients were admitted for assessment because of three main reasons.

1. Primary care capacity – GPs were already working to saturation in many practices and were generally able to spend less than 10 minutes with a patient on home visits. This was not enough time for detailed evaluation of other alternatives and frequently resulted in admission as the safest option.

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2. Patient and carer expectations – most of those requesting a home visit were genuinely concerned about the seriousness of the medical condition, or because of the 24/7 lifestyle many people now lead needed rapid access to healthcare to allay their concerns. If the GP could not visit within the timeframe to suit their expectations, then the risk of the patient or carer dialling 999 or attending A&E was high and often resulted in an emergency admission.
3. Defensive practice - many admissions were initiated because GPs felt unable to disrupt planned work for fear of complaints and so felt unable to risk delay attendance for home visits in case of deterioration of the clinical situation. This dilemma frequently resulted in admission as a safer option for the patient.

General Practice has evolved in such a way that to expect practices to deal with planned and urgent care at the same time is not sustainable. We needed to look at how to separate them to make them both more efficient and effective.

We have the opportunity, ahead of this winter, to scope an AVS for Bolton (proof of concept) – utilising winter resilience monies (although these have not yet been confirmed) or practice transformation funding. Please note these funding streams are non-recurrent. If successful, recurrent funding would need to be identified.

This paper will outline the aims and objectives of an AVS, evidence from other schemes, proposed service delivery model and potential costs.

2. Aims and Objectives

Objectives

A service to address immediate health needs of patients contacting their GP practice and describing symptoms which, when reviewed by the GP, as deemed appropriate for an AVS intervention, thus reducing a potential hospital attendance and improving sign posting into alternative community pathways

An AVS schemes aims to:

- Reduce emergency admissions/A&E attendances
- Improve access to General Practice by releasing capacity for planned care
- Support secondary care over the winter period where admissions and A&E attendances are higher
- Achieve improved patient satisfaction with response times
- Increase use of community pathways as an alternative to admission
- Reduce emergency hospital admissions from care homes

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3. Bolton CCG Position

During December 2017, Bolton CCG undertook an audit with GP practices. The practices were asked to report how many GP visits were undertaken each day in the morning and the afternoon.

Morning					Afternoon				
Mon	Tues	Wed	Thurs	Fri	Mon	Tues	Wed	Thurs	Fri
230	153	180	152	148	21	15	17	21	19
TOTAL 863					**TOTAL 93**				

We did not, however, collect the age of the patients. Similar schemes have reported that 75% of home visit requests are for patients over 65 and 60% are over the age of 75.
We also did not collect whether these visits would have been deemed urgent or routine.

However, Westhoughton neighbourhood have looked at the breakdown for acute on the day versus review visits and found approx. 75% were on the day acute requests.

GP engagement thus far has been informal, and we have received a mixed response to the concept of an AVS for Bolton.

Some GPs prefer to undertake their own home visits acknowledging they know their patients and will undertake comprehensive holistic assessments. Whereas others have stated they would use an AVS were it available.

4. National Evidence

Whilst reviewing the national evidence, many other schemes reference the service commissioned by St Helen's CCG.

St Helen's CCG found that, in the first six months of piloting an AVS, 370 visits were made, resulting in only four hospital admissions. A detailed analysis of 118 of these visits revealed that referral into the AVS avoided approximately 30% of admissions. This figure resonates with national statistics which suggest that 30% of patients in hospital are admitted for less than 24hours (Dr Foster 2012), suggesting that perhaps they should not have been admitted at all. The AVS outcomes strongly indicate that these 'zero days' admissions can be avoided in many cases by having appropriate rapid access in the community.

The two main reasons identified for the successful outcomes achieved by the AVS were the speed with which patients were seen and assessed and also the time the AVS doctor was able to spend with each patient. Patients felt reassured because anxiety about their illness was quickly allayed and the extended consultation allowed time to ask questions and discuss options other than hospital admission.

An unexpected benefit has been the increased capacity for planned appointments. GPs no longer have to leave unexpectedly for urgent home visits which can take up to 30 minutes once travel time is included, so on average each surgery can now offer two additional

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appointments per day. This is clearly a better and more productive use of existing clinical resources and equates to an extra fulltime GP across the CCG without any additional funding.

A full presentation of evidence from St Helens is embedded here.

St Helens AVS presentation.pdf

The *Heywood, Middleton & Rochdale CCG* evaluation report states if their service wasn't operational, 63% of cases may have resulted in an attendance at A&E. Of these they also estimated the service deflected a number of complex elderly patient admissions. In the 6 month pilot (seeing almost 1500 patients) they report a saving of £130,000.

Evidence (based on outcomes from St Helens) presented by Ashfield & Newark CCG, (practice population 151,217), to their Primary Care Commissioning Committee suggested that by implementing the service they could prevent 572 non-elective admissions and save £772,000. This was based on an assumption of one admission saved for every 51 visits. The total cost to implement FYE was £597,200 therefore the actual savings were £174,800

5. Service Delivery Model

<u>Service Delivery Model</u>

There are several delivery models that could be considered from a service that undertakes ALL home visit requests to selected / targeted visits.

1. One option is that an acute visiting service accepts all home visit requests.
2. Another option is a frail Home visiting service – to deliver higher quality care for frail vulnerable patients (at practice level, as a more proactive approach)
3. Another option could be that GP practices will still be responsible for carrying out routine home visits including, and not limited to, medication reviews, chronic disease management reviews and domiciliary flu vaccinations. These visits can be carried out by suitably qualified healthcare professionals and not necessarily GPs. Any acute requests could be triaged to an acute visiting service

Whilst reviewing many schemes, it is clear that services are using a wider workforce, rather than just GPs, e.g. paramedics, nurse practitioners and consideration will also need to be given to the workforce used within Bolton

In any option the service should link closely with GP practices including planned services such as practice / neighbourhood based mental health workers, Physiotherapists, Community Paediatric Nurse etc, Community Services, the admission avoidance team, out of hours services and other patient services as necessary.

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Service Delivery Times

Again there are differing operational hours up and down the country

1. The Acute Home Visiting service could be operational during the same core hours of the GP practices. This is currently 8am – 6.30pm. However, as practices move towards extending their hours the Acute Home Visiting service will adapt to be able to serve these GPs during their new working hours. This can be achieved via shift working, with the emphasis still being on visits carried out early in the day with skeleton staff available later in the day to deal with any late visit requests. This could overlap with current out of hours services but may support 'shoulder time calls'
2. The service could be from a local provider which provides the driver and vehicle and manages the calls. There would be a mobile, community-based doctor available between 9:00 am and 6:30 pm. Using a local provider, and hopefully local GPs on a sessional basis to make the visits would be preferable so they are familiar with local services and care pathways.

In any model, previous areas have found that increasing numbers of doctors are retiring early or going part time in their own practices and this has helped as they are available for this work. These GPs have found it very satisfying – there is no QOF work, no tick box exercises, no prompts to achieve targets, they are just seeing the patient and can spend twenty minutes with them to more fully explore the options for integrated and community care, helping the patient to make a safer choice to stay at home, essentially assessing-to-admit rather than admitting-to-assess.

It is also noted that the service should aim to visit within 60 minutes, ideally within 30 and have access to the patient's clinical records but as a minimum the basic clinical history and information including the following:

- Direct access telephone number for practice with named contact in case of queries
- Presenting complaint
- Relevant history
- Repeat medication list

Access to an Acute Visiting Service

The patient should contact their own GP to make a request for a home visit, they should be triaged and if appropriate a referral can be made to the AVS (see pathway at appendix 1).

Previous schemes noted that it was vital that the referral came via the patient's own practice. GPs know their own patients and their circumstances and can make a safe decision about their needs and the appropriateness of their request. It also means that the patient has confidence in the decision about whether they should receive a visit as they have spoken to the practice with which they are registered and familiar.

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If the patient referred themselves into the service there is a risk of inappropriate self-referral as well as the risk that the patient would still end up contacting their own practice for reassurance.

The GP or nurse at the patient's own practice should use a standard form to triage and refer into the service and tell the patient that, although they are unable to visit at the moment, their colleague is working within the local area and is able to visit within the next hour. The AVS GP is described as part of the practice team and introduces them as from the practice at each visit so the patient is more accepting of the service.

A completed visit sheet is sent to practice at end of each session.

Other schemes have also required, if there is a quiet patch, they have a cold case load for the visiting doctors to work on, carrying out reviews in all our care homes and re-visits or telephone reviews for those at higher risk of admission or readmission.

6. Bolton Requirements

Bolton has a registered population of approx. 300,000. We can assume from the data collection exercise undertaken by primary care that currently there are approx. 50,000 home visits by GPs per year.

Dependent on service delivery model:

Full AVS – approx.50,000 visits per year – on average 150 – 230 per day, depending on the day

Acute visit requests only – 37,500, based on assumption from analysis done in Westhoughton (approx. 75% were on the day acute requests), potentially on average **112-172 per day**, depending on the day

If an average visit takes 40 minutes per day (Including travel) this would save 25,000 hours of GP time across Bolton, which could be freed up to focus on longer appointments for the complex patients.

An alternative would be to 'allocate' each practice a number of home visits slots, based on list size, and let the practice decide which patients are suitable for a home visit and which they would prefer to undertake themselves.

7. Benefits and Outcomes

Under this proposal there are many benefits and outcomes:

1. An early visit prevents the admission to secondary care with the services in place to ensure that patient remains at home.
2. If a visit to A&E is necessary for diagnostic tests this will happen earlier in the day. This enables the consultant to assess the patient and for any required community support to put in place promptly enabling the patient to be sent home rather than be admitted.

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3. If admission to secondary care or a step up bed is deemed to be necessary following the acute home visit, it will be earlier in the day facilitating better clinical planning and an improved patient experience.
4. Increased capacity for planned appointments and longer appointments for GPs to see the more complex patients.
5. Time freed up could also be beneficial for those GPs that wish to engage more in the work of the neighbourhoods, either in a provider or commissioning role. Or engage in clinical leads roles for specialist areas, referral reviews etc.
6. An AVS would distribute the activity better throughout the day, therefore this could be better for the ambulance service and would help to reduce the "batching"

8. Finance

On review of several visiting services, the costs to deliver are very different.

Year	Area	Costs per patient / population	Costs for Bolton population
2013	HMR (GP)	£1.55	£465,000
2016	Ashfield (ANP)	£3.95	£1.18m
2016	St Helens (GP)	£8.00	£2.4m

NB: operating hours may be different

The CCG has recently requested a costing for an acute visiting service to accept any deflections for the nurse practitioner reviewing the NWAS 'stack' of patients requesting ambulance. The finance in this section is based on these costings.

The service submitted a cost of £125,000 for a 3 month pilot (i.e. £42,000 per month) – 7 hours per day – visiting 21 patients. This was based on 2 GPs and 2 drivers.

In order to accommodate 126 visits per day, we would need to commission 6 times this activity and therefore the costs would be £252,000 per month and for a 3 month pilot **£756,000.** (And over £3m FYE)

Considerations:

- Hours of operation
- GP versus ANP
- Demand in am / pm
- Availability of GPs to undertake home visits
- Could this be delivered on a neighbourhood basis, if we allocate an indicative amount to each neighbourhood.

9. Risks and Issues

Recruitment – There are concerns around the ability to recruit a sufficient number of GPs to deliver this service

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Managing fluctuations in demand for visits – The unpredictability of home visit requests on a daily basis may lead to the service reaching capacity and not being able to accept referrals. We need to be transparent with practices in terms of how the service operates so that expectations are managed.

Clinical risk – where does the clinical responsibility lie? With the patients usual GP, or the attending GP / ANP etc.

Access to records – Currently there isn't wider access to clinical records? We would need to scope use of Bolton Care Record

10. Evaluation

The following measures are proposed to evaluate impact.

Impact on primary care workload:
• Qualitative survey of general practice users on the extent to which this has supported them in providing high quality home visits

Impact on quality of care for patients:
• Survey of patients who receive home visits to ask about quality of provision and what they would have done if they had been unable to receive their home visit within 48 hours. (I.e. Might they have called an ambulance)

Efficiency and sustainability of service:
• Review of appointment slots available, utilisation, and patient 'attendance' at home for appointments.
• Audit of referrals for appropriateness

• Audit of length of time taken to undertake home visits by the new service compared to standard practice service
• Review of effectiveness of IT
• Qualitative survey of provider staff on experience of delivering the service

11. Recommendation

Primary Care Commissioning Committee are asked to discuss the contents of this paper and the merits of a 'pilot' AVS over the winter months.

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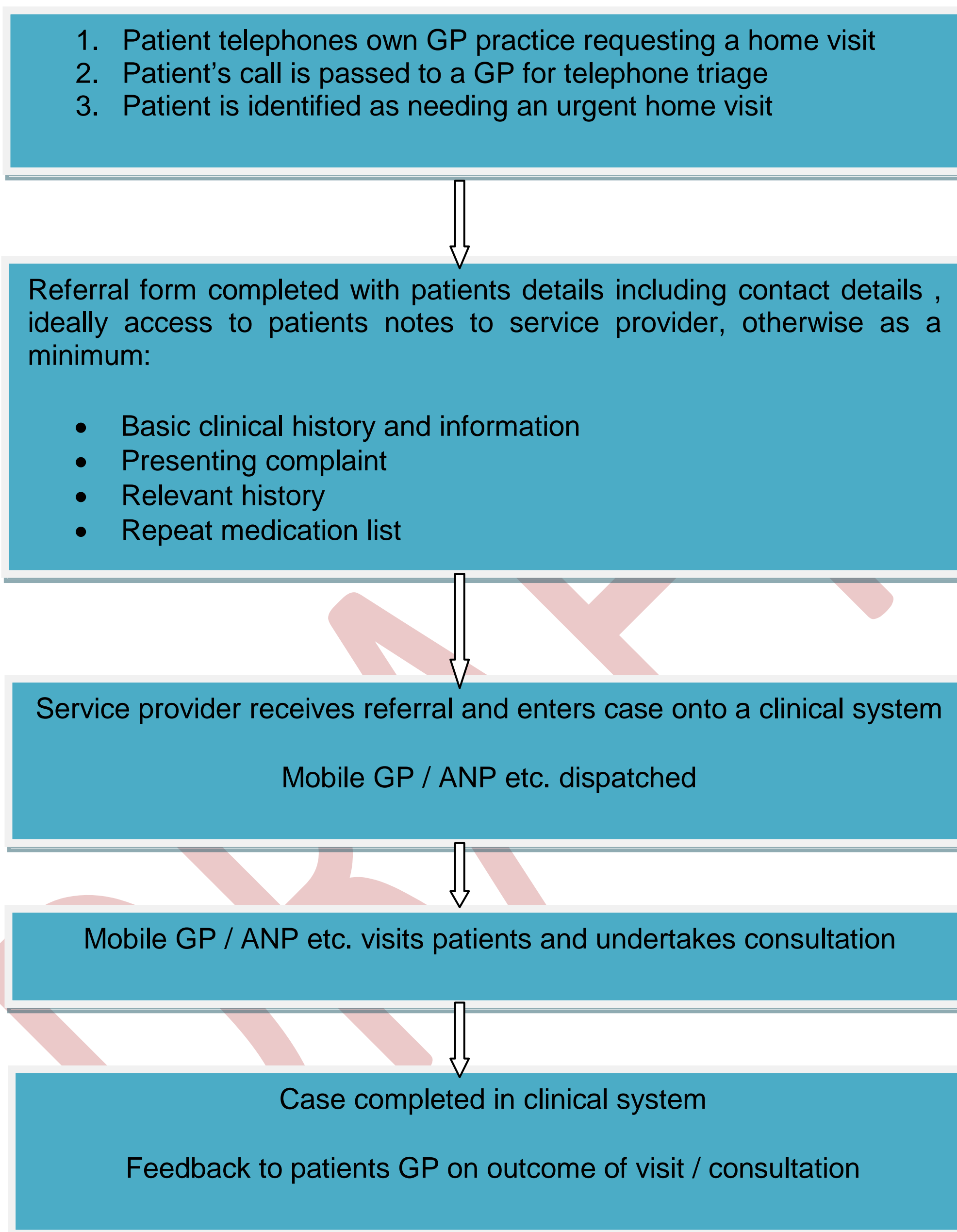
Appendix 1 – AVS Process



CCG Primary Care Commissioning Committee

AGENDA ITEM NO: …………6……………

Date of Meeting: ………….14th June 2018………………

TITLE OF REPORT:	Special Allocation Service (SAS) – Process for Appeals
AUTHOR:	Kathryn Oddi
PRESENTED BY:	Kathryn Oddi
PURPOSE OF PAPER: (Please be clear e.g. decision(s) required, a discussion, for noting) To seek the approval of the Committee regarding the attached document.	
FINANCIAL IMPLICATIONS [discussed with Chief Financial Officer]: **N/A**	
COMMITTEES/GROUPS PREVIOUSLY CONSULTED: Primary Care Operational Group	
REVIEW OF CONFLICTS OF INTEREST:	
RECOMMENDATION(s) The PCCC is asked to support the implementation of the attached process as and when appeals are submitted to the CCG following a referral to the SAS.	

NHS BOLTON CCG
SPECIAL ALLOCATION SCHEME (SAS)
APPEAL PROCESS

1. Context

There will undoubtedly be instances when practices have to deal with patients who are difficult, challenging, aggressive and abusive as well as, in some cases, violent. In order to protect GPs and practice staff, and to allow them to carry out their roles, NHS Bolton CCG commissions a designated GP practice to provide a service to patients by prior appointment and at specific locations and times. This service is known as a Special Allocation Scheme (SAS) and patients are allocated to the SAS following a process of immediate removal as a result of an incident that was reported to the police.

The Regulations regarding the removal of patients who are violent are specific in terminology and the Regulations require that GMS/PMS/APMS contracts provide for "Removal from the list of patients who are violent". However, within the Regulations it is further specified that the grounds on which a contractor may request that a person be removed from its list of patients with immediate effect are that "the person has committed an act of violence against any of the persons specified in subparagraph (2) or has behaved in such a way that any of those persons has feared for their safety".

The Primary Medical Care Policy and Guidance Manual (as updated 9th November 2017) which aims to support a consistent and compliant approach to primary care commissioning across England, makes it clear that 'violence does not have to be physical or actual. It can be perceived, threatened or indeed a perceived threat of violence. A person's fear for their safety can also be actual or perceived' (Chapter 6, para.6.1).

2. The Right of Appeal

All patients have the right to appeal against being placed on the SAS scheme. It should be noted that the appeals process will not delay the immediate removal of a patient from a practice's list following an incident that has been reported to the police and Primary Care Support England (PCSE) by that practice. Similarly, should a patient need to access primary care medical services pending the outcome of an appeal, these should be provided by the SAS.

3. The SAS Liaison Team

Once notified of their referral to the SAS by PCSE, the patient has 14 days from the date of PCSE's letter to appeal in writing, or by email, to the SAS Liaison Team at NHS Bolton CCG. On receipt of an appeal, the SAS Liaison Team will notify the referring GP practice of the appeal and advise the practice to contact the Local Medical Committee for advice and support if needed. The SAS Liaison Team will ask the referring practice to submit information to the Panel to explain why the patient was originally placed on the scheme. This information should include:

- A brief description of the incident;
- Information about previous incidents of violence and aggression by this patient;
- Any written warnings that the patient has received from the practice
- Any current or previous risk assessments;
- A statement describing the impact of the incident on the member(s) of staff involved;

This information should be received by the SAS Liaison Team at least 5 working days prior to the Appeals Panel Review.

The SAS Liaison Team will aim to convene an Appeals Panel within 28 days of receipt of an appeal. The appellant and referring GP practice will be given at least 7 days' notice of the date, time and venue. Both parties will be invited to attend the review if they wish; however, the option of submitting written evidence will also be available to both parties.

4. Membership of the Appeals Panel

The Panel will consist of:

1. Associate Director of Governance and Safety
2. Head of Primary Care Contracting
3. The Chair of Bolton Healthwatch
4. LMC Representative (GP)

The Chair of the Panel will be identified on the day. All members should identify a named deputy to stand in during periods of leave, sickness etc.

5. Purpose of the Panel

It is the role of the SAS Panel to review the evidence provided by the patient in support of their appeal. The Panel may uphold or reject an appeal where it has

reasonably considered that a removal under the regulations was made in error, or inappropriately.

6. Following an Appeal

If the patient's appeal is upheld they will be given a list of practices in their area where they will be able to register without restriction. This should usually include the practice from which they initially were referred. If a patient is unable to be registered it may be necessary for NHS Bolton CCG to liaise with PCSE to allocate the patient to a practice. NHS Bolton will provide all practical support to allow a patient to become successfully registered with a practice.

If the patient's appeal is rejected, the patient will be advised that their registration on the Scheme will be reviewed on a 6 monthly basis by the SAS provider who will ensure regular assessment and monitoring is in place to enable the patient to be repatriated back in to main stream Primary Care as soon as possible.

The SAS Liaison Team will notify the patient of the Panel's decision in writing within 14 days of the Panel Review. The outcome should be notified to the referring GP practice first, however.

The SAS Liaison Team will inform PCSE of any upheld appeals via: Pcse.immediateremovals@nhs.net. This will ensure the patient's records are amended accordingly (i.e. VP flag removed from patient record) allowing the patient to re-register at their chosen practice.

The Panel's decision does not affect the patient's right to raise a formal complaint with NHS England via the customer contact centre.

7. Contact details

NHS Bolton CCG Special Allocation Scheme Liaison Team
St Peters House
Silverwell Street
Bolton BL1 1PP
Telephone 01204 462000
Email: bolccg.sas-bolton@nhs.net

NHS England Complaints Team
PO Box 16738
Redditch
B97 9PT
england.contactus@nhs.net

Primary Care Support Services England
PO Box 350, Darlington, DL1 9QN
Customer Support Centre: 0333 014 2884
pcse.registrations-preston@nhs.net
www.pcse.england.nhs.uk

Bolton Community Practice (Local SAS Provider)
Bernie Gildea, SAS Service Manager
Waters Meeting Health Centre
Waters Meeting Road
BL1 8TU
Email: bolton.communitypractice@nhs.net
Telephone: 01204 463444

CCG Primary Care Commissioning Committee

AGENDA ITEM NO: ………7…………

Date of Meeting: ………14th June 2018………………..

TITLE OF REPORT:	Primary Care Investment Agreement – May 2018 Update
AUTHOR:	Lesley Hardman, Head of Primary Care Development
PRESENTED BY:	Lynda Helsby, Associate Director Primary Care & Health Improvement
PURPOSE OF PAPER: (Please be clear e.g. decision(s) required, a discussion, for noting) The Committee is asked to review the update as at May 2018 on the Primary Care Investment Agreement projects.	
COMMITTEES/GROUPS PREVIOUSLY CONSULTED: Primary Care Commissioning Committee CCG Executive	
RECOMMENDATION(s) The PCCC is asked review and note the update as at May 2018.	

GM Primary Care Reform - Year 1

Bolton Investment Agreement - MILESTONES OVERVIEW

Initial meetings - scoping, tasks, timescales - to be completed by Nov 2017

	Projects	Meet with the Federation	Meet with the LMC	Identify project leads	Meet with Project Lead/s	Meet with Finance	Comments
1	Training - Clerical & Reception Staff						Meeting booked 2 Nov.
2	Care Navigation						
3	Online Consultations						Meeting booked 11 Nov.
4	GM Excellence						Meeting booked 31 Oct.
5	Improving Access						Meeting booked 13 Nov.
6	Clinical Pharmacists						Meeting booked 30 Oct.
7	General Practice at Scale						Lhe progressing with WB/ SuL/Exec
8	Enhanced Care Homes						Meeting booked 2 Nov.
9	Sustainability						Lhe to progress withSuL
10	Workforce Planning						MH & HIPS progressing. MSK - delays with OIS

GM Primary Care Reform - Year 2

Bolton Investment Agreement - MILESTONES OVERVIEW

Q1. April - June 2018

	Projects	Milestones met ? April 2018	Milestones met? May 2018	Milestones met? June 2018		Comments
1	Training - Clerical & Reception Staff					
2	Care Navigation					
3	Online Consultations					
4	GM Excellence					
5	Improving Access					
6	Clinical Pharmacists					
7	General Practice at Scale					
8	Enhanced Care Homes					
9	Sustainability					
10	Workforce Planning					

GM Primary Care Reform - Year 3

Bolton Investment Agreement - MILESTONES OVERVIEW

Q1. April - June 2019

	Projects	Milestones met ? April 2018	Milestones met? May 2018	Milestones met? June 2018		Comments
1	Training - Clerical & Reception Staff					
2	Care Navigation					
3	Online Consultations					
4	GM Excellence					
5	Improving Access					
6	Clinical Pharmacists					
7	General Practice at Scale					
8	Enhanced Care Homes					
9	Sustainability					
10	Workforce Planning					

GM Primary Care Reform - Year 1

Bolton Investment Agreement - MILESTONES OVERVIEW

Q2. July- September 2017

	Projects	Milestones met? July 2017	Milestones met? August 2017	Milestones met? September 2017		Comments
1	Training - Clerical & Reception Staff					Scoping period
2						
3	Online Consultations					
4	GM Excellence					
5	Improving Access					
6	Clinical Pharmacists					
7	General Practice at Scale					
8	Enhanced Care Homes					
9	Sustainability					
10	Workforce Planning					

GM Primary Care Reform - Year 2

Bolton Investment Agreement - MILESTONES OVERVIEW

Q2. July - September 2018

	Projects	Milestones met ? July 2018	Milestones met? August 2018	Milestones met? September 2018		Comments
1	Training - Clerical & reception Staff					
2						
3	Online Consultations					
4	GM Excellence					
5	Improving Access					
6	Clinical Pharmacists					
7	General Practice at Scale					
8	Enhanced Care Hmes					
9	Sustainability					
10	Workforce Planning					

GM Primary Care Reform - Year 3

Bolton Investment Agreement - MILESTONES OVERVIEW

Q2. July - September 2019

	Projects	Milestones met ? July 2018	Milestones met? August 2018	Milestones met? September 2018		Comments
1	Training - Clerical & reception Staff					
2	Care Navigation					
3	Online Consultations					
4	GM Excellence					
5	Improving Access					
6	Clinical Pharmacists					
7	General Practice at Scale					
8	Enhanced Care Hmes					
9	Sustainability					
10	Workforce Planning					

GM Primary Care Reform - Year 1

Bolton Investment Agreement - MILESTONES OVERVIEW

Q3. October 2017 - December 2017

	Projects	Milestones met ? October 2107	Milestones met? November 2017	Milestones met? December 2017		Comments
1	Training - Clerical & Reception Staff					On track - see Exec update for details
2	Care Navigation					
3	Online Consultations					Progressing but new Lead/Project Lead yet to be identified (GB & JG leaving)
4	GM Excellence					On track - see Exec update for details
5	Improving Access					On track - see Exec update for details
6	Clinical Pharmacists					On track - see Exec update for details
7	General Practice at Scale					Lhe progressing with WB/ SuL/Exec
8	Enhanced Care Homes					On track - see Exec update for details
9	Sustainability					Lhe progressing with IB/JM
10	Workforce Planning					MH & HIPS progressing well. MSK - delays with OIS

GM Primary Care Reform - Year 2

Bolton Investment Agreement - MILESTONES OVERVIEW

Q3. October - December 2018

	Projects	Milestones met ? October 2018	Milestones met? November 2018	Milestones met? December 2018		Comments
1	Training - Clerical & Reception Staff					
2	Care Navigation					
3	Online Consultations					
4	GM Excellence					
5	Improving Access					
6	Clinical Pharmacists					
7	General Practice at Scale					
8	Enhanced Care Homes					
9	Sustainability					
10	Workforce Planning					

GM Primary Care Reform - Year 3

Bolton Investment Agreement - MILESTONES OVERVIEW

Q3. October - December 2019

	Projects	Milestones met ? October 2018	Milestones met? November 2018	Milestones met? December 2018		Comments
1	Training - Clerical & Reception Staff					
2	Care Navigation					
3	Online Consultations					
4	GM Excellence					
5	Improving Access					
6	Clinical Pharmacists					
7	General Practice at Scale					
8	Enhanced Care Homes					
9	Sustainability					
10	Workforce Planning					

GM Primary Care Reform - Year 1

Bolton Investment Agreement - MILESTONES OVERVIEW

Q4. January - March 2018

	Projects	Milestones met ? January 2018	Milestones met? February 2018	Milestones met? March 2018		Comments
1	Training - Clerical & Reception Staff					On track - see Exec update for details
2	Care Navigation					
3	Online Consultations					On track - see Exec update for details
4	GM Excellence					On track - see Exec update for details
5	Improving Access					On track - see Exec update for details
6	Clinical Pharmacists					On track - see Exec update for details
7	General Practice at Scale					Lhe progressing with WB/ SuL/Exec
8	Enhanced Care Homes					On track - see Exec update for details
9	Sustainability					Lhe progressing with IB/JM
10	Workforce Planning					On track - see Exec update for details

GM Primary Care Reform - Year 2

Bolton Investment Agreement - MILESTONES OVERVIEW

Q4. January - March 2019

	Projects	Milestones met ? January 2019	Milestones met? February 2019	Milestones met? March 2019		Comments
1	Training - Clerical & Reception Staff					
2	Care Navigation					
3	Online Consultations					
4	GM Excellence					
5	Improving Access					
6	Clinical Pharmacists					
7	General Practice at Scale					
8	Enhanced Care Homes					
9	Sustainability					
10	Workforce Planning					

GM Primary Care Reform - Year 3

Bolton Investment Agreement - MILESTONES OVERVIEW

Q4. January - March 2020

	Projects	Milestones met ? January 2020	Milestones met? February 2020	Milestones met? March 2020		Comments
1	Training - Clerical & Reception Staff					
2	Care Navigation					
3	Online Consultations					
4	GM Excellence					
5	Improving Access					
6	Clinical Pharmacists					
7	General Practice at Scale					
8	Enhanced Care Homes					
9	Sustainability					
10	Workforce Planning					

Funding Flow

Funding Flow	Receiving organisation	Flow
7 Day Access	CCG	Inter authority transfer
Training Care Navigators & medical Assistants	CCG	Inter authority transfer
Developing a GM Resilience Programme	GM HSCP	Budget transfer
Clinical Pharmacists	APMS Contract Holder	Invoice
Online Consultations	CCG	Inter authority transfer

Bolton Investment Agreement

	Care navigators & Workflow optimisation	Online consultations	GM Excellence (Resilience)	Additional access £ to meet national req	Clinical Pharmacy Pilot**	Grand total
2017/18	£ 78,723	£ 78,685	Coordinated at GM Level	£ 1,023,966	£ 615,000	£ 1,796,373
Q2	£ -					£ -
Q3	£ 39,361	£ 26,168			£ 153,750	£ 219,279
Q4	£ 39,361	£ 26,168		£ 255,992	£ 153,750	£ 475,271
Total	£ 78,723	£ 52,336		£ 255,992	£ 307,500	£ 694,550
2018/19	£ 52,343	£ 104,784		£ 1,023,966	£ 420,000	£ 1,601,093
2018/19	£ 52,343	£ 104,784		£ 1,023,966	£ 517,500	£ 1,698,593
2019/20	£ 52,350	£ 52,336		£ 1,023,966	£ 230,000	£ 1,358,652
2019/20	£ 52,350	£ 78,685		£ 1,023,966	£ 440,000	£ 1,595,000
2020/21	£ 52,255					£ 52,255
2020/21	£ 52,255	£ -				£ 52,255
Total	£ 235,670	£ 235,805	£ -	£ 3,071,898	£ 1,265,000	£ 4,808,373
Total	£ 235,670	£ 235,805	£ -	£ 2,303,924	£ 1,265,000	£ 4,040,399

Key	
(yellow)	GM values
(grey)	Bolton value - included in IA

** Clinical Pharmacy pilot funding to be paid to Bolton GP Federation via APMS contract

	Bolton Investment Agreement - **Update for Bolton CCG Executive - May 2018**	
1	**Training - Care Navigation**	Steering group developed. Inital meeting has taken place to scope a bespoke training programme to upskill primary care admin and reception staff , and possibly relevant FT staff groups to navigate patients across the health and social care system. **On schedule.**
2	**Training - Workflow Optimisation**	Formal sign up with practices still ongoing. So far, 26 practices have confirmed and have started the pre-work (online questionnaire). Training sessions booked for 21-22 June - ahead of schedule. There will be 4 sessions - each session can accommodate 12/13 practices. Training to be held at The Bridge. **On schedule.**
3	**Online Consultations**	After a recent meeting with members of the NHS digital team it has come to light that Bolton may be one of the few CCGs working on this at the moment. The project group have met with a group of potential providers to scope the product/IT. Procuurment is being delayed due to the potential to collaborate on provision across GM. AU to attend a meeting being organised by GMHSCP **On schedule.**
4	**GM Excellence**	**No further update from April**. A GM wide initiative to develop a programme of support which focusses on commonalities and themes relating to resilience, to ensure the funding of £2m over 3 years is used smartly. Recent support includes - **GM Working at Scale Course:** Focusses on why a practice might want to work at scale and helps delegates to think through what they might be trying to achieve – which option might suit them best and starting to think about how practices might go about doing this. The course is aimed at practices who think they might possibly need to work at scale in the future, or practices who are beginning to do this already. Again it is suggested that a team approach works best and builds on course one. **On schedule.**
5	**Improving Access**	The procurement process has ended. The Contract has been awarded, and the successful provider has been notified. The Provider is working towards service mobilisation on 1st July 2018.
6	**Clinical Pharmacists**	Gaps in recruitment and retention **-** new recruitment ongoing. NHS Jobs advert closes 8 June - 1 Band 8a and 3 x Band 7s. Interviews 25 & 26 June. **On schedule.**
7	**General Practice at Scale**	**No further update from April.** Timescales to be determined.
8	**Enhanced Care Homes**	Immedicare have implemented steps to improve call waiting times. Evidence shows that call waits have improved significantly. However not all care homes in Bolton are using Immedicare. As part of a remedial Action Plan (RAP) 6 'Ambassador' Care Homes have been identified to encourage the use of Immedicare and to spread good news stories. Steps are being taken now to closely monitor usage data and analyse against KPIs
9	**Sustainability 10 High Impact Changes**	**No further update from April.** Scoping continuing on the 10 high impact changes, and potential application in Bolton. No further update. Links to other work streams.
10	**Workforce Planning**	The practice workforce audit was sent to all practices last quarter.Analysis is ongoing. **Update on wider workforce:** 1. Pharmacists - see above 2. HIPs recruitment - only 1 more cohort to recruit - this will be Sept 2018 3. MH Practitioners - starting in post mid June 2018. Ready to practice mid July 4. MSK Practitioners - interviews w/c 11 June - project timescales delayed - but progressing

GPFV Implementation Plan

CARE NAVIGATION - Training for clerical staff in GP surgeries

Key milestone - March 2020				LEAD/s Lesley Hardman/James Mallion/Louise McDade/Ian Davies/Kelly Skolosdra	
Links with					
	Task	**Lead**	**Expected completion date**	**Actual completion date**	**Comments**
Planning & developing					
1	Scope training project	Lesley Hardman/james Mallion/Louise McDade/Ian Davies/kelly Skolosdra	Dec-17	Jan-18	Lynda Helsby met with DK and discussed this project as part of the wider CANs/Connectivity of assets. Darren offered CVS as a potential training provider.
2	Identify Project Lead	Lesley Hardman	Dec-17	Jan-18	see above comment
3	Develop an action plan and training schedule	Lesley Hardman/james Mallion/Louise McDade/Ian Davies/kelly Skolosdra	Jan-17		Meetings yet to be arranged - diaries have been impossible to coordinate during January. Meeting arranged for april.
4	Organise Task & Finish Groups	Lesley Hardman/james Mallion/Louise McDade/Ian Davies/kelly Skolosdra	Feb-18		Delays as per above
6	Identify potential training providers, and commission a single provider	Lesley Hardman	Feb-18		No longer needed - Lhe discussed with DK
5	Develop training content	Lesley Hardman/james Mallion/Louise McDade/Ian Davies/kelly Skolosdra	Apr-18		this will be delayed due to prioritisation of finances - Year 1 & 2 monies to be used for EZ DOC
Delivery					
1	Roll out a schedule of training	Lesley Hardman/james Mallion/Louise McDade/Ian Davies/kelly Skolosdra	Mar-20		
Comms & Engagement					
1	Engage with the LMC and GP Federation	Lynda Helsby/ Lesley Hardman	Oct-17		Ongoing updates to both organisations
2	Develop engagement plan and timetable	james Mallion/Louise McDade/Ian Davies/kelly Skolosdra/Nicola Onley	Apr-18		this will be delayed due to prioritisation of finances - Year 1 & 2 monies to be used for EZ DOC
Training					
1	As per delivery				
Monitoring & Evaluation					
1	Develop evaluation mechanisms and framework	Lesley Hardman/james Mallion/Louise McDade/Ian Davies/kelly Skolosdra	Jun-18		this will be delayed due to prioritisation of finances - Year 1 & 2 monies to be used for EZ DOC
3	Implement the evaluation according to the developed framework	Lesley Hardman	Mar-20		
4	Regular updates to Bolton CCG Exec	Lesley Hardman/Lynda Helsby	ongoing		
5	Feedback the evaluation findings to the CCG, Bolton GP Federation & LMC	Lesley Hardman/Lynda Helsby	Apr-20		

GPFV Implementation Plan
WORKFLOW OPTIMISATION - Training for Clerical staff

Key milestone - March 2020	LEAD/s Lesley Hardman/Nathan Goldrick/Dunstan GP/Gill Warburton/Vera Bourn/Vicky Bourn/ Eve Byrom/Dunstan clerical rep
Links with	

	Task	Lead	Expected completion date	Actual completion date	Comments
Planning & developing					
1	Organise a Task & Finish Group - to include GP, PM, Clerical Asst, Receptionist	Lesley Hardman	Dec-17	Dec-17	complete
2	Meet the group and identify a lead	Lesley Hardman	Dec-17	Dec-17	Complete
3	Identify project support	Lesley Hardman	Dec-17	Dec-17	Complete
4	Develop an initial action plan with the group	Lesley Hardman	Dec-17	Dec-17	Complete
5	Identify potential training providers	Nathan Goldrick/Gill Warburton/Vera Bourn/Vicky Bourn/Eve Byrom	Dec-17	Dec-17	Complete
6	Meet with potential providers.	Nathan Goldrick/Gill Warburton/Vera Bourn/Vicky Bourn/Alana Hall/Eve Byrom	Jan-18	Feb-18	complete
7	Commission a single provider for Bolton to ensure consistency across Bolton	Nathan Goldrick/Dunstan GP/Gill Warburton/Vera Bourn/Vicky Bourn	Feb-18	Mar-18	**Feb 2018** - Awaiting decision from CCG Finance lead about procurement process. Also, have emailed NHSE Leads for clarification about the need to follow NHS procurment processes or able to decide on any provider. **March 2018** - Jackie Murray - decision on a provider can be made locally without the need for formal tender AT Medic comissioned to provide *EZ Doc*
8	Task & finish group to visit other areas to identify lessons learned	Nathan Goldrick/Gill Warburton/Vera Bourn/Vicky Bourn/Alana Hall/Eve Byrom	Jan-18	Feb-18	Phone call made to other areas to discuss success/learning points fo existing schemes/providers. This was undertaken rather than visits due to demands of time on Practice Managers.
9	Engage all 49 practices - identify a GP champion in each practice	Nathan Goldrick/Gill Warburton/Vera Bourn/Vicky Bourn/Alana Hall/Eve Byrom	Mar-18	Mar-18	Complete April 2018
10	Develop a bespoke programme of training across all 49 Practices/10 neighbourhoods	Nathan Goldrick/Gill Warburton/Vera Bourn/Vicky Bourn/Alana Hall/Eve Byrom	Jun-18	Apr-18	Complete June 2018
Delivery					
1	Roll out the training according to the developed programme	AT Medics	Mar-20		
2	Organise a programme of support visits to Practices	Nathan Goldrickr/Alana Hall	Mar-20		
Comms & Engagement					
1	Engage with the LMC and GP Federation	Lynda Helsby/ Lesley Hardman	Oct-17	ongoing	
2	Develop engagement plan for Practice Managers & GPs	Nathan Goldrick/Gill Warburton/Vera Bourn/Vicky Bourn/Alana Hall/Eve Byrom	Jun-18		
Training					
1	Identify trained staff to become 'workflow buddies' for other practices	A T Medics/Nathan Goldrick/Gill Warburton/Vera Bourn/Vicky Bourn/Alana Hall/Eve Byrom	Jun-18		
2	Provide 'workflow buddies' with any identified training needs	A T Medics/Nathan Goldrick/Lynda Heywood/Gill Warburton/Vera Bourn/Vicky Bourn/Alana Hall/Eve Byrom	Sep-18		
Monitoring & Evaluation					
1	Develop evaluation mechanisms and framework	Nathan Goldrick/Gill Warburton/Vera Bourn/Vicky Bourn/Alana Hall/Eve Byrom	Sep-18		
2	Develop an audit trail	Nathan Goldrick/Gill Warburton/Vera Bourn/Vicky Bourn/Alana Hall/Eve Byrom	Sep-18		
3	Implement the evaluation according to the developed framework	Nathan Goldrick/Gill Warburton/Vera Bourn/Vicky Bourn/Alana Hall/Eve Byrom	Dec-19		
4	Regular updates to Bolton CCG Exec	Lesley Hardman/Lynda Helsby	ongoing		
5	Feedback the evaluation findings to the CCG, Bolton GP Federation & LMC	Lesley Hardman/Nathan Goldrick	Jun-20		

GPFV Implementation Plan
ONLINE CONSULTATIONS

Key milestone - March 2019

Links with - Improving Access

LEAD/s
Avtar Ubbi/Kath Oddi/Paul Singh/Aimee Hilton

	Task	Lead	Expected completion date	Actual completion date	Comments
Planning & developing					
1	Appoint a Project Lead	Lesley Hardman/Lynda Helsby	Nov-17	Dec-17	Grace Birch has left the CCG and in the interim Avtar Ubbi has been appointed as the new Lead for this Project. Janice Gilbert has left the CCG and Naz Hussain has been appointed as the new project coordinator. June 2018 - Paul Singh has replaced Naz Hussein as the project coordinator.
2	Source early adopter deployments, possible visits, and scope lessons learned	Grace Birch/ Avtar Ubbi/ Kath Oddi / Aimee Hilton	Dec-17		This task is no longer required as NHSE are to host a workshop in February to enable CCGs to meet potential providers from a national list of 'Preferred Providers'.
3	Organise a series of workshops to identify a locally preferred solution ▪ GPs / Practice Nurses ▪ Practice Managers ▪ Seconday Care Clinicians ▪ Social Care	Avtar Ubbi/ Naz Hussain/ Kath Oddi / Aimee Hilton	Feb-18		Project Coordinator attended roadshow on 28/02/2018, met with suppliers and received further info on DPS framework. Need to discuss information and next steps with Project group.
4	Develop a procurement strategy	Avtar Ubbi/ Naz Hussain/ Kath Oddi / Aimee Hilton	Jun-18		delayed - meetings pending to scope collaboration across GM
5	Award the contract	Avtar Ubbi//P{aul Singh/ CCG Contracts Team	Sep-18		
6	Implement online consultations	Avtar Ubbi/ Naz Hussain/ Kath Oddi / Aimee Hilton	Oct 2018 - Mar 2019		
IT					
1	Cooperate with the development of a national App	Grace Birch / Martin Heuter / ??	ongoing		
Comms					
1	Promote the use of online consultations to patients	Nic Onley / Comms Team / Grace Birch	ongoing		
2					
Training					
1	Engagement and training for local clinicians: ▪ GPs ▪ Practice Nurses ▪ MSK Practitioners ▪ Pharmacists ▪ MH Practitioners	Grace Birch/Kath Oddi	Jan 2018 - Oct 2018		
Monitoring & Evaluation					
1	Regular updates to Bolton CCG Exec	Lesley Hardman/Lynda Helsby	ongoing		
2	Regular updates to Informatics Startegy Delivery Group	Kath Oddi/Grace Birch	ongoing		
3	Regular updates to GM Excellence Group	Kath Oddi / Fed??	ongoing		

GPFV Implementation Plan — GM EXCELLENCE (Resilience)

	Task	Lead	Timescales	RAG rating	Comments
Key milestone - April 2018				**LEAD/s Kath Oddi /Kam Khan / Saveena Ghaie**	
Links with -					
Planning & developing					
1	Identify local provider and commissioner leads to support GMHSCP in the development and shaping of a GM 'offer' that will support General Practice and act as a programme for improvement.	Kath Oddi / KamKhan/Saveena Ghaie	End of September 2017		CCG project group including representation from LMC and GP Federation met with GMHSCP colleagues in Sep 17 to identify principles and priorities for the utilisation of the funding locally. At the first meeting, we discussed initial thoughts which centred on the need to develop tools to allow practices to build resilience and continually improve at both practice level and at scale. We talked about striking a balance between the ability to provide reactive support in a crisis situation as well as offering early input on a more proactive basis. We highlighted the need to link with the GP Reference Group which is already a well-established forum for providing timely support to struggling practices and we discussed the need to 'grow' local leaders to ensure a continual flow of peer support.
2	Support the production of the GM GP Excellence Programme	Kath Oddi / KamKhan/Saveena Ghaie	End of November 2017		The output from the meeting in September was documented and forwarded to GMHSCP in order that themes and commonalities across GM may be pulled together. This now forms the basis of the GM Training Needs Matrix and will also includes any locality-specific priorities.
3	Establish formal links between CCG Reference Group and the GM Group	Kath Oddi	Jan-18		Reviewed TOR. LMC rep on the reference group. Referrals to RCGOP support are verified by this group
IT					
1	not applicable to this scheme				
Roll Out / Comms					
1	Promote the GM GP Excellence Programme Locally	K Oddi	ongoing		Since the programme was developed: 1. Two Bolton practices have been referred, via the GP Reference Group, onto the RCGP Peer Support Programme. This is following CQC visits which rated one as 'Requires Improvement' and the other as 'Inadequate'. The programme is fully funded by GM HSCP under the GM Excellence Programme. 2. Two candidates from Bolton practices have been accepted onto the Practice Manager Development Programme which is offered by National Association of Primary Care as part of the GM Excellence Programme. The total cost of the course is £3360 per candidate. GM HSCP will fund: • the 1/3rd NHS England contribution • the CCG 1/3 contribution in full • provide a 50% contribution towards the practice contribution by means of a training grant therefore the practice contribution is £560. 3. Two training courses have been offered to practices across GM. Attendance is fully funded by GM HSCP under the GM Excellence Programme. • Course one LMT (Leadership) is delivered to GPs, Practice Nurses, and Practice Managers and covers personal leadership and resilience, teamwork and delegation as well as workplace skills such as time management, political skills, culture, conflict and difficult conversations. • Course two (Working at Scale) focuses on why a practice might want to work at scale and helps delegates to think through what they might be trying to achieve – which option might suit them best and starting to think about how practices might go about doing this. Thirty one individuals from across Bolton practices have expressed an interest in attending Course One and 37 for Course Two. The courses will be held in early April. ▪ Leadership Course - all Clinical Neighbourhood Leads are being strongly encouraged to attend
Training					
1	not applicable to this scheme				
Monitoring & Evaluation					
1	Attend GM Excellence Group	Kath Oddi / KamKhan/Saveena Ghaie	ongoing		Attendance at groups not needed any more as the programme has been set.
	Regular updates to Bolton CCG Exec	Lesley Hardman/Lynda Helsby	ongoing		
4	Regular updates to Locality S&P Groups	Kath Oddi/Primary Care Leads/Fed	ongoing		

GPFV Implementation Plan
IMPROVING ACCESS

Key milestone - April 2018	LEAD/s Helen Wright / Gill Baker
Links with - online consultations	

	Task	Lead	Expected completion date	Actual completion date	Comments
Planning & developing					
1	Organise a *Market Engagement* Event	Gill Baker	Sep-17		complete
2	Develop and finalise a Service Specification	Gill Baker	Oct-17		The feedback from the Market Engagement event has informed the final draft of the Service Spec.
3	Procurement - publish adverts, open the supply portal	Gill Baker	Nov-17		The portal is now open
4	Procurement - submission of QQ response, response evaluation, clarification from bidders, notify bidders of evaluation outcome, assessment of bids, determine recommended bidder	Gill Baker	Jan-18		QQ Complete, notification has been given to the provider to take through to the next stage of the bespoke process to developing the model. Dialoague process has begun with the provider and the next key milestone is to have the draft proposal by the 16th March, this will then be reviewed to inform next stage.
6	Procurement - submisions due, award stage evaluation	Gill Baker	Mar-18		complete
7	Procurement - final proposal from bidder of the model, evaluation of th proposal, clarification and assurance of the model and the contract award.	Gill Baker	Apr-18		Complete
8	Procurement - commence the new service	Gill Baker	May-18		Delayed - Mobilisation of the new service is planned for July 2018
IT					
3	Establish links with the online consultations scheme	Helen Wright	Dec-17		Online consultations scheme delayed
Comms					
1	Develop a communications plan	Nic Onley/Gill Baker/Helen Wright	Dec-17		Delayed due to procurement delay
2	Establish links on CCG and GP surgery websites	Nic Onley	Dec-17		Delayed due to procurement delay
	Awareness raising sessions for Practice staff: ▪ Practice Managers/Assistant Practice Managers ▪ Receptionists	Helen Wright	Jan -Mar 2018		Delayed due to procurement delay
Training					
Monitoring & Evaluation					
1	Complete GM information requirements	Lesley Hardman	Apr-18		no reporting has yet been requested
2	Regular feedback to CCG Executive	Lynda Helsby/Lesley Hardman	Apr-18		ongoing
3	Produce an Equality & Impact Assessment	Gill Baker/Helen Wright	Dec-17		Delayed due to procurement delay
4	Regular feedback to the Health & Wellbeing Board	Helen Wright/Jane Bradford	Jun-18		

GPFV Implementation Plan
CLINICAL PHARMACISTS

Key milestone - March 2020				LEAD/s Ben Woodhouse/Joel Hannan/Fiona Meadowcroft/Shaun Hockey	
Links with - Improving Access, online consultations					
	Task	**Lead**	**Timescales**	**RAG rating**	**Comments**
Planning & Developing					
1	Develop the current clinical pharmacist role in primary care	Ben Woodhouse / Jole Hannan/Fiona Meadowcroft/Shaun Hockey	Mar-20		
2	Develop plans for recruitment and retention	Ben Woodhouse / Jole Hannan/Fiona Meadowcroft/Shaun Hockey	Mar-20		Ongoing recruitment - as people leave posts
2	Ensure effective and efficient resource for delivery at a neighbourhood level	Ben Woodhouse / Jole Hannan/Fiona Meadowcroft/Shaun Hockey	Mar-20		Under CCG leadership as from March 2018 - mentorship currently being formalised at a neighbourhood level
IT					
1	Remote access required for one locality	Ben Woodhouse / Jole Hannan	Mar-20		
2	Training & updates on Practice systems	Ben Woodhouse / Jole Hannan	Dec-18		This will be ongoing as the clinical pharmacists move around the locality
Comms					
1	Regular communications to local GPs and wider partners	Ben Woodhouse / Jole Hannan/Fiona Meadowcroft/Shaun Hockey/Nic Onley	ongoing		
Training					
1	Organise for the clinical pharmacists to attend relevant GM networks	Ben Woodhouse / Natalie Fleming			
2	Attend 28 days of CPPE training	Natalie Fleming	ongoing		
3	Internal and Federation induction processes	Ben Woodhouse / Jole Hannan/Fiona Meadowcroft/Shaun Hockey/Natalie Fleming			
4	Shadowing existing MOT	Ben Woodhouse / Natalie Fleming	ongoing		
Monitoring & Evaluation					
1	Attend meetings and provide regular updates to relevant GM groups	Ben Woodhouse / Jole Hannan/Fiona Meadowcroft/Shaun Hockey	ongoing		
2	Regular updates to Bolton CCG Exec	Lesley Hardman/Lynda Helsby	ongoing		
3	Regular feedback to the Primary Care Strategy & Planning Group	Ben Woodhouse / Jole Hannan/Fiona Meadowcroft/Shaun Hockey	ongoing		
4	Regular feedback to the Health & Wellbeing Executive	Wirin Bhatiani / Su Long	ongoing		
5	Regular feedback to the Sustainability & Transformation Board	Lynda Helsby/Stephen Liversedge	ongoing		

GPFV Implementation Plan
GENERAL PRACTICE AT SCALE

Key milestone - April 2018				LEAD/s Su Long/ Exec Team / George Ogden	
Links with -					

	Task	Lead	Expected completion date	Actual completion date	Comments
Planning & Developing					
1	Develop a proposal for a Bolton LCO model, working with key partners	Su Long / Wirin Bhatiani/ George Ogden	Mar-18		Awaiting updates
2					
3					
IT					
1					
2					
3					
Comms					
1					
2					
Training					
1					
2					
Monitoring & Evaluation					
1					
2					
3					
4					

	GPFV Implementation Plan **ENHANCED CARE HOMES**				
Key milestone - November 2017				**LEAD/s** **Helen Wright / Paul Beech**	
Links with -					
	Task	**Lead**	**Timescales**	**RAG rating**	**Comments**
Planning & developing					
1	Development of the Enhanced Care Homes Specification	Paul Beech / Helen Wright/ Lynda Helsby	Sep-17		Complete
2	Send Spec to practices for expression of interest and sign up	Paul Beech / Helen Wright/ Lynda Helsby	Oct-17		Closing date 2 October 2017
3	Review all expressions and identify gaps in care home coverage	Paul Beech / Helen Wright/ Lynda Helsby	Oct-17		Complete
4	Organise implementation	Paul Beech / Helen Wright/ Lynda Helsby	Nov-17		Complete
5	Continue to ensure all Bolton Care Homes have a link Bolton practice	Paul Beech / Helen Wright/ Lynda Helsby	Ongoing		April 2018 - 5 Care Homes still have no dedicated link Practice
IT					
1	Roll out of Immedicare in care homes	Paul Beech / Helen Wright/ Lynda helsby	Oct-17		Complete - but Immedicare are implementing changes to improve call waiting times.
2	Practices to sign up to data sharing agreements	Helen Wright / Assad Hayat	Nov-17		Complete
Comms					
1	Clinical Leads updates	Helen Wright	Sep-17		Complete
2	Updates to Care Homes	Paul Beech	ongoing		ongoing
Training					
1	Immedicare to train care homes on the use laptops	Paul Beech	Nov-17		complete
Monitoring & Evaluation					
1	Regular updates to Bolton CCG Exec	Lesley Hardman/Lynda Helsby	ongoing		
2	Regular updates to the Primary Care Strategy & Planning Group	Lynda Helsby	ongoing		
3	Regular updates to the Urgent Care Strategy & Planning group	Lynda Helsby	ongoing		
4	Regular updates to the Care Homes Startegy & Planning group	Helen Wright	ongoing		

GPFV Implementation Plan
SUSTAINABILITY

Key milestone - April 2018	LEAD/s Lynda Helsby/Lesley Hardman
Links with -	

	Task	Lead	Expected completion date	Actual completion date	Comments
Planning & Developing					
1	Develop a plan to demonstrate primary care investment as a priority	Lynda Helsby	Apr-18		Ongoing
2	Scope the 10 High Impact Changes - take part in NHSE webinars/events	Lynda Helsby	Nov 2018 - March 2018		not required at present
3	Initiatives - scope potential opportunities for Bolton	Lesley Hardman/Lynda Helsby	Nov-18		Paper to Exec June 2018
4	Workforce - links to the Locality Plan/Workforce element/ GM Workforce remit	Lesley Hardman/Lynda Helsby	Nov-18		
IT					
1					
2					
3					
Comms					
1					
2					
Training					
1					
2					
Monitoring & Evaluation					
1	Regular updates to Bolton CCG Exec	Lesley Hardman/Lynda Helsby	ongoing		
2	Regular updates the the Primary Care Commissioning Committee	Lynda Helsby / Stephen Liversedge	ongoing		
3	Regular updates the Primary Care Strategy & Planning group	Lynda Helsby	ongoing		

	GPFV Implementation Plan **WORKFORCE**				
	Key milestone - April 2018			**LEAD/s** **Kath Oddi / LMC?/FED?**	
	Links with -				
	Task	**Lead**	**Expected completion date**	**Actual completion date**	**Comments**
Planning & Developing					
1	Workforce audit to be undertaken	Kath Oddi	Mar-18		Audit planned for Q4
2	Analysis of the results of the workforce audit	Kath Oddi	Apr-18		analysis in progress
3	Work with GM HSCP to identify opportunities for recruitment and retention in Bolton	Kath Oddi	Mar-20		ongoing
IT					
1	not applicable to this workstream				
Comms					
1	Present findings of the Audit to GPs/PMs - Exec/Clinical Leads/PM Forum	Kath Oddi/Stephen Liversedge	Apr-18		analysis in progress
Training					
1	not applicable to this workstream				
Monitoring & Evaluation					
1	Regular updates to Bolton CCG Exec	Lesley Hardman/Lynda Helsby	ongoing		
2	Regular updates the the Primary Care Commissioning Committee	Lynda Helsby	ongoing		
3	Regular updates the Primary Care Strategy & Planning group	Lynda Helsby	ongoing		

AGENDA ITEM NO: ……11…………………

Date of Meeting: ……14th June 2018………………………

TITLE OF REPORT:	Access Audit Report May 2018
AUTHOR:	Helen Wright
PRESENTED BY:	Lynda Helsby

PURPOSE OF PAPER: (Please be clear e.g. decision(s) required, a discussion, for noting)

To present to the CCG Executive Committee the outcome of the Access Audit carried out by the Primary Care Team in November 2017. The Committee are asked to:

- Note the outcome of the Access Audit
- Consider the 3% penalty that will be applied to Practices who do not provide 75 contacts per 1000 population
- Agree the process for the 2018/19 Access Audit

FINANCIAL IMPLICATIONS [discussed with Chief Financial Officer]:

Practices who do not achieve the target to provide 75 contacts per 1000 population will have a 3% claw back of the final year end payment

COMMITTEES/GROUPS PREVIOUSLY CONSULTED:

Primary Care Managers Meeting
Primary Care Commissioning Committee

REVIEW OF CONFLICTS OF INTEREST:

GP representatives on the committee will need to declare an interest

RECOMMENDATION(s)

Access Audit Report
May 2018

1. Introduction

Standard 1 of the Bolton Quality Contract for 2017/18, Improving Access in General Practice requires practices to ensure that patients receive a good standard of access to their GP Practice.

Practices are expected to deliver:

- Provide 10 bookable sessions (am/pm). Out of hours cover should not be utilised on Wednesday afternoons. Federated arrangements are acceptable to provide cover between practices
- Offer access to both male and female clinicians
- Be open between 8:00am – 6:30pm. Monday to Friday
- Provide a minimum of 75 contacts per 1,000 population, per week. Contacts may be provided by a GP or Nurse Practitioner, and may be face to face or by telephone
- Offer pre-bookable appointments one month in advance
- Have a process for unplanned or urgent appointments
- Offer telephone consultations
- Ensure children under 12 are assessed by a clinician the same day
- Accept deflections from A&E, NWAS, Community Services
- Improve on patient survey measures

To measure improvements made by individual GP Practices the Primary Care Development Team carry out an Access Audit twice a year.

In addition, there is a 3% penalty stipulated in the contract if a practice does not meet the target to provide 75 contacts per 1000 population.

2. Audit principles

Practices are asked to pick 2 well-staffed weeks out of a month given to them, this is usually a month where there are no bank holidays or in the height of holiday season.

Only 3 people carried out the audit for consistency and followed a set of principles:

Potential contacts (provided)	**Delivered contacts**	**Additional contacts**
Total number of potential contacts for GP and ANP and other 1st contact AHPs (Pharmacists, MSK Practitioners, and Mental Health Practitioners)	Total number of delivered contacts for GP and ANP and other 1st contact AHPs Include: • Seen • DNA • Telephone	Count all delivered Practice Nurse Appointments • Seen • DNA • Home Visits

Include: • Seen • DNA • Empty (actual appointment slots) • Telephone • Home visits	• Home visits	

3. **Access audit November 2017**

The access audit carried out highlighted that 10 practices did not achieve the target 'To provide 75 contacts per 1000 population'. Upon checking the data collected, it appeared that they were some discrepancies. Therefore the Primary Care Commissioning Committee agreed that a re-count should be done for the 10 practices.

Following the re-count, the audit has highlighted:

- Of the 49 practices, 8 have not achieved the target of providing 75 contacts per 1000 population.
- On average practices have provided 25,813 contacts per week; this is 83.65 per 1000 population, which is an achievement across Bolton.
- 3.6% of appointments are DNA'd
- 7.7% of appointment slots are left empty

4. **2018/19 – BQC requirement and Access Audit**

For 2018/19, Standard 1 – Access to General Practice will continue with the same target and will be one of the KPIs for the standard.

As the audit in 2017/18 highlighted some discrepancies, the Primary Care Development Team wish to alter the way the information is collected.

Practice Managers will be asked to initially collect the information from their clinical system, following this, one person from the Primary Care Development Team will visit each practice to validate and finalise the information. Only on agreement with the Practice Manager will the information be submitted for the final audit.

5. **Actions for PCCC / Exec:**

- Note the outcome of the Access Audit
- Agree for the 3% penalty to be applied to Practices who do not provide 75 contacts per 1000 population
- Agree the process for the 2018/19 Access Audit

NB: *One practice refused the access audit in practice due to concerns around patient confidentiality. The practice provided a list of contacts. However the list did not include DNA's.*

Access Audit Nov 2018