Primary Care Network Plan

Fleet

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Contents

Section 1: Overview

Purpose

- The purpose of this section is to provide basic details on your network, where the network is currently against each of the 5 pillars and an overall summary assessment, plus the network's level of ambition by the end of March 2019
- Following the submission of the plans a peer review process will be organised for networks to share their plans and ambitions.
- This section also provides a summary of the top 5-8 changes that general practice is committing to delivering by the end of March 2019 including 3 areas where a clinical variation in outcomes or access will be targeted.
- Detailed action plans should be included in Appendix B.

1.1 Network Members

Please list the practices within your network and the number of patients on each of their lists with a population total for the network.

Practice Name	**Patient Numbers** (Q1 Raw)	
Branksomewood Health Care Centre	12987	
Crondall New Surgery	5161	
Fleet Medical Centre	14584	
Richmond Surgery	13457	
	Total Number of patients in network	**46,189**

1.2 Maturity Matrix Summary

Please rate your current and planned position on the maturity matrix on a scale of 1 to 3 (see Appendix A) against each of the pillars and provide and rating of your overall position across all 5 areas.

Pillar	Baseline Maturity (now)	Maturity Ambition (end March 2019)
Right Scale	2	2
Integrated Working	2	3
Targeting Care	0	2
Managing Resources	1	2
Empowered Primary Care	1	3
Overall position assessment	6	12

1.3 Priority Change Areas (5-8)

Please confirm the three key areas where you are planning to deliver some reduction in variation across the network in access or clinical outcomes **before the end of March** (more detail in Targeting Care narrative section …). Remember to think about aligning with national/ICS priority areas and work that is already in existing plans.

Please confirm 2-5 other key focus areas for your network for delivery **before the end of March**.

The aim of this section is to see at a glance what is most important for your network and where you have buy-in from your practices to make a difference. The description should be outcome focused and measurable…..by the end of March we will deliver "x" quality improvements for our patients and/or staff.

The purpose of limiting to 5-8 is to give focus for the remainder of this year. Delivery of these priorities may have a number of actions (see Appendix B) and it is expected that the plan will have additional priorities (additional to the 5-8) that will start this year but will not deliver tangible improvements until after the end of March.

Priority Change Area	Description	Rationale for Choice	Measure (How will you know you've made a difference)
Reducing variation 1.	Learning Disability health checks – wide variation across networks – either support practices to be able to provide service or set up a network clinic.	Identified as wide clinical variation – this group of patients often not well provided for – achievable within next six months.	LD health check figures – easy to count target is at least 75%
Reducing variation 2.	Atrial fibrillation – wide variation in both identification and optimal treatment of AF.	Significant variation in care between practices identified- important/ common condition - adequately treating patients with AF prevents stroke – fits in with existing project and achievable within the next six months.	Clinical staff will keep record – figures collated by Salus ICT admin staff how many cases of AF identified?
Reducing variation 3.	Falls – ensure all ICT and home visiting patients are receiving optimal falls advice/intervention	Rushmoor identified as an outlier for falls causing injury and fracture Important cause of morbidity, loss of independence and hospital admission. ICT team has existing expertise and achievable in the next six months.	Record of fall interventions both by ICT staff and Hampshire Fire Service.

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Priority 4	Maintain and develop existing paramedic workforce. Increasing the resilience of the service to allow time for staff training/CPD whilst at the same time being able to maintain a good level of service delivery especially over the winter months.	New models of care – if we had to give everything back apart from one service; practices would probably elect to keep the paramedic home-visiting service. It provides a great service for patients; it has really helped to unload GP's and has shown a demonstrable benefit to the local health system.	This service has already been closely evaluated and this should continue. Regular meetings with and review of staff job satisfaction/need for development. Wessex Academic Health Science Network has evaluated via detailed interview – could be repeated. Practice satisfaction survey has been done – can be repeated. On-going monthly CCG metrics re emergency admissions – under continual review.
Priority 5	Maintain and develop existing Clinical Pharmacist workforce with particular reference to enhancing the impact on practices and providing useful input into our Integrated Care Teams.	NHSE pilot 1st wave pharmacists – 2 years into the scheme – mandatory training and Independent prescriber courses complete – increasing cost to practices – need to really start to prove the model. Huge need for medication review/rationalisation medication particularly for our population living with frailty – polypharmacy evidence-based cause of morbidity/hospital admission.	Continual evaluation already underway – regular data collection for NHSE and Federation collecting data to measure impact on general practice – not a simple measure of numbers of patients that would otherwise have seen another clinician within the practice but also are there quality of life benefits for GP's and improved safety for patients?

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Priority 6 (optional)	Integrated Care teams (ICT's) a work in progress – developing and building on what we already have. Over the next six months we need to improve practice engagement with the ICT's – the message has to be that this work is good for patients and can mean less work for GP's (handing over complexity). We need to implement existing on-going plans for frailty, introduce new staff, increase GP and pharmacist clinical input into the ICT's. Start to use the long awaited risk stratification (IPA) tool – choose patient groups to target and design effective interventions.	Much work has gone into ICT's over the last couple of years, it has felt like an uphill struggle at times – we firmly believe that the Coordination/management of ICT's is best placed done from within primary care and feel that we are finally starting to prove the point with other providers – need to really maintain the momentum.	Continue with present on-going evaluation. Use of R outcomes to measure patient satisfaction with the service. Continue present contract review process with CCG. Continual review of on-going monthly evaluation metrics – are we keeping people out of hospital?
Priority 7 (optional)	Work force – continue to work with CCG/ICS colleagues to understand the problems and the solutions. Can we do anything locally to make better use of the skills we have – would setting up a network nursing bank be useful? Innovative, positive practices running new models of care should be more attractive for young GP's and other clinicians.	Figures for GP recruitment and retention worrying, figures for practice nurse recruitment even more worrying – new skill mixed work force lead by GP 'consultant generalists' has to be the way forward.	Workforce figures easy to obtain from practices.

Priority 8 (optional)	Back office services – further develop services for practices to add to GP resilience/sustainability and help to make general practice feel better. Can we start to help with CQC?	Some work already underway but now Federation has achieved a certain critical mass really should be accelerating progress.	Feedback from practices.

Section 2: Narrative Section (Maturity Matrix Pillars)

Purpose

- The purpose of this section is to describe for each of the 5 pillars the network's current arrangements, its future aspirations and how these have been developed and agreed. Your narrative needs to align with your maturity summary on page 5.
- Each pillar includes a question to be answered and some guidance on what should be covered.
- The detailed actions of how the network plans get from its current position to its future position should be detailed in Appendix B. Please ensure there is a read through from this section to Appendix B i.e. if there is a planned change in section 2 there is a subsequent action (s) in Appendix B.

2.1 Right Scale: Building the Vision

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How will network governance, decision making, communication and engagement work now and into the future?

This section needs to cover:

2.1.1 Governance and decision making: *Aim: Clear processes in place to make **collective decisions** and the nature of the relationships between network members understood by all.*

- Is there a mechanism for collective agreements to be made within the network already in place? Please describe briefly and attach any relevant documents if available.

  One of our first tasks on setting up our Federation was to try and fully understand the problems facing our constituent practices. We were tasked by our local Vanguard program to 'take the temperature' of local general practice. During three months of the winter of 2015/16 we visited all 23 practices within our CCG area. We listened to their problems, asked them to fill in a questionnaire and presented them with some solutions all of which involved working at scale across practices. We then presented their responses back to them during a large engagement event sharing a platform with Dr Nigel Watson (LMC Chair) and Prof Sam Everington (Tower Hamlets CCG chair). Local problems largely mirrored the national picture. 80% of local GP's felt that general practice had to change and had to change significantly, a similar proportion were happy to be represented by a GP Federation.

  We have been holding regular monthly Network (Fleet Locality) meetings for a number of years. The meetings take place on the first Tuesday of every month with the venue rotating between the four Fleet practices. The meetings are attended by practice GP leads with practice managers also attending depending on the agenda. The practice managers also meet separately to review operational issues and provide mutual support.

- What is the current form of the (business) relationship between network members /are there any written agreements in place? This may be via a Federation structure or “mega practice agreement”. Please describe briefly and attach any relevant documents if available.

  Relationships between the four practices within the Fleet Network work on an informal basis. Our collaborative working relationships are all under the umbrella of the local GP federation Salus Medical Services and all local practices are shareholders in Salus.

  See Appendix C

  We hold an annual AGM for our shareholder practices and invite colleagues from NEHF CCG and other local provider organisations.

  See Appendix D

- To what extent does the network lead currently have to mandate and to represent the voice of practices within its geography?

  Salus our local GP Federation had a mandate to represent the locality during the planning stages of the Fleet Locality Plan for our recent Vanguard Program – decisions being made at the locality meeting. We would expect to continue in a similar fashion although will reaffirm this mandate during our initial discussions of the ICS Network Plan.

- Do you envisage the governance, decision making and business relationships between network members to have changed by March 2019 and how?

  Our present arrangements have served us well so no – obviously we will be guided by discussions at forthcoming Network meetings, but we would expect to continue with the present well tried and tested model.

2.1.2 Practice communication and engagement: Aim: *Two way communication process in place. Network plan is owned and developed by all practice staff.*

- Please describe how your engagement process with practices is going to work. Are there any existing forums that you are going to use/new structures being put in place?

  Whereas the present system of locality meetings has worked well we do realise that one of the problems with meetings is that one always tends to see the same faces. We need to try and engage more widely with practices for example with practice admin staff and particularly with practice nurses and some of our younger GP's who rarely seem to attend meetings.
  We are planning to use the Federation website to provide information as the ICS and Network plans develop. We will also provide a secure space for each of our networks so that network staff can make their views known. We have just produced the first of what will be a regular 'ICS Newsletter'. Practice managers will be asked to circulate this as widely as possible.

  See Appendix D

- How do you currently engage with the wider primary care/community team e.g. community matrons etc?
  We circulate our monthly newsletter to colleagues in other organisations already and this will now include a regular ICS update slot.
  Salus ICT and management staff have been active participants in regular organisational development (OD) days for the Integrated Care Team staff in each locality (network). These OD days have been running regularly every couple of months for nearly two years. We presented our Vanguard Locality plan to the ICT staff members at an OD day. It is envisaged that the OD days will continue certainly until the end of 2018/19 and probably beyond this. Joint OD days for ICT team members in our Aldershot, Farnborough and Fleet networks are planned for November 2018 and January 2019; we will present our network plan to the teams in November and provide an update on progress in January.
  There will be an ICT System leaders OD day in October and this will be another opportunity to discuss our network plans with senior colleagues from other provider organisations.

We have recently submitted a business case to provide a Locality Access Point (local single point of access) in three of our networks (Fleet, Farnborough and Aldershot). The business case has been approved and funding agreed by North East Hampshire and Farnham CCG. Implementing the plan will involve meeting with colleagues from social care, community services and mental health and these meetings will be on-going over the next few months.

- What is your thinking about how you will ensure that practices and your wider community team are appropriately involved/sighted on your network plan, agree with your vision for the future and this will help you deliver the changes required?

  See above

- How will you manage ongoing communication with member practices on the development and delivery of your network plan?

  See above

2.1.3 Population communication and engagement*: Aim: Two-way communication in place. Local population is engaged and sighted on key changes planned in general practice.*

- Please describe your key mechanisms for engaging with your local population currently? E.g.PPGs, CCG/locality events

  Practices have regular meetings with PPG's and Salus have had occasional meetings with the area patient group over the last two to three years.

  In partnership with North East Hampshire and Farnham CCG we were also involved in an intensive piece of engagement work during the setting up of the local extended access/improving access to primary care service.
  We had responses from 383 Fleet residents (0.86%) of the population. The experienced gained during this work would mean that it could easily be repeated – co-producing this work with our commissioning colleagues was a valuable experience for both organisations. We found that a very effective way of circulating our questionnaire was via practices sending out a link using a commercial mass text messaging service.
  See Appendix E

- Are there any plans to change the means that this engagement takes place with the emergency of networks e.g. network wide PPG?

  We will hold an engagement event and invite members of all PPG's across Fleet, Farnborough and Aldershot networks – this will work well if co-produced with colleagues from NEHF CCG communications team. As part of our local Vanguard program, 80 community ambassadors representing different patient groups were appointed, we would include them in this engagement event.

- How has the network engaged with its population on the development of this plan to date?

  In so far as this plan is a continuation of work already undertaken during our local Vanguard program see above.

  The extended access engagement evaluation has provided us with some important messages particularly regarding introducing a clinical skill mix into local general practice.

- What were the key messages from your population and how have these shaped your plan? Note: Previous engagement activities can inform this plan.

  Headline figures from the extended access engagement work:
  85% of Fleet respondents were happy to see a different health professional *(non-GP*) at their own GP surgery – this suggests routine appointments with different health professionals, as appropriate, could be more widely used and promoted.

  86% of Fleet respondents were happy to be visited at home by a different health professional. Again, this suggests that use of different health professionals, as appropriate, could be more widely used and promoted.

2.1.4 Population and general practice benefits of networks: *Aim: Clear articulation of network benefits for general practice and local populations*

- Please describe the local benefits that you have identified of networks for general practice (including staff), your local communities and the wider system (other providers, the ICS system)

To answer this, it may well be worth starting with what are the problems we trying to solve for local general practice, our patients and the local health system. As a provider organisation we have always made our aims clear – high quality sensible services for patients but at the same time making general practice feel better for those of us working within it. We also aspire to the triple aim – better health for our local population, better healthcare for our patients and to achieve this at a reasonable cost to the local health system.

The problems faced by general practice are well documented for example, (https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Understanding-GP-pressures-Kings-Fund-May-2016.pdf). This has been confirmed by engagement work with local practices done by Salus the local GP federation and more recently by North East Hampshire and Farnham CCG (NEHF CCG).

To summarise – workload, workforce including recruitment and retention, demographic changes, the increasing intensity of GP work and not enough time to spend with patients with complex needs.

Working at scale via networks has enabled us to employ a wider range of staff to meet the needs of our patients and help lessen the strain on local general practices. The development of network ICT's has allowed us to start to provide improved/joined up care for our patients and help general practice hand over/cope with complexity. These changes to the way we work have been evaluated closely and the benefit to patients and the local health system have been demonstrated. Funding for these services for the first year came from our local Happy Healthy at Home Vanguard program but these services are now commissioned by NEGF CCG.

See Appendix F

2.2 Integrated Working

What at scale care (service) delivery models are in place now or that you aim to develop as part of this plan?

2.2.1 What "at scale" service delivery models are network members collaborating on **now** & a brief description of each? Available documents can be attached and referenced with a brief description. This is so we can evidence progress already made.

Further details of all Salus Services are available at: http://www.salusmedical.co.uk/

Paramedic Home Visiting Service

We now have two paramedic practitioners working across the four Fleet practices.

They provide home visits for patients in hours. All visits are triaged by GP's and the paramedics have full access to the patients' full GP (EMIS) record via laptop computers. Once the visit is completed the paramedics have quick access to practice GP's to discuss diagnosis, management and arrange treatment. The service combines the very thorough assessment skills of paramedics with the clinical knowledge and risk management skills of experienced GP's. The service has been hugely successful with good feedback from patients and very grateful GP's. We believe this service has contributed very significantly to preventing a rise in emergency admissions, especially for ambulatory care sensitive conditions during 2017/18. Emergency admissions in Fleet were maintained at 2016/17 levels and this should be seen in the context of national figures showing a 5-6% increase.

See **Appendix G** – a presentation prepared by the paramedics themselves which explains the service including the important liaison work they do with colleagues in the ambulance service and results of a practice satisfaction survey. Also see feedback from practices in the Aldershot network.

See **Appendix H** – what do the paramedic's think of the new role? – Full independent evaluation.

Musculo-skeletal (MSK) Assessment Service

In the summer of 2016 we ran a pilot in one of the Farnborough practices to evaluate the viability of using physiotherapists from first appointment onwards to assess and treat patients with musculoskeletal problems.

See Appendix I

The pilot:

- Provided a high-quality service for patients;
- Delivered this at a reasonable cost;
- Saved money on referrals to the existing physiotherapy service, and secondary care orthopaedics (the service more than paid for itself).

Because of this NEHF CCG agreed to fund a service for all NEHF practices, the service is delivered by some of our existing AQP Physiotherapy providers and the contract has been managed by Salus.

The service is staffed by highly qualified extended scope practitioners. Across Fleet there are 9 clinics a week – each clinic lasts 4 hours, appointment lengths are 15 minutes. Patients can be booked directly into the clinics following signposting by practice reception staff. Signposting training is provided by Salus. Waiting times are short generally only 2-3 days, the clinic is an assessment clinic with a strong emphasis on giving patients the tools to deal with their own problem e.g. advice on exercise/rehab. Over 50% of patients are dealt with in one appointment. The practitioners can also refer on to existing physiotherapy treatment services, perform joint injections, request further investigations or refer to secondary care (rarely).

We know that up to 20% of GP appointments are for MSK problems; this service has proved very popular with patients and has really helped to reduce the load on GPs. It is a high-quality cost-effective service which also reduces demands on secondary care. An unexpected benefit has also been its popularity with practice reception staff who appreciate the extra availability of appointments.

Clinical Pharmacists in General Practice

The Federation employs 6 clinical pharmacists working across practices within NEHF; one of the Fleet practices has a clinical pharmacist working within their practice with the hours roughly proportionate to list size. The pharmacists were part of an NHSE first wave pilot and four of them have now completed their mandatory training and qualified as independent prescribers. The service is subsidised (60%, 40%, 20%) over the first three years with practices funding the shortfall. The pharmacists perform a range of tasks within practices according to the needs of the practice:

- Prescribing administration
- Medication enquiries
- Liaison with community pharmacy
- Medication reviews
- Chronic Disease management
    - Vitamin D
    - Lipid lowering
    - Hypertension
    - COPD
    - Asthma
    - Diabetes

Enhanced Integrated Care

Fleet now has an established integrated care team (ICT).

The GP Federation has the contract for co-ordinating integrated care in Farnborough, Fleet and Aldershot. Staff are employed by Salus with our Associate Director of Nursing providing clinical leadership.

ICT staff employed by Salus:

ICT manager – operational manager working across 3 ICT's (Farnborough, Aldershot and Fleet).

Senior (Band 7 Community nursing experience) nurse – leads the clinical team, undertakes assessments of patients with complex needs, goes into Frimley Park hospital to facilitate discharge planning, liaison with community nurses, social care and other agencies, liaison with GP practices, leads the weekly MDT meeting in each of the 3 localities.

Band 6 nurse with community experience (new post) – to support senior nurse with above.

Band 5 clinical associates x3 planned, 2 members of staff in post one with a community nursing background and one with a social care background. Their main duties are to assess patients in their own home and then liaise with all the other agencies e.g. GP, community nurses, social care. We have a very open access policy for referrals into the ICT but at present the main sources of referrals are from general practice and the paramedics working for the home visiting service.

Band 3 administrators x3 one per network – general admin duties maintaining a tracker for each patient on the ICT caseload – which records details of each patients' problems/needs and what actions are needed from the multi-disciplinary team that makes up the ICT's.

Salus have just been awarded a contract from NEHF CCG to provide a Network Access point service. The new service will provide a single point of access in for health and social care professionals in each of our three networks. Very importantly hospital clinicians will just need one email address/telephone number to arrange community services prior to a patient discharge from hospital.

There is a weekly multi-disciplinary team meeting held in each network – attendees:

Clinical Lead (Salus Medical Services) – Chairs meeting

- Full time (band 7) nurse (Salus Medical Services)
- ICT Business manager (band 5) (Salus Medical Services)
- Clerical administrator (band 3) (Salus Medical Services)
- Community Matron (Frimley Health NHS Foundation Trust)
- Social services representative (Hampshire County Council)
- Mental Health Practitioner (Surrey and Borders Partnership Trust)
- Making Connections Coordinator (Social prescribing, Hart Voluntary Action)
- Allied health professional (Frimley Health)
- Community Nurse specialist (Frimley Health)
- Enhanced Recovery Service representative (Frimley Health)

This is an increasingly successful service, it means that the work of the Integrated Care Teams is organised and co-ordinated from within local general practice. In addition to administrative staff we have found it very important to employ our own clinical staff. If a GP is concerned about a patient they can only ask for a home assessment from for example, a community nurse if the patient has established nursing needs. Having our own staff means that if GP's, carers/patients' families, or other health and social care professionals are concerned the patient can be quickly and comprehensively assessed. This means that we are working more proactively, and we believe means that local people are looked after in their own homes whenever possible.

When the service was first introduced some of our local GP's were worried that it would mean more work for hard pressed general practice, but we have managed to show them that this is not the case. Instead of having to make several referrals to different agencies one simple referral to our ICT team who have full access to the patients' full GP record is all that is needed. Local GP's can 'hand over' the complexity.

See Appendix J - an Independent Evaluation of Fleet ICT but please note the evaluation is now nearly a year out of date and the ICT has developed considerably since.

Extended Access

Three of the four Fleet practices have been working together to provide extended access for all Fleet patients for nearly a year now.

Extended Access hours are 6:30 to 8:00 pm weekday nights and 9am until 12pm on Saturday mornings. During these hours there is always one practice in Fleet open providing a mixture of appointments – GP routine and on the day, Practice nurse appointments and health care assistant appointments. The service was co-designed with colleagues at NEHF CCG, other NEHF networks and our local out of hour's provider. On Sundays a service is provided by North Hampshire Urgent Care. During the design of the service we worked hard to understand the needs of our patients. (see **Appendix E**).

Practices have access to patient GP records using a local Salus version of EMIS (IT system used by all practices).

Oasis

The Oasis, at 86 Cove Road, Farnborough is an out-of-hours drop-in service, which provides people with a safe place where they can talk to support staff or to each other. This support has been shown to improve people's conditions and prevent mental health crises. It opened as a pilot in April 2017 after local people told the area's health service planners that it was needed, and the success of the service has resulted in continued funding by the North East Hants and Farnham CCG. The service is managed by Salus Medical Services Ltd, and run by Just Wellbeing, which also runs the Young Persons' Safe Haven, in Aldershot. The service runs from 6.30pm to 9.30pm, seven days a week. It primarily serves the population of Farnborough although we now happy to cover a wider area by inviting patients from Yateley and Fleet to attend.

For more information see Salus website - http://salusmedical.co.uk/our%20services/the%20oasis/oasis%20open%20day%202018.html

For the full Oasis report and evaluation -
http://salusmedical.co.uk/onewebmedia/Oasis%20Report%20and%20Evaluation%202017%20to%202018.docx

2.2.2 What new “at scale” service delivery models are network members planning to develop as part of this plan. Please add a brief description of any, including planned benefits to patients, practices/staff, and ICS delivery. Benefits should link to where there are known local issues and/or variation in care. (NB National/ICS priority areas)

Rather than developing new ‘at scale’ delivery models we feel that we need to develop some of the existing service delivery models. We feel that to transform general practice a new workforce is essential.

Paramedic Home Visiting Service

This service has been extremely successful with proven benefits for patients, local general practice and the local health system.

(See appendices **F**, **G** and **H**)

We have developed a paramedic workforce with over a years' experience of working in general practice providing a home visiting service. We need to maintain and develop this very valuable workforce. Salus now employs eight paramedic practitioners and two paramedics. Recent recruitment experience has suggested that most of the paramedic practitioners wanting to come and work in general practice have already done so and our last two appointments have been paramedics with a view to training up to become practitioners over the next couple of years. We have heard complaints from other system partners that we have 'poached' staff from the ambulance service. This was not actually true, six of our original eight paramedics had already left the ambulance service and two were actively looking for jobs. Nevertheless, we do recognise the need to be involved in training to maintain and develop the workforce.

One of our paramedics is about to start a course at St George's and a second paramedic will be looking to embark on similar course in six months' time. This will involve them attending university for a day a week over the next 2 years.

Up until this year paramedics could not become independent prescribers but the necessary changes in legislation have now been made and from autumn 2018 they will be able to embark on prescribing courses. We think it is best not to do this during the winter, but our plan would be for one paramedic from each of our four networks to begin an independent prescriber course from next April onwards. This will involve them being away from clinical duties for a day a week for six months. We will need to also arrange mentors from amongst our local GP's. The role of GP mentors will need discussion between practices within networks, if we could all agree to take a fair share in accommodating and teaching the paramedics it would really promote the cause of working collaboratively to maintain and develop each networks workforce.

We will not be able to completely maintain our present service delivery and carry out the above training activity without employing more paramedics to backfill absence due to training. We would need to employ two more paramedics (working across 4 networks) to cover for training absence, they would then of course embark on training themselves once others complete their courses.

Further enhancing our paramedic service and improving staff/patient ratios in some networks will be of great benefit to patients and will also help to reduce local variation in care. If we look at our emergency admissions figures for 2017/18 (Appendix G p.18) Yateley with 2 paramedic practitioners for 28,000 patients achieved a reduction in admissions of 5.1% compared to Fleet (0% increase) with 2 paramedic practitioners (in post for only half of the year) with a population of 46,000. Although we cannot say that the home visiting service was the only reason for the reductions in emergency admissions we believe it played a significant part. Figures collected daily by our paramedics suggest many admissions saved. This aligns well with the National ICS priority area of urgent and emergency care.

Musculo-skeletal (MSK) Assessment Service

This service had a difficult first few months. We chose our local acute trust as the provider for Farnborough and Aldershot. We experienced staffing difficulties, clinics cancelled at the last moment and a service which we felt was more aligned to a complex secondary care MSK setting. We have now appointed providers who have engaged with our general practice focused model of MSK assessment and this is now producing a reliable, successful service. Monthly figures suggest that we are producing outcomes in line with the initial Farnborough pilot of 2016.

We need to maintain this service and have identified significant variation in uptake between different practices. We have discussed this with practice managers; practice engagement with the service and the ability of reception staff to signpost patients to the service is variable. There is some turnover of practice reception staff and a need for regular training opportunities to give them the skills and confidence they need to signpost patients into the service without needing to see a GP first. Respectfully asking patients why they need an appointment must become second nature if we are to successfully introduce a skill mix into general practice.

One would not normally think of this as part of a prevention strategy (an ICS national priority). However, many GP's would agree that it is important to not allow often self-limiting MSK conditions to become chronic. Our approach in these clinics is early intervention with a positive, helping patients to help themselves approach. There is an evidence base for this; we have all seen how patients can easily become anxious, depressed and overwhelmed by their pain. Chronic back pain for example blights patients' lives and is a huge drain on system resource.

Clinical Pharmacists in General Practice

Fleet has a Salus Clinical Pharmacist working in just one practice. Most of our pharmacists are coming to the end of their first three years of the NHSE first wave pilot and from April 2019 onwards the full cost of the pharmacists will be borne by the practices. Recently there has been push back from some NEHF practices that the pharmacists are an expensive luxury that they cannot afford, and we have had to re-allocate to other practices. Our challenge to this view would be that they do increase capacity in general practice, the service is valued by patients and considerably increases patient safety; importantly in addition to this we feel that they really do unburden GP's i.e. there is a strong quality of life argument.

The recent national evaluation of Clinical Pharmacists is supportive of their role in general practice – 'The introduction of pharmacists has led to increased capacity in practices. Although the role requires financial commitment from practices, GPs believe the role to be sustainable, most will keep the one they are working with after the funding expires'.
https://www.nottingham.ac.uk/pharmacy/research/divisions/pharmacy-practice-and-policy/research/cpigp.aspx

However, we need to increase the pharmacists' impact on practices. One of the difficulties has been that what the pharmacists can usefully do depends on the size of the practice and therefore the number of sessions they work. In a small practice with one clinical pharmacy session a week it is difficult to have much impact on repeat prescribing, whereas in a larger practice with three or more sessions a week they can really help with repeat prescribing/prescription administration. Practices also have very differing needs when it comes to chronic disease management. We have therefore made sure that our pharmacists are equipped with core chronic disease management skills (see above), our impression is that practices are still underutilising this aspect of their role.

Increasing impact and planning for development of the Clinical Pharmacist as the NHSE pilot comes to an end will involve initially engaging with our local practices and the pharmacists' GP mentors. We will need to review progress so-far and understand future needs and expectations. Now the service is further developed there may also be a need for an education event for GP's and practice staff.

We feel that there is a really pressing need for clinical pharmacy input into our Integrated Care Teams and this is already happening in the Yateley network which ended 2017/18 with better figures for emergency admissions compared with Fleet (-5.1% cf -0.0%). Yateley have a pharmacist working within the ICT. We know that there is a strong link between polypharmacy and avoidable hospital admissions (https://www.pharmaceutical-journal.com/news-and-analysis/news/polypharmacy-linked-to-unplanned-hospital-admissions-for-people-with-fewer-conditions/11132980.article?firstPass=false). Employing additional pharmacy time to work within Fleet ICT will align well with the National ICS priority area of urgent and emergency care and help to reduce the local variation we are seeing in emergency hospital admissions.

We are increasingly interested in some of the work done by Primary Care Home practices to work with community pharmacies. http://napc.co.uk/wp-content/uploads/2018/05/Community-pharmacy.pdf.

The first steps will involve meeting with community pharmacy colleagues and our local CCG medicines management team.

Enhanced Integrated Care

Increasingly Salus ICT staff are working across the ICT's in three networks – Farnborough, Fleet and Aldershot. Initially our Enhanced ICT service was funded by one off funding from our local PACS Vanguard (Happy and Healthy at Home). This service is now commissioned by NEHF CCG with a contract in place for 2018/19. We are still not fully staffed to run the service and we are in the process of recruiting another band 3 administrator and a band 6 community nurse. A new ICT manager has just joined the team and at the time of writing is completing her induction.

As the Farnborough and Aldershot ICT's have developed we have identified a need for a specialised drug and alcohol worker. Our ICT's deal with anyone with complex health and social care needs and this includes patients with mental health/substance misuse problems. We have just presented a business case to NEHF CCG for funding and it has been approved. The drug and alcohol worker will also be able to see patients in Fleet if the need arises.

NEHF CCG working with local general practice, community providers and Frimley Park hospital have identified the need for Locality/network points of access. We need to enable the hospital to easily contact and then navigate 'the community' including general practice when planning discharge from hospital. Salus have just been awarded the contract to provide this service across Farnborough, Fleet and Aldershot. (See **Appendix K**).

IT/IG has been a huge problem in the setting up of this service – Salus ICT staff have access to the patients full GP (EMIS) record but we still after over a year do not have full access to some community/hospital IT systems. This for example makes it difficult to ensure that the work of the community nursing teams and Salus ICT staff is not duplicated.

Frailty – we are about to start working with consultant colleagues from Frimley Park to try and introduce some elderly care consultant input into our ICT MDT meetings to advise on the care of some of our patients living with frailty.

It has been expected that using a risk management tool to start to work more proactively especially with patients who are not at immediate risk for hospital admission but may be in the next few months. A year ago, we did some work to look at the evidence base for case management, shared our thoughts with colleagues locally and in Slough and finally held a workshop with the participation of secondary care colleagues. (See **Appendix L**).

We have not been able to start this proactive work because of information governance problems with the use of the chosen risk stratification tool (IPA tool). We have been told that a solution is in sight.

Once we can use the tools we will need to finally decide on which patient groups we need to identify and what sensible achievable interventions may look like. We will need to discuss the effective use of a risk stratification with colleagues in other networks both locally and more widely and would value an ICS wide discussion of the evidence-based use of risk stratification tools.

On-going in Aldershot and Farnborough but not in Fleet is GP involvement in the weekly ICT multi-disciplinary team meetings. Instead of each practice being given a time for a phone call to participate in a discussion about their patients on the ICT caseload Fleet GP's would value discussion between the ICT and the patients' own GP. With more staff and the introduction of Network Access points we will endeavour to provide this service over the next 6 months.

Going back to our initial 2016 practice engagement work there was very strong support amongst local GP's for integrated practice and community nursing teams. This was further confirmed by work done by the CCG in 2017 (See **Appendix M**). NEHF CCG is presently engaged in a consultation process for a new community services contract. This is some time in the future, but our ambition is to be able to bid for this contract perhaps in a years' time and probably in partnership with another larger provider organisation. We have recently researched the Buurtzorg model of community care which has been so successful in the Netherlands.

Oasis

The service is up and is very well run by our colleagues at Just Wellbeing. However, as with any new service we need to regularly communicate the benefits of the service to local GP practices. GP's are often faced with a bewildering range of referral options and if they do not refer to a service often it is easy to forget some of the options. Oasis has been invited to present at locality meetings, and the practices are supplied with posters for waiting rooms and business cards for consulting rooms. This work needs to continue and we need to start work on the 2018-19 evaluation report. At present Fleet patients can attend a similar service the Safe Haven in Aldershot but this is 7 miles away. Hart has one of the highest suicide rates in Hampshire. We will now be able to make the Oasis service available to Fleet residents (distance to travel 3.5 miles). Work will start with informing the Fleet practices about the service and we will ask Just Wellbeing to present to a Fleet network meeting.

2.2.3 Where are these models in their development (an initial idea, designed and tested, fully embedded and benefits evidenced? Please share any documented evidence.

See above

2.2.4 The footprint of these models (may be bigger than some of the smaller networks/in collaboration with other networks, or may be structured at a sub-network level for some services) Please describe how you are going to deliver the right scale if not the existing network footprint.

See above and summary table below.

2.2.5 Please add any actions you need to take in Appendix B

Optional Summary Table (Detail of actions in Appendix B)

Description of "at scale" service	Development Stage			Footprint	Benefits
	New	Current			
	Idea	Designed and tested	Fully operational and benefits evidenced		
Paramedic Home visiting service working at scale across practices in five networks Farnborough, Fleet, Aldershot, Yateley.	*Training – Paramedic Practitioner Course for non-practitioners and prescribing courses for practitioners. Extra staff to cover working across networks whilst practitioners attend courses.*	*Home visiting service fully established.*	*Monday to Friday home visiting service in place and benefits evidenced.*	*Work across 4 NEHF networks to deliver the service*	*Timely visits for patients combine assessment skills of paramedics with knowledge and risk management skills of GP's. Has really helped to keep people in their own homes wherever, possible and safe.* *Service has really helped to unload local general practice.* *Vanguard metrics have shown reduced emergency admissions to hospital especially for ambulatory care sensitive admissions.* *Very valuable workforce and need to maintain and develop.* *As workforce so important Federation needs to be committed to training and developing staff however, need to maintain service delivery whilst clinicians take time out for training.*

MSK Assessment Service	*Hold regular practice staff training sessions.*	*MSK assessment clinics fully established.*	*Benefits evidenced, monthly figures collected and scrutinised and 2 monthly contract review meetings with providers.*	*Work across Farnborough Fleet and Aldershot*	*This service depends on practice reception staff having the training and the confidence to signpost patients into the service.* *Needs to become second nature for us to successfully introduce skill mixed teams into local general practice.*
Clinical Pharmacists in General Practice	*Engagement/ Planning event with practices*	*Clinical pharmacists now fully established in practices*	*Benefits evidenced but push back re value for money/impact from practices*	*Work across all five NEHF networks*	*Increase impact on general practice – further increase capacity and patient safety*
Clinical Pharmacists in General Practice	*Clinical Pharmacy Input into ICT*	*Local model available and CCG doing similar work with pharmacist for nursing homes but no dedicated pharmacy input into ICT's.*	*Not yet fully designed and not locally evaluated but evidence base for reducing polypharmacy impacting patient well-being, safety and rate of hospital admission good.*	*Work across three NEHF networks – Farnborough, Fleet and Aldershot ICT's*	*Improvement to patient safety and wellbeing – System benefit reduced hospital admissions/use of resources.*

Fleet

Working with community pharmacy	*Develop Integrated working between local community pharmacies and local general practice*	*Not yet designed and not yet tested locally*	*Not yet designed and not yet tested locally but good examples from elsewhere in the country*	*Initially very local just within Farnborough network but scaled up rapidly if working well*	*Possible more effective, safer chronic disease management benefiting patients, reducing GP workload and with system benefits via reduction of iatrogenic harm.*
Enhanced Integrated Care team	*Achieve full staffing as per original Vanguard locality plans. Increase Fleet GP engagement with Fleet ICT by liaising directly with patients GP if on the ICT caseload.*	*Enhanced ICT designed and tested*	*Fully operational and benefits evidenced but we have taken on staff as the workload has increased full staffing as per original vanguard network plans is now a pressing need and recruitment under way*	*Working across 3 networks Farnborough, Fleet and Aldershot*	*Co-ordinated integrated working between providers of out of hospital health and social care. Joined up sensible system for patients with easy access to full GP record. Easy access to patient centred care; looking after patients in their own homes whenever possible and safe. Unloading GP's by handing over the inter-agency complexity. System benefits from more effective use of community resources and reduced hospital admissions and lengths of stay.*

Fleet

Enhanced Integrated Care team	*Drug and alcohol worker to work within ICT team*	*Not yet fully designed and not tested.*	*Recruitment process due to start*	*Work across Farnborough Aldershot initially because that is where we have identified most need but help and advice also available to Fleet patients*	*Substance misuse problems affect a wide range of patients – problem drinking is common, including amongst our frail elderly population it has a hugely negative effect on their health and wellbeing – harm reduction work amongst this group of patient could also unload general practice and secondary care.*
Locality/Network Access Point	*A single network point of Access to community services for health and social care professionals*	*Fully designed and approved not yet tested*	*Recruitment process underway and discussions re implementation with other stakeholders in progress*	*Across 3 networks Farnborough Fleet and Aldershot*	*A single conduit to facilitate the safe and efficient transfer of care by building on the relationships already established by the ICT in the local healthcare community* *Facilitates joined up care for patients and efficient and timely discharge from hospital, helps to reduce delayed transfers of care.*
Fully inter-operational IT between at least the health provider members of the Integrated Health Team	*Not a new idea but a source of considerable frustration*	*Systems fully designed and tested but access still a problem*	*Systems fully designed and tested but access still a problem*	*Across 4 networks Farnborough Fleet Aldershot Yateley*	*If we cannot see for example what the community nurses are doing very difficult to co-ordinate care and ensure that work is not duplicated.*

Fleet

Frailty work stream working with consultant colleagues from the Frimley park Frailty service	*Monthly meeting and clinical discussion – to discuss patients living with frailty – elderly care consultant – network GP advisor to ICT and ICT members*	*Fully designed – model tested and helpful in Yateley network*	*Service about to start*	*Across 4 networks Farnborough Fleet Aldershot Yateley*	*Add the benefit of expert frailty advice to the care of patients on ICT caseload.*
Use of Risk Stratification Tool to work more proactively within Integrated Care Teams	*Start to use a risk stratification tool to work proactively to identify patients on the second tier of the Kaiser Pyramid and provide effective interventions to maintain patients' health, wellbeing and independence*	*Some preparatory work done on evidence base but not yet implemente d and not tested PDSA likely to be important*	*Risk stratification tool shortly to become available benefits may take time to evidence – careful evaluation will be important*	*Use across 3 networks Farnborough Fleet and Aldershot*	*Maintain patients' health, wellbeing and independence. Action taken before the crisis happens and benefit the system by reducing social care need and emergency hospital admission.*

Fleet

Integrated Community and Practice Nursing Teams	*Strong local support for developing integrated practice and community nursing teams*	*CCG consultation exercise on going*	*Future ambition Be in a position to bid next year.*	*Across all 5 NEHF networks*	*Wide range of skills between both practice and community teams – pooling these skills so that we are putting the right clinician in front of the patient irrespective of whether at home or being seen in the practice would mean an efficient use of the workforce we have – good for patient and system benefits.*
Oasis Mental Health Drop in Service	*Make service available to Fleet patients*	*Service fully designed tested and operational*	*Continual communication with practices important benefits evidenced via detailed evaluation*	*Across 4 NEHF networks*	*Local service with easy access for patients with mental health crisis. Evidenced benefit for patients – much valued by local general practice and some evidence to suggest reduced A+E attendance.*

2.3 Targeting Care

How and where should variation in care and outcomes be reduced across the network and how can increased practice level engagement in the development of these network plans made delivery of improvements more likely.

2.3.1 Network level “needs assessment” summary

Network to pull together in one document; (CCG staff likely to be able to help with this, particularly around data sourcing)

- A description of the population covered by the network and key features. This can use available intelligence e.g. JSNA, existing CCG or locality plans Local Health Profiles but should also be sense checked with practices and be informed by local knowledge.
- Summary of the key areas of health and wellbeing needs and areas of inequality
- How network working will improve understanding of needs of local population

2.3.2 Network level "clinical variation" summary

Network to pull together in one document; (CCG staff likely to be able to help with this, particularly around data sourcing)

- A description of areas where there is **variation in care, access to services and outcomes**. Again there is a lot of information already available to support this analysis.
- Networks should consider variation in NHSE/ICS priority areas outcomes by populations groups/communities and practices: cancer, MH, urgent care (access to general practice, A&E attendances, emergency admissions, care home admissions etc) and children (including A&E usage)
- Areas of variation in **clinical practice or access** that could be reduced to improve outcomes and workload in general practice. (long list –may be more than 3)

Fleet is healthier and wealthier than England and Hampshire as a whole. Although there is currently a large working population compared to the elderly, projections show that by 2020 there will be an increase of 10.2% in the number of people in the 65-84 year age group and an increase of 47.4% in the number of individuals aged 85 and over. This contrasts with an expected increase of just 3.6% in the working age population. The population is expected to increase by 5% overall. Fleet also has the highest density of care homes compared to the other localities within NEHF CCG.

The main acute care provider serving the Fleet population is Frimley Health NHS Foundation Trust. The Farnham Community Hospital operated by Virgin Healthcare and the Fleet Community Hospital operated by Southern Health/Frimley Park provide rehabilitation services for adults and older people, however both are under-utilised by GPs due to their geographical location. There are 4 GP Practices and community, mental health, and social care service providers.

http://documents.hants.gov.uk/public-health/JointStrategicNeedsAssessment2015-HartDistrict.pptx

Hart has a higher rate of hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24) that either England or the South East.
Hart District council feels that key issues for the health of children and young people are childhood obesity, emotional wellbeing, vulnerable children (disabilities and special educational needs).
Hart residents have the third highest suicide rate across Hampshire.
For adults the main causes of premature death are cancer, heart disease and respiratory disease. Hart has lower mortality rates from causes of death considered preventable than England or the South East. Mortality rates from cardio-vascular disease and cancer in Hart is less than England and the South East but there is a significant difference between men and women – with a larger reduction in mortality for men when compared with England and the South East.
Malignant melanoma incidence in Hart is high and disproportionally affects young people.
A higher proportion of Personal independence payments in Hart are for malignant disease and musculoskeletal disease compared with England, Hampshire or the South-East.
The proportion of working age population is reducing with increasing pressure on services and care provision.
There are higher levels of preventable mortality for those living with serious mental illness.
The council highlights falls and fractures in older people leading to loss of independence and comments that 'preventing falls has a major impact on health and wellbeing. Hart is no better that the national figures for injuries due to falls in the over 65's and only slightly better for hip fracture and rates of hip fracture seem to be increasing.

See below for the Hart Health and Wellbeing plan 2017 -19

https://www.hart.gov.uk/sites/default/files/1_Residents/More_for_residents/Health_and_wellbeing/Hart%20Health%20%26%20Wellbeing%20Plan%202017-19%20.pdf

Fleet

If we look at NHS England Right Care data for North East Hampshire and Farnham several areas can be highlighted as priorities.

- Trauma and Injuries/MSK – injuries due to falls in over 65's and fractures in the over 80's.
- Lower GI cancer late diagnosis.
- Poor smoking quit rates when compared with other similar CCG areas – smoking quit rates in Hart have plateaued recently.
- A high prevalence of Chronic Kidney Disease when compared with other similar CCG areas.
- A high rate of emergency admissions in over 65's with dementia when compared with other similar CCG areas.
- A lower proportion of patients with serious mental illness who have had their recommended health checks when compared with other similar CCG areas.
- We are currently not hitting the achievement target for dementia diagnosis – 63.4% against target of 66.7%
- We score poorly for early diagnosis of breast cancer when compared with other similar CCG areas.

- NHS England Right Care Commissioning for Value where to look pack: https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2017/02/cfv-north-east-hampshire-and-farnham-jan17.pdf
- Long term condition pack: https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2016/08/cfv-north-east-hampshire-and-farnham-ltc.pdf
- Cancer focus pack:https://www.england.nhs.uk/rightcare/products/ccg-data-packs/focus-packs/focus-packs-for-cancer-mental-health-and-dementia-msk-and-trauma-may-2016/
- Mental Health and Dementia pack: https://www.england.nhs.uk/wp-content/uploads/2017/07/cfv-north-east-hampshire-and-farnham-mhidp.pdf

Looking at our local CCG's performance pack we can see that we are not achieving the target for annual health checks for people on our practice learning disability registers. We can also see a wide variation in care just within the Fleet network here with some practices easily overachieving the
target (87% cf target 75%) and others only achieving 16% of required health checks done.

- CCG performance dashboard and IAF indicators https://www.nhs.uk/service-search/performance/search

If we look at Quality and Outcomes framework (QOF) data across the Frimley Health and Care STP (2016/17):

- Over a third of practices are significantly below the national figure for proportion of over 45-year-old patients with a recorded blood pressure.
- There is a wide variation in the % of hypertension diagnosed as compared with expected prevalence amongst NEHF practices – highest 62.7% cf lowest 51.9%
- There is a wide variation in the % of hypertension treated to QOF target amongst NEHF practices – highest 51.6% lowest 38.6%
- There is a wide variation in the % of atrial fibrillation diagnosed as compared with expected prevalence amongst NEHF practices – highest 100% and lowest 59.2%
- There is also considerable variation in the % of patients who should be receiving anticoagulation treatment compared with those that are amongst NEHF practices highest 96.1% and lowest 71.9%
- The highest rate of exception reporting for high risk AF patients anticoagulated amongst NEHF practices is 23.4% and the lowest 1.9%

Frimley STP CVD Prevention Supportin

If we look at the Vanguard metrics for last year 2017/18 (**Appendix F**) we can see that Fleet did very well, there was no annual increase in emergency admissions compared with national figures suggesting a 5-6% year on year increase but we can identify some local variation in care/outcome e.g. Yateley achieved a 5.1% reduction.

- Three priority areas for working on collectively before March 2019 (short list) – to be included in section 1.3 (Priority Areas for Change)

Three priority areas for working on collectively – what is achievable by the end of 2018/19?

1. Learning disability (LD) health checks – we have noted a wide variation between some practices who see nearly all the patients on their LD register to some that are undertaking few LD health checks. We have just obtained some up to date figures from the CCG and they show little evidence of improvement. With only 6 months of the financial year to go we now need to act to either assist practices that are struggling to provide this service. This could be just helping them with administration and nurse training or it could mean setting up a network LD health check clinic.
2. Atrial fibrillation – we have identified a significant variation in care; both in diagnosis and then anticoagulation treatment. We will obtain practice specific data from the CCG for discussion at locality meetings. We have already embarked on a project working with Wessex Academic Health Science network and NEHF CCG to supply Alivecor monitors to some of our clinical staff (paramedics and pharmacists). This will allow them to screen easily for atrial fibrillation; the training for the use of these monitors is already planned.
3. Falls – we have identified Fleet as having a high rate of injury and hip fractures in the frail elderly. One of our clinical associates has developed a high level of clinical expertise in this area and has worked locally with the Hampshire Fire and Rescue service. We need to formalise this service and make sure that all our ICT or home visiting service patients are getting appropriate fall advice/interventions. We can also work to increase awareness of the falls service at Fleet Hospital.
   https://www.southernhealth.nhs.uk/services/community-health-services/hospitals/fleet/

- A description of how clinical practice and outcome variation is going to be benchmarked and discussed at a network level on a regular basis and how educational needs/support from secondary care will be identified and shared with the ICS to inform educational programmes. This may be building of what is in place currently. May require new reports to be produced/better access to information.

  We will introduce a clinical variation slot at each locality meeting and discuss. We need to engage with practices in a supportive way – if there is clinical variation why? What are the problems and what might be the solutions? Educational needs can be discussed with the CCG. NEHF CCG hold regular 2 monthly Target afternoons which are very well received and attended by GP's and other practice clinicians.

- A description of how working in the network will improve the traction/buy-in to the clinical behavioural changes required to reduce variation in outcomes.

  Our experience of working together as a network and meeting regularly has shown that shared problems often lead to shared solutions. Extended Access working required very considerable clinical behavioural change.

2.3.3 Population segmentation summary

- Describe how and where population segmentation is being used currently) and any future plans to better match population need and service delivery e.g. frailty tools, complex case management etc

We are about to embark on a project which involves identifying and better managing frailty (see frailty work stream p26). We have initially chosen to use the Rockwood Frailty Score and our clinical staff are all encouraged to use this scoring system when clinically appropriate. We are also about to start using the IPA (similar to ACG) risk stratification tool (see p26).

2.4 Managing Resources

How does the network plan to use working at scale as part of future workforce planning, greater practice resilience and creating economic benefits.

2.4.1 Workforce resilience, skill mix and staff development

All practices that form the Farnborough Network are shareholders in Salus Medical Services Limited the CCG wide GP Federation. Salus was formed with 4 specific objectives in mind:

- To be a credible service provider delivering Primary Care at scale.
- To stabilise, sustain and shape plans for the development of Primary Care locally.
- To provide a unified voice for Primary Care in North East Hampshire and Farnham.
- To ensure high quality education and training for all practice staff and students

Now in its fourth operating year and directly employing 30 staff Salus has delivered on these aims and intends to continue developing 'at scale' solutions and innovative delivery models to make General Practice more resilient. In a lean operating model, all but 4 of the staff employed by the Federation are in patient facing or service delivery roles and as set out in 2.2 above currently cover Integrated Care, Pharmacists, Paramedics and associated administrative support. In total 6 are employed in whole-time posts supporting Farnborough practices exclusively with a further 7 whole-time staff engaged in roles that cover Farnborough and two other networks. We anticipate developing this skill mix as set out 2.2.5 above in the short to mid-term. We employ a mix of funding solutions with some contracts being fully supported by the CCG and others with funding shared between commissioners and practices.

The successful delivery of jointly funded posts has made General Practice more willing to consider funding specialist capacity from GMS resources and many now recognise the benefits inherent in paying for a share of an 'expert' employed by the Federation compared to the cost and risk of continuing to do everything in-house. At its simplest level two dedicated people operating across a network of 50,000 patients

provide a more resilient and better resourced service than a person in each practice devoting half their time to the role. Implementing this through a federation wholly owned by the practices it serves engenders a sense of stability and confidence.

We particularly recognise the benefits in training and education that accrue from this workforce model and, for example, as the employer of 8 paramedic practitioners Salus can set up meaningful development sessions and is even using its experienced staff to mentor new starters through university and practical on-the-job training which will see them achieve 'practitioner' status in time. This model also helps to reduce clinical variation and service inconsistency by promoting a homogenous workforce with a common employment model, common training profile, shared SOPs and a wider peer support network.

We see this 'pooled resource' approach becoming the backbone of both 'at scale' services and many gains in back-office efficiency. We are considering working with practices to re-model elements of the Practice Nurse role and improve integration with Community Services to elevate skills in LTC management through cross-practice working. IT advances now facilitate the delivery of more specialist clinics from locations outside the patient's home GP and the Farnborough Network already uses this capability to deliver GP Extended Access from some locations which see patients from a mix of surgeries.

2.4.2 Back office efficiencies and economies of scale

It is only in the past 12 months that Salus has started to look seriously at providing shared support services to member practices, but these are already starting to show results with demonstrably reduced costs and improvements in consistency. Specifically, we have delivered:

- A federation wide discounted purchase of Bluestream Academy on-line training resources.
- A group purchase scheme for Mjog SMS messaging services
- A shared Data Protection Officer and harmonised GDPR documentation
- Harmonised data entry Templates for practice EMIS Systems to support Local Contracts
- Harmonised local and enterprise level EMIS reporting to support Local Contracts.
- Regular BLS and Medical Terminology training for member practice staff

We expect to see significant developments in this area with practices starting to share resources more readily, particularly those that are more specialised but not supported by mainstream outsourcing services. We believe that HR and Financial Services will continue to be outsourced where appropriate and as there are many options available this is unlikely to be viable for delivery at scale by a single provider in the short term. Locally estates continue to be a mixed picture with some excellent facilities and some woefully inadequate. Locally, Farnborough is the region with the most challenging facilities and given the complexity of both local planning regulations and NHS funding criteria we believe this work is best delivered at CCG level. There are however, several back-office opportunities that we will be exploring with partner organisations, each of which has the potential for cost reduction through shared resources:

- CQC (policies and processes)
- Clinical Governance (policies and processes)
- Digital Transformation (web development, online services, etc)
- Training services and staff development
- Utilising cloud-based services to centralise document management and clinical typing.

We firmly believe that in addition to cost reduction, working at scale on back office services will yield better consistency, less clinical variation (arising from more efficient admin systems) and a more homogenous look and feel across the local range of practice services.

Fleet

2.4.3 Managing resources at network level: budget for care services, staff (capacity), activity (demand).

The question of identifying demand in General Practice is anything but simple and any concept of balancing demand across a network of GP services is relatively novel. Whereas in many services demand is easily measured by the number of 'customers'; which in NHS terms often translates to the number of patients referred and may even be predictable using national models of disease prevalence, in General Practice this is rarely possible. There are several factors contributing to this:

a) The need to see and reassure the worried well.
b) Variation in the threshold between 'urgent' and 'routine'
c) False demand created by patients who could not get an appointment.
d) The breadth of services available all accessed through the same input system.

The CCG has deployed the Alamac Kitbag across all practices, a tool that aims to capture the urgent demand and appointment availability across the system. The Alamac Kitbag produces reports at practice and CCG level indicating the fluctuation in demand and appointment availability. It also provides some indication of the uptake in Rapid Home Visiting and its impact on visits made by GPs. Kitbag has been used successfully in other settings but seems at present to have limited potential in Primary Care principally because of the wide variation in appointment systems in operation. Practices account for and manage urgent and on-the-day demand in different ways making any direct comparison of little value. The tool is also a retrospective view making any demand balancing to reduce daily pressures impossible. A final limitation is that the Alamac tool only compares appointment availability with actual bookings thus does not take account of total demand that will include patients unable to secure an appropriate appointment and those who abandoned the process.

Modern telephone systems can assist by providing data about the number of calls answered, number of calls abandoned etc. and comparing this to actual appointment availability gives some measure of when and by how much demand exceeds appointment capacity. Patients do of course call the surgery for many other reasons and perhaps longer term a network level (or even multi-network level) call centre may offer a solution with calls answered quickly, patients seeking results, appointment confirmations, advice etc being routed directly to a specialist team, urgent need directed straight to clinical triage and the remainder being given appointments even some weeks ahead. Serving the patient 'first time' would eliminate frustration for both reception teams and patients alike, whilst reducing call traffic appreciably.

Fleet

The possibility of balancing demand through offering an appointment at another surgery may also be possible in time and Salus already has the technology support in place in the Fleet Network to facilitate this through EMIS Clinical Services and Docman Share. Expected enhancements to support eRS, EPS and direct access pathology from within EMIS will make this option more attractive to both clinicians and patients.

With the opportunity of extra space because of the development of Fleet Hospital the Fleet practices may consider an urgent care arrangement. This would require additional funding for to set up an urgent care facility with the need to employ additional reception staff.

Given that any call-centre based solution is some time away, we believe our existing pooled resource approach goes some way to helping the Fleet network archive a measure of demand balancing. The Paramedic Home Visiting service allows practices to triage and effectively outsource home visits to the Salus team on a case by case basis. The team then operates as an additional staff resource for the practice for the duration of each visit, liaising with the GP team and writing notes directly in the practice EMIS system from 4G enabled laptop devices. This service is now well established and popular across the community. It provides a unexpected benefit by strengthening links between the ICT team, Community Nursing and General Practice thereby enhancing service integration.

We are currently working with the CCG to deliver a Locality Access Point which aims to provide an improved link between secondary care and community-based services by providing clinicians with a single point of access when discharging patients. This facility will be provided through our Integrated Care Teams and operate across the Farnborough, Fleet and Aldershot networks. The LAP will be operational 08:00 to 20:00 Monday to Friday and be able to coordinate care between the various agencies required and staffed by an administrator and a Band 7 nurse.

We would welcome business information in any available format that provides an accurate measure of agreed activity, cost, performance etc. Historically we have found a ‘dashboard’ approach the best way to provide information in a way that is easily communicated to those who are less close to the process. As service providers, however, we need to be very clear about how and where data is acquired to ensure that decisions are properly informed. We therefore welcome processed information but would prefer also to receive raw data to enable more specific and detailed local analysis where necessary. Microsoft Excel or a cloud-based data warehouse such as Power BI with access to downloadable source files would be ideal.

2.5 Empowered Primary Care

- How would you envisage communication between networks and your representative GP providers on the ICS Board working?

  GP provider representative will be happy to attend network meetings whenever invited.
  Planned meetings of NEHF network leads – the first meeting is scheduled for October 3rd.
  There will be a regular ICS newsletter with an opportunity to feedback easily via email.
  There will be dedicated space on the Salus website for networks to express their views.

- Are there any other (in addition to the ICS Board) system-level decision making meetings that the network believe should include a general practice provider voice?

  Yes, probably but would be happier to answer this when we have a better understanding of ICS.

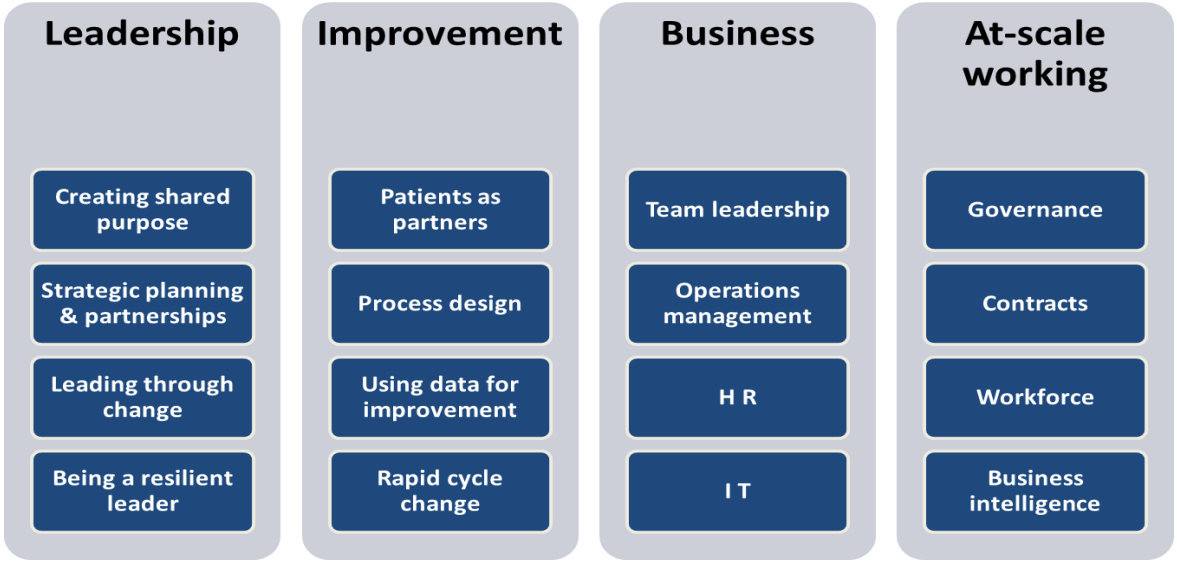
  We need to keep in mind that having provider GP representatives on the ICS board does not necessarily mean a strong voice in shaping the future. We are more likely to make a difference by working with, developing relationships and therefore influencing other providers.

  See https://ockham.healthcare/category/blog/ Blog from September 19th, 2018.

Section 3: System Support

3.1 Network Development Needs

- Please describe any development needs that might be required to deliver this plan. This might be for individuals or groups. The framework below is a useful framework for thinking about these needs.
- Which of these do you feel comfortable delivering internally and where might some support be required?



Leadership

Across the five NEHF CCG networks we are fortunate in that three of our network leads have now been involved in driving forward GP transformation for at least the last four years and have therefore developed considerable experience. This is now complimented with two new network leads with considerable experience in working for NEHF CCG. Our new models of care range from a large merged practice, through working very closely together in a locality, to a more 'federated' way of working over a wider footprint. There is much to be learnt from each other and it would be helpful to be able to take some time out to facilitate these discussions both within the NEHF networks and more widely with all the ICS network leads. We are all still working clinicians so funding for backfill may be important if we are all going to be able to attend. This could also be an opportunity to introduce some 'light touch' leadership training.

Improvement

As we design and implement new models of care we should be committed to 'patients as partners' this has taken some time to gain full acceptance amongst GP colleagues. The fear is that patient's will always ask for services that we simply do not have the resources to provide. However, our experience has been that patients' suggestions are usually extremely sensible and that they do take into account limited resource. It was interesting to note the output from our extended access engagement – routine appointments on a Sunday afternoon were no more popular with patients than they were with doctors.
We have already discussed how we intend to engage with our patients in the future and explained some of the work already done. Support from communications experts at our CCG was invaluable during this process and we would suggest that this sort of work is much better co-produced; it reflects the fact that the CCG's are responsible for representing their population and the federations represent the practices.

During the preparation of network plans it has been instructive to look at some of the data surrounding variation and it is clearly a good exercise to get networks to start thinking about the needs of their populations and the needs of practices if variations in care are to be reduced. The provision of data packs and then meeting with the CCG was very helpful and leads us to the thought that commissioners have much more experience and expertise in this area.

We have discussed some of the work already done last year with regard to what might be effective, evidenced based interventions for patients once risk stratification tools are operational. Our work suggested that the evidence base for case management in an NHS setting was hard to find. Most GP's will have some knowledge of how to interpret original research but we cannot claim to be providing an expert opinion. 'Expert' support across the ICS networks to review the evidence base and then input into the planning of the necessary proactive work could be very helpful. How do we use the data to provide effective new services and then how to we continually evaluate and improve the service via rapid PDSA cycles?

We have learnt the importance of continual evaluation during the local Vanguard program and the CCG continuing to supply us with monthly performance data is extremely helpful.

Business

Our business Salus Medical Services has been up and running for some time, it is tempting to think that we have most of the areas in this section covered but we must avoid complacency. Both HR and IT have been a problem.
We have needed HR advice but have found the available advice both expensive and inconsistent. HR advice for federations at scale would be an important resource – could this be provided by Commissioning Support Units at a reasonable cost?
Information technology has been extremely difficult and frustrating at times. Some of our problems have been finally solved by commissioning our own professional IT support. However, we do still have challenges with regard to interoperable systems; if this is to change, it will need driving forward at a senior level amongst ICS provider partners.

At-scale working

Workforce is the huge issue here. We have described how we are starting to be involved in training our own work force. We need to be thinking about maximising training and development opportunities for practice and federation staff across the ICS. Transforming general practice so that it becomes a much more attractive place to work will help, so will easily accessed affordable training and as we have said 'you tend to keep the people you train'. Most of our new young GP's we have managed to recruit locally trained with local practices.
Finally our managers advise that training, support and advice on Business Intelligence tools would be very useful.
To this I would also add making use of technology it is becoming increasingly obvious that local general practice cannot ignore new technology based ways of working for example Babylon. The new Health Secretary would seem to agree.

Fleet

3.2 ICS Support/Actions – See Appendix B

Appendix A: Frimley ICS GP Maturity Matrix: Plan on a Page

Aims: - Improved care quality * Sustainable general practice * Strong voice within system

NHSE Pillars	*Foundations for transformation*	*End State Step 1*	*End State Step 2*	*End State Step 3*
Right Scale	**Plan** There is a plan in place to achieve full geographical coverage articulating a clear end state vision and steps to getting there, including actions required at practice, network and system level. **System responsibilities to** include: • Articulation of system wide network benefits • Development needs identification • Resources to support: money, people, technology, estate • Agreeing levels of ambition and baseline and pace of change with general practice **Engagement:** GPs, local primary care leaders and other stakeholders believe in the vision and the plan to get there.	Practices identify partners for network-level working. Full geographical coverage across the ICS. Year 1 plans agreed.	End state **business, relationship** between network partners is discussed and stepped plans developed.	Agreed business model at network level fully operational. Interoperable systems. Shared workforce and optimum estate usage.
Integrated Working		Opportunities and benefits for integrated care delivery are identified. Form part of year 1 plans	New care delivery models are agreed, designed and tested. Fully functioning integrated care teams covering all networks.	New care delivery models embedded and benefits evidenced. Person level data is linked and shared between service delivery partners
Targeting Care		Outline plans to reduce unwarranted variation in care & outcomes identified . Inform year 1 plans. Development /educational needs are identified.	Process to analyse & discuss variation between practices have been agreed and acted upon. Required data and analysis support is available.	Networks can track population resource usage using real time data and information.
Managing Resources		Opportunities for shared skills, workforce planning and delivery discussed and agreed. Clinical and back office. Form part of year 1 plans	Plans implemented. **Career opportunities** across the network described.	Networks have the opportunity to take collective responsibility for funding.
Empowered Primary Care		Relationship between the networks and the provider voice on the ICS Board described.	General Practice as a provider has a seat at the table for all system-level decision making	Single voice from general practice represents the views of networks (internal relationships) and influences system decision making (external relationships**).**

Appendix B: Network Action Plan

NHSE Pillar	Action reference	Description	Benefits	Start date	Finish date	Owner	Support Required
Right scale	1	Regular 1-2 monthly network meetings Initial meetings to present ICS network plans and then subsequent meetings to keep practices in touch with plan as it evolves	Practice buy in to plan, much more likely if they are fully informed and involved in shaping the plan and maintain Network Lead mandate	Sept 2018	On going	Network Lead	Nil at present
	2	Regular ICS Newsletter for practices, circulated widely to try and reach those unable to attend meetings. Dedicated space on Salus website where practices can feedback as network plan develops	Practice buy in to plan, much more likely if they are fully informed and involved in shaping the plan and maintain Network Lead mandate	Sept 2018	On going	Salus Clinical Lead Salus Business Manager	Nil at present
	3	Engagement with wider community partners – presentation of network plans to ICT OD days	Key theme of plan is enhanced ICT driven by general practice so very important that community partners understand plan and buy in.	Oct 2018	Jan 2019	Salus Clinical Lead Salus Associate Director of Nursing Salus ICT Manager	Nil at present

	4	Working towards optimum estates usage – continue to be fully involved in shaping development	Continue to engage with meetings and planning of Fleet Hospital Extension	Jan 2018	On going	Network Lead	Supported by NEHF CCG at present
Integrated working	5	Paramedic 1 Paramedic Practitioner course	Develop and maintain workforce – 'tend to keep people you train'	Sept 2018	June 2020	Salus HR manager	Funding for backfill to maintain service delivery
	6	Paramedic 2 Paramedic Practitioner course	Develop and maintain workforce – 'tend to keep people you train'	April 2019	June 2021	Salus HR manager	Funding for backfill to maintain service delivery
	7	Network discussion on role of GP mentors for prescribing course paramedics – will networks share the work e.g. paramedics sitting in with GP surgeries or will we need to appoint paid GP mentors	Promotes practices working collaboratively within a network to develop and maintain workforce.	Nov 2018	Feb 2019	Salus Clinical Lead Network Leads	Nil initially but funding may be necessary if we need to appoint paid mentors
	7	One paramedic from each of 4 networks (Farnborough, Fleet, Aldershot, Yateley) to attend six-month independent prescriber course	Develop and maintain workforce – 'tend to keep people you train'	April 2019	Oct 2019	Salus HR manager	Funding for backfill to maintain service delivery
	8	One paramedic from each of 4 networks (Farnborough, Fleet, Aldershot, Yateley) to attend six-month independent prescriber course	Develop and maintain workforce – 'tend to keep people you train'	Oct 2019	March 2020	Salus HR manager	Funding for backfill to maintain service delivery
	9	MSK assessment service. Regular training sessions for practice reception staff	Reduce variation in uptake of clinic appointments so all patients benefit from the service. Promote signposting skills necessary to introduce skill-mix into general practice	Oct 2019	On going	Salus Clinical Lead and HR manager	No immediate support needed. NEHF have provided some signposting training for practices which was well received. In the future there maybe an ICS wide need for this training.

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	10	Clinical Pharmacists in General Practice future planning as pilot comes to an end – what do practices feel they need and how can we improve the service for patients and maximise the benefits for general practice	Practice Engagement/Education event	Oct 2018	Feb 2019	Salus Clinical lead Salus Senior Pharmacist and HR manager	Nil immediate Discussion with and learning from other networks within the Frimley ICS who also have clinical pharmacists working in GP will be helpful to develop this model of care
	11	Clinical Pharmacists in General Practice Working within ICT's Planning and discussion with a view to funding application	Improve patient care and safety reduce avoidable hospital admissions and reduce local variation in care/outcomes	Oct 2018	Dec 2018	Salus Clinical lead Salus Senior Pharmacist Salus Associate Director of Nursing	We are not funded for this role at present and so new sources of funding would need to be found – could it be done as a closely evaluated pilot that ICT's across the ICS could learn from?
	12	Working with Community Pharmacy - Engagement/feasibility meetings with local community pharmacies and CCG medicines management team	Possible more effective, safer chronic disease management benefiting patients, reducing GP workload and with system benefits via reduction of iatrogenic harm.	Oct 2018	March 2019	Salus Clinical lead Salus Senior Pharmacist	Support and advice from CCG medicines management team.
	13	Enhanced Integrated Care – achieve fully staffed ICT teams as per original Vanguard Locality plans and complete staff inductions. Introduce new system in Fleet of the ICT team phoning GP with most knowledge of patient.	See above p 26	In progress	Nov 2018	Salus Clinical Lead Salus Associate Director of Nursing	No immediate support needs – contract with NEHF CCG in place and regular monitoring/contract review meetings on-going

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	13	Drug and alcohol worker to work with ICT's Recruit and induct into role Discuss with other local providers and ensure work not duplicated.	Harm reduction to improve patient health and wellbeing reduce load on system – GP, acute trust and social care.	Oct 2018	Jan 2019	Salus Associate director of nursing Salus HR manager	No immediate need – funding has been agreed but if other networks have any experience of this type of service we would be grateful to share learning
	14	Implement Network Access Point Plan	Efficient seamless transfers of care facilitate timely hospital discharge and reduced delayed transfers of care	In progress	Go live end Oct 2018 Fully staffed Jan 2019	Salus Associate director of nursing Salus ICT manager	No immediate need – funding has been agreed but if other networks have any experience of this type of service we would be grateful to share learning
	15	Full IT access to community systems for Salus ICT staff	More efficient joined up work in ICT's	In progress	?	Salus Business Director Salus ICT manager	If escalating this within the ICS could be helpful we would be most grateful
	16	Frailty MDT meetings	Expert frailty advice to inform the work of the network ICT's	Oct 11th 2018	On going	Salus Associate director of nursing Salus ICT manager Fleet GP advisor to ICT (appointed)	No immediate need – funding has been agreed but if other networks have any experience of this type of service we would be grateful to share learning

Fleet

	17	Start using risk stratification tool to work more pro-actively within ICT's	Maintain patients' health, wellbeing and independence. Action taken before the crisis happens and benefit the system by reducing social care need and emergency hospital admission.	Nov 2018 If IPA Available for use	On going	Salus Clinical Lead Salus Business Director Salus Associate director of nursing Salus ICT manager	How do we effectively use a risk stratification tool, is there an evidence base, what is working already in the ICS networks? This could be the subject of a half day workshop to inform future development and planning.
	18	Integrated Practice and Community Nursing Teams – continue to build relationships with CCG and other potential provider partners	Wide range of skills between both practice and community teams – pooling these skills so that we are putting the right clinician in front of the patient irrespective of place of consultation would mean an efficient use of the workforce we have – good for patient and system benefits.	June 2018	Oct 2019	Salus clinical lead Salus Business Manager Salus Associate Director of Nursing	No immediate need – but if other networks have any experience of this type of service we would be grateful to share learning
	19	Make Oasis drop in mental health service available to Fleet patients and complete comms exercise with Fleet practices	Somewhere for patients in crisis to go considerably closer than alternative in Aldershot for most Fleet residents	Oct 2018	Dec 2018	Salus Clinical Lead Just Wellbeing	No immediate need

Targeting care	20	LD Health checks assist practices so that all are achieving the 75% target or better	Reduce variation in care important way of reducing inequality for vulnerable group of patients	Sept 2018	March 2019	Network lead Practice managers	No immediate need already supported by NEHF CCG
	21	Increase number of patients accurately diagnosed with AF and then appropriately treated	Reduce incidence of stroke	Oct 2018	March 2019	Salus Clinical Staff Salus Clinical Lead	No immediate need already supported by NEHF CCG
	22	Falls – increase the proportion of ICT and rapid home visiting patients receiving fall advice/intervention	Falls significant cause of injury/morbidity	Oct 2018	March 2019	Salus Clinical Staff Salus Clinical Lead	No immediate need
Managing Resource	23	Develop digital services to act as an enabler for enhanced back-office collaboration.	Enable better sharing of resources using digitally enabled cloud-based services and common web technologies.	Oct 2018	On going	Salus and CCG/ICS staff	Collaboration across providers
	24	Develop the 'pooled resource' employment model.	Facilitate the employment of more shared resources to build clinical and non-clinical specialist expertise across the network and potentially across multiple networks as appropriate.	Oct 2018	On going	Salus & Network leads/ICS Board	No immediate need

Fleet

Empowered primary care	25	Provider Rep to attend network/locality meetings when invited/meetings with network leads NEHF and ICS	Practice engagement/buy in – views/concerns of grass roots general practice made available to the board	Sept 2018	On going	Salus GP Provider Board Rep	Support needed to arrange network/federation leads meetings
	26	Regular ICS newsletter dedicated web space for feedback	Practice engagement/buy in – views/concerns of grass roots general practice made available to the board	Sept 2018	On Going	Salus GP Provider Board Rep Salus Business Manager	Nil at present
Development needs	27	Network lead meetings NEHF and ICS	Much to be learnt from each other	Sept 2018	On going	Network Leads	Support needed to arrange network/federation leads meetings
	28	Commissioner/ Expert advice on clinical variation data/ what to do with output from risk stratification.	Understand need better and be able to target intervention more effectively	Sept 2018	On going	Salus Clinical Director Salus Business Manager	Support needed to provide 'expert' advice.
ICS Support actions	29	TBC and above					

Appendix C – Salus Shareholder Agreement

Shareholder Agreement.doc

Appendix D – Presentation from Salus AGM 2017/Salus ICS Newsletter

AGM 2017.pptx

PrimaryCareNetworkplans.docx

Appendix E – Patient Engagement Evaluation

Extended Access Engagement

Appendix F – Month 12 Vanguard Dashboard March 2018

M12 201718 - Vanguard Dashboa

Appendix G – presentation prepared by Salus paramedic practitioners/Feedback from practices in one of our networks

Salus Community Paramedic Practitione

Copy of Aldershot Paramedic Practice fe

Appendix H – Independent evaluation of the Paramedic Home Visiting Service

NEHF Fleet RHV Evaluation Final Draft 080618.pdf

Appendix I – Farnborough Physio Pilot

Farnborough Physio Pilot report(fi

Appendix J – Fleet ICT evaluation

Fleet ICT Evaluation Report Draft 2 080618.pdf

Appendix K – network access plan business case.

NetworkAccessPoin
tBusinessPlanfinal1.

Appendix L – case management is there an evidence base?

Next
Stepsdiscussion.doc

Appendix M – GP resilience survey results

NEHF CCG survey
results.pptx