Site visits additional information

Contents

BB02 Waltham Forest CCG

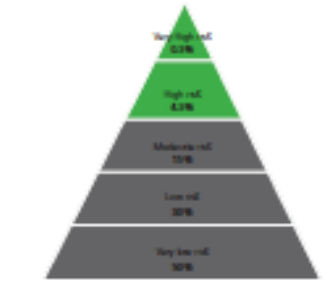
WELC Pioneer Programme Service Model

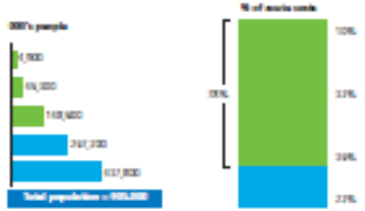
Care Co-ordination

WELC Care Collaborative

1. Care co-ordination in WELC

- Care co-ordination is aimed at people who have a 'very high risk ' or 'high risk' of hospital admission over the next 12 months (5%, approximately 10-12,000 per borough)
- In all three boroughs an extended primary care team is being aligned to GP networks or clusters.
- All three boroughs have struggled but found ways to top up the Avoiding Emergency Admissions DES that covers the first 2% of the population we are targeting. The DES contains some but not all the elements we are implementing as part of the care co-ordination model in WELC
- Elements of care co-ordination are being commissioned from GPs and community health services teams.





2. Key elements of care co-ordination

- Joint assessment of health and social care needs to produce a tailored care plan
- Case management for the very high risk
- Care navigation for all in the top 5%
- Outcomes based commissioning approaches to reduce emergency admissions and re-admissions (using acute CQuIN in 16/17)
- Digital health records to share care plans.

2. Operating model in Newham

5. Care co-ordination with NELFT in Waltham Forest

4. Tower Hamlets Care Co-ordination Network Improved Service (NES)

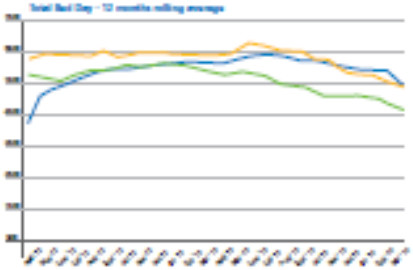
- Commissioned from GP networks to top up the DES
- GPs responsible for coding consent to share information with all providers
- Crisis plan (using the DES model) for all patients in top 4% in 2014/15
- Personalised care planning for a proportion of patients
- Payment based on item of service for activity in 2014/15. Return to outcome based in 2015/16.

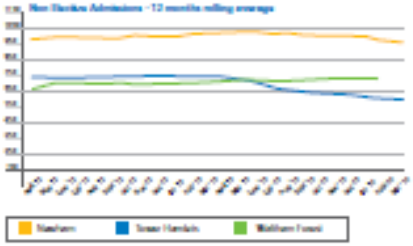
6. Workforce

- Consultant support from the hospital is critical and boroughs have invested in community geriatricians and other consultants to support GP clusters/networks
- A new workforce of care navigators has been created - 32 staff (full time equivalent) recruited in 2014/15
- Additional resources identified to support the extended teams including social workers, mental health nurses and a review of the current community nursing offer to identify the resources to deliver case management.

7. Outcomes and early system wide indicators

	completed care plans to date	enrolled patients to date
newham	2296	4233
tower hamlets	909	1007
waltham forest	912	1492





BB03 Bedminster Medical Group

Federation Proposal

- Why is federation on the agenda?
- Who is the federation model being proposed to?
- What is the model being proposed?
- Pros and cons
- Key items for consideration

Why is federation on the agenda?

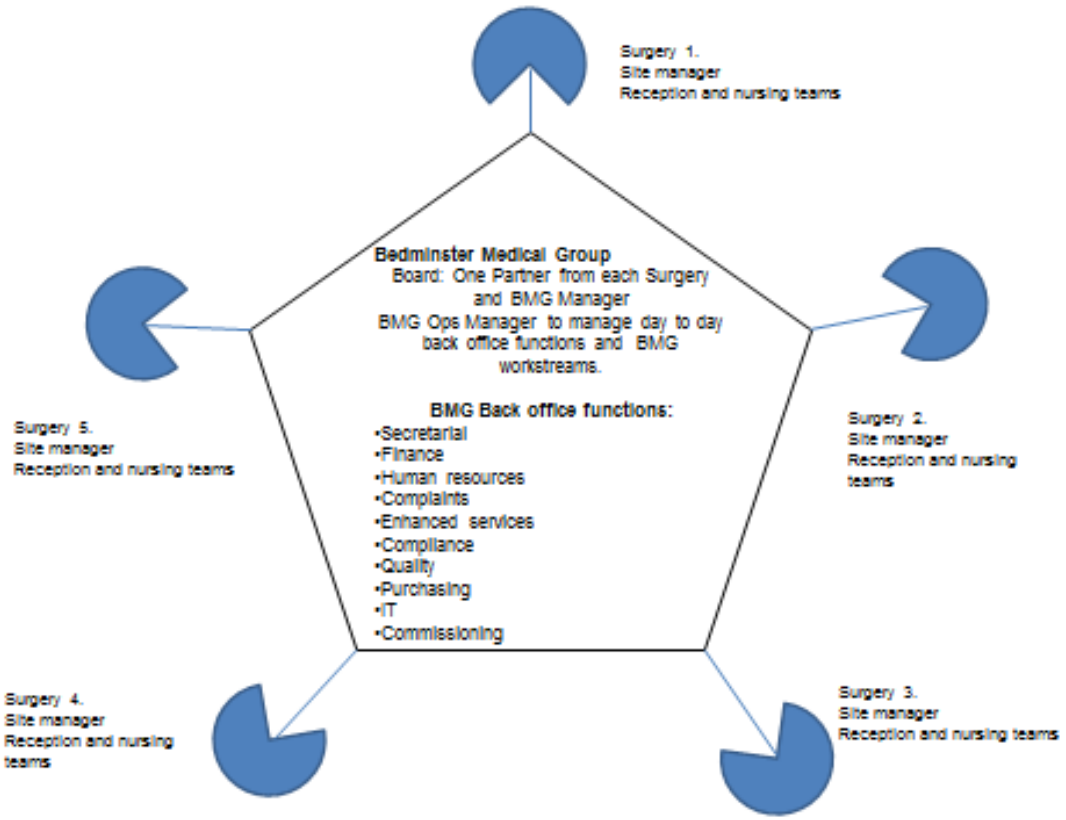
- Realisation that it is not financially sustainable in the future to replicate all of a Practice's functions in every practice
- Future demands from NHS England, such as 8am to 8pm access 7 days a week, mean that practices are going to have to work together to spread the workload
- As work flows out of secondary care and into the community, federated practices will be in a robust position to bid for the work
- We can strengthen the position of the Practices in the local community, and become more integrated with the third sector providers
- We can offer a more robust service to our patients

Who is the federation model being offered to?

Discussions to date have involved:

- Bedminster Family Practice
- Gaywood House Surgery
- Malago Surgery
- Southville Surgery
- Wedmore Practice

The advantage of the model is that it can accommodate any number of practices.



Pros and cons

I understand the logic of federating to maintain my profits despite all the changes the government are introducing and their drive to reduce costs – but of course I don't actually want to change anything that I am doing!

- The proposed model allows for expansion in the future, or contraction if necessary
- The model allows engaged practices to meet the demands envisaged in the medium term
- Individual practices maintain their own income streams and accounts.
- There are no concerns about buildings
- Practices will maintain their own internal cultures, and particular service offerings to their patients
- The model allows time for practices to develop trust with each other
- The model has been adopted in other sectors
- There may be some short term staff turnover as the new structure is implemented
- Financial savings will not be material in the short term unless Partners accept greater staff turnover and/or staff dissatisfaction

Key items for consideration

•Each partnership needs to consider what issues federation poses for them, and whether any of these issues become 'show stoppers' What is the target date for creation of the federation (31/3/15 suggested)

•What are the rules by which the Group operates. These rules are necessary to ensure the centralised function remains the slave of the practices, and not the master

•Adopting the correct legal structure

•NHS pensions

•Financial structure and consideration such as VAT

•Decision on Board members

•Choice and funding of project resource

BB04 Health Education South West Bedminster Medical Group

Bedminster Medical Group

Federation Business Case

Executive summary

Five GP practices covering the greater Bedminster area of south Bristol are in agreement to create a legal entity to be called Bedminster Medical Group (BMG). BMG will be the entity used to drive our federation activity from 2015 onwards, to the benefit of all engaged stakeholders.

The agreed structure will allow:

- the federation to deliver enhanced levels of clinical services to our patients
- each partnership to continue to hold its own GMS or PMS contract with NHS England
- each partnership to make its own unique offering to its patient list allowing patient choice
- the federated practices to deliver a more robust clinical service across the city ward
- the federated practices to tender for services that will directly benefit the patients by bringing healthcare out of the acute sector and into the community
- the practices to become more financially robust in the face of future financial pressures on the NHS in general, and primary care in particular.

The practices are requesting financial support to engage a project manager who will undertake the preparatory work necessary to create Bedminster Medical Group as a functioning entity with correct legal status, ready and able to sign-up for enhanced services by April 1st 2015. In addition we believe that we need to employ a nurse practitioner to release a Partner to support the project manager. The estimated cost of this support will be £XXXX, in the current financial year.

Business description of the engaged practices.

The five practices involved in this proposed federation are:

Practice	Local Code	Contract	Partners	Salaried GPs	Manager	Nurse WTE	List size
Bedminster Family Practice		PMS			Gabby Prowse		
Gaywood House Surgery	L81057	PMS	Dr D Kessler Dr M McRobert Dr D Weil Dr A Blythe Dr Goodger Dr A Platt	One	Brent Stephen	2.9	7,546
The Malago Surgery		PMS	Dr A Green				

The Southville Surgery		GMS	Dr R Adams Dr B Compitus Dr S Colthurst	Five	Andrew Bale		8,748
The Wedmore Surgery		PMS					

Bedminster Family Practice

Gaywood House Surgery

The practice benefits from a strong Partner base, a stable patient list and very low staff turnover. This enables the practice to deliver a very consistent level of service and clinical care to its patients. In comparison to many other practices in Bristol it is very low funded and therefore receives additional funding from Bristol CCG under the Primary Care Offer. This additional funding enables the practice to maintain the status quo, but does not allow for the development of additional clinical provision. The Partners see the federation as an exciting opportunity to work closely with neighbouring practices, strengthen their current healthcare offering, and develop a range of new services that will enable NHS England and Bristol CCG strategies to be delivered. The Partners are determined that the federation will bring improvements in healthcare above other considerations.

The Malago Surgery

Southville Surgery

Southville Surgery is a growing practice located in the South of Bristol. Historically, Southville Surgery has received lower levels of investment than surrounding practices and as a consequence struggles to deliver accessible care the meets the needs and expectations of registered patients. We also receive additional funding via the Primary Care Offer, which is due to continue until March 2014.

Funding lags behind need and our ability to recruit additional staff is affected. Southville Surgery is facing a number of pressures – retirement of two partners (2014) and our practice manager (2015), maternity leave for both full time salaried GPs with the inability to source adequate locum cover for this leave, a growing list size, flat funding and below average patient survey results.

We have identified the need to make changes and we are actively engaged with four other practices to explore our options for federation and the benefits this brings. We are struggling to free up GP time to fully engage with this and require a step change in our practice set up to enable this to happen, such as the introduction of a nurse practitioner. We also recognise that we need the expertise of an experienced project manager to enable this complex process to proceed in a safe and efficient way.

The Wedmore Practice

Our federation model

The structure is laid out in appendix 1.

We see federation as an evolutionary process, rather a revolutionary one. The model has been chosen because:

- it has a track record of working in other areas such as education
- it is simple in concept
- we accept that our patients have made a free choice of which practice to join, and this choice is based upon the unique offering each practice makes. To make major changes to our operating structure would negatively affect the patients with no immediate gain.
- It strengthens our nursing teams
- it respects our staff and will not cause undue concern
- the model can be implemented with comparatively little effort – not sure I agree!
- it makes best use of available resource within the practices
- it can be expanded in the future with relatively little disruption to the existing practices
- the model can deliver administrative efficiencies very quickly

Cabot Learning Federation is a successful federation of 11 academies across the BNSSSG and B&NES area. Its model allows each academy to concentrate on the core activity of engaging with its students to deliver the national curriculum. To do this as effectively as possible as many of the non-educational activities, traditionally the responsibility of the head teacher, have been made the responsibility of the central administrative function. This leaves the head teacher free to concentrate on the teaching staff, the students, and the delivery of the national curriculum through excellent teaching and pastoral care.

Health care example? There are federated practices already within England, can we use one of them as an example if not a blueprint for our own federated model? Or add in our discussion with Merlin here.

The proposed model is simple in its concept and structure. There are no major legal or financial obstacles to be overcome, as has been demonstrated in talks given by various legal and financial firms of late. (Veale Wasborough Vizard and Baker Tilley)

The barriers in place relate to the time and the logistics of bringing together separate practices with very distinct personalities and agreeing a shared vision that can be taken forward in a safe and caring

way. This is why we are seeking support to fund a project manager. We see this as a key role in the journey to federation and one that cannot be provided from within any one practice. We would envisage them working closely with individuals from our five practices who have had time freed up by employing new or additional nurse practitioner services.

We accept that our patients have chosen each of the five practices for very individual reasons, and we have no desire or need to cause significant change for them. We accept that it is our responsibility to enhance our service levels, and create a more robust structure, with minimal disruption to the patients. The evolutionary view taken by the federation partners will allow for effective Patient & Public Involvement (PPI) as we move forward with service re-design and development in the future.

We would envisage having a nurse manager working for the federation to develop and coordinate our nursing strategy.

At one of the practices we have a trained nurse undertaking Doppler assessment and applying four layer bandages - but the patient numbers are not high enough to ensure her skills are maintained. If this more specialist role was concentrated at one practice with access available to all practice patients within the federation, it allows the option to train and maintain specialist skills as the patient numbers then become high enough even for less common conditions.

This approach could also be applied to Teledermatology and the exploration of other telehealth interventions, advanced sexual health provision including implant fitting, insulin conversion, alcohol harm reduction, smoking cessation – enabling us to run support groups, diabetic structured education programmes, ambulatory BP and ECG machine fitting and evaluation of results, specialist chronic disease management nurses – where each practice can access support and advice e.g. Heart failure expertise, an area that Bristol lags behind when it comes to gold standard management and prevention of unnecessary hospital admissions.

All of the practices benefit from having loyal and dedicated staff, attuned to their patients and the culture of each practice. This model allows implementation with the minimum of change to staff in the short term, but has a clear road map to follow as new staff are recruited. This approach avoids the need for redundancies which can be unsettling and expensive.

On a more basic and practical level it will also allow us to develop a local bank of nurses to cover holiday and sick leave, which is vital to avoid variations in service provision and quality.

The model allows for expansion, and contraction if necessary, in the future will little or no disruption to the existing federated practices. It will also withstand the formal merger of two or more practices and remain intact. There may be stepped changes in management costs in the central function if the federation increases to the degree that the BMG staffing numbers grow too large, but it is envisaged these costs will be offset by savings accrued at practice level.

Each year we are faced with QOF changes, DES changes, contract changes, Primary Care Agreement (PCAg) changes and changes to shared care services with our local city council. At the moment each practice must wade through hefty contracts and identify changes, communicate changes and plan for delivery of services as well as understanding who and how to invoice for these services. We

would propose having a business manager across the practices with local practice link workers to ensure this work is streamlined with the avoidance of the current unnecessary duplication of work.

Whose needs are we trying to meet?

In the first instance we are concentrating on the needs of the five practices to manage some short term needs, and in order to develop an ability to work collectively as we move forward as a federation. Bedminster Family Practice has recently lost their manager, and is operating with an interim manager. Southville Surgery's manager will retire in early 2015 to be followed by the manager from The Malago Surgery within a further couple of years. Federating at this time provides an ideal opportunity to re-structure this necessary but expensive resource, with the real potential to re-invest the cost savings in additional clinical resource for the benefit of patients across the Federation.

Our patients. Everything that the federation does will be aligned with the delivery of robust enhanced healthcare and service levels for our patients. The federation is determined to meet the challenges; of delivering healthcare closer to the patient's home, of managing an increasing elderly population with complex health issues, reducing demands on secondary care through the delivery of locally based extended access to GP services seven days a week, facilitating community working for our secondary care colleagues.

Third sector organisations. The federation recognises the valuable role the third sector undertakes at present, and that we will be increasingly dependent on this sector in the future. We believe that the federation will provide a more effective communication link for the various providers, than trying to spread their thin resources across five or more individual practices. The federation can provide a single point of access for the voluntary organisations, and also act as a single referral point outwards from the practices. All member practices accept the benefits that can be derived from social prescribing, and we are already working closely with the My Place project lead by Greater Bedminster Neighbourhood Partnership to grow this initiative. Initially this will benefit the elderly who tend to be the most socially isolated, but it will develop in scope to cover all age ranges and social needs across the local area.

Community Healthcare

The intention is to have the federation functioning as an entity by April 2015. This will place it in an advantageous position to work with Bristol CCG as it looks to pilot various adult and children community health initiatives, during its major re-procurement project due for completion in October 2016. With a central point of contact into the five practices there will be enhanced communication links with the community and specialist nursing teams from the community provider(s). This will make it easier to plan and develop more effective ways of multi-disciplinary working, potentially facilitating GP lead training of the cluster nurse team to supplement that delivered by the community provider.

Example of Innovation that could be delveloped and supported within our federation

- Apologies for the brain dump here but I think it is important to look forward to what potential exists beyond the first wave of combining management functions and it may be helpful for each practice to suggest a scheme that they would – in an ideal world – like to get

off the ground because we have federated. What can we do together that we can't do alone?

Mobile Community Elderly Care HOT clinic

It is well recognised that patients are living longer and inevitably living with multiple co-morbidities. Often these patients are housebound, isolated and of limited means. Some individuals have the benefit of family or friends to support them but many do not. This can lead to low mood, anxiety, poor compliance and ultimately end with a hospital admission that was avoidable.

The aim of the mobile HOT clinic would be to use technology to bring a joint patient review directly to the patient within their home. Focusing on the most vulnerable and complex cases who are often sadly excluded from the same level of care as their more mobile peers. This is especially true now that, due to financial restraints, elderly care consultants do not provide home visits. If the patient can't get to the hospital and the consultant can't get to them and the GP feels out of their depth, we are unlikely to be delivering best care and achieve best outcomes.

This service/pilot would allow GPs to directly link with their elderly care colleagues and seek real time advice on the management of complex individuals that crucially actively includes the patient in the care discussion and management planning.

GPs do not currently have consistent and timely access to advice that would enable high level discussions to improve management decisions of many patients with poly-pharmacy and multiple-comorbidities. This service would seek to remedy this current service gap.

This service would need good access to mobile technology – iPAD for face time or Skype, enabling the GP and patient to chat 'face to face' with a consultant and a laptop with remote access to allow direct access to the patient care record to inform dynamic management and care discussions. A back office coordination function will also be required that allows joint reviews to be booked and their effectiveness monitored.

NHS England Area Team

The federation recognises its responsibilities to the Area Team, and is focussed on the core aim of enabling each individual practice to deliver against the various elements their GMS or PMS contract. The federation also recognises that the Area Team has strategies to delivery through its various enhanced service contracts, which we believe will be more effectively managed and delivered through centralised control and monitoring, and distributed delivery at practice level.

The federation recognises the difficulties that the Area Team has in delivering its commissioning intentions with limited resources. We will engage with co-commissioning to aid progress in this key initiative, as we see it as an effective way of influencing service design which will ultimately strengthen the delivery of healthcare to our patients.

Bristol CCG

All of the practices are member practices of the CCG; contributing locality members, planned care leads, the lead GP in the Mental Health re-procurement project, PPI lead, and generally contributing to the effectiveness of the dynamic South Bristol locality. As with the Area Team, we believe the

federation has the capability to contribute effectively to the delivery of the CCG's strategic aims through engagement with Bristol Primary Care Agreement (BPCAg) and Bristol CCG's work on co-commissioning.

AcuteTrusts

The federations recognise that excellent healthcare can best be delivered to our patients when Primary and Secondary care work effectively together. To facilitate this the federation is better able to develop ways of bringing secondary care specialists out into the community than working as individual practices. The federation is also better placed to develop and deliver test and learn pilots with secondary care departments.

Public and Patient Involvement

The practices recognise the critical role that PPI has towards the delivery of a successful federation. To meet our PPI commitments we will:

- work with the patient reference groups within each practice
- hold focus groups with the community facilitated by the Greater Bedminster Neighbourhood Partnership
- hold engagement events with other healthcare providers
- hold engagement events with third sector organisations in the area

The practices have a clear view of the federation model that we wish to adopt, but accept that effective PPI will inevitably inform the way that we move forward and influence the federation model. One of our Practice Managers is on the PPI group for Adult Community Health re-procurement and lessons learnt in this role will be applied directly to the PPI work undertaken by the federation.

Is there any way that practices can undertake a quick survey of patients for some sound bites here? We are lucky in that we have a few hundred virtual patients we can fire a survey monkey link to via e-mail to achieve this quickly. I think if we can demonstrate how we are liaising with our patients already – all be it at a very high concept level - this would add some depth to our case?

SWOT on Federation Model

Strengths	**Weaknesses**
The five practices have co-operated on a number of local initiatives already, including an EOI for the PM Challenge Fund. The practices have broadly similar views on healthcare provision. Trust amongst the practices. The model is simple and based on a proven	Difficulty in finding suitable time to bring GPs and practice managers together, to discuss and develop ideas. The model requires additional management time to move it to the point that the federation exists as an entity, and this has a financial cost, when practices are seeing their income reduce.

federation.	
Opportunities Single point of tendering enables the federation to seize opportunities and deliver new services very quickly. Consistent level and delivery of service across the five practices will make it easier to convince patients to engage with different practices for OOH care and speciality nurse lead clinics. Further federated work will strengthen the trust between the practices, making it easier to meet the demands of a changing health care landscape.	**Threats** Potential that the new federated entity will not be able to offer NHS Pensions to new staff and clinicians. Increasing workloads on GPs prevent effective meetings being held. Financial pressures from the lower funded practices may force the need to have a two-tiered/speed approach to federation. Poor communication of the federation affects staff morale

What do we want, and who are we asking?

We have found to date that one of the scarcest resources is GP time, followed closely by practice manager time. Whilst we can work around this problem in terms of strategy meetings, time for communication with staff etc., what we cannot avoid is the fact that we do not have enough time to manage the project of delivering the federated entity that will be Bedminster Medical Group. To this end we need to recruit a project manager to:

- Develop and deliver a project plan that takes us from where we are now to the delivery of an integrated federated model
- manage the various meetings
- engage with legal and financial firms to ensure the BMG is set up correctly that will comply with the various regulations that will apply
- advise the steering group on best practice
- liaise with the various stakeholders
- deliver an effective PPI strategy

I think we need to beef this section up with some clear aims and outcomes?

Again it would be really useful for each practice to come up with an aim and an outcome they would like to see happen because we have a project manager and because we are working together – get them thinking about - what we can achieve together that we can't achieve alone?

The practices accept that the base costs of setting up Bedminster Medical Group, such as legal costs for an agreement, financial costs for accounts and software should be borne internally. We are

therefore looking for financial support to employ a project manager for six months, and for nurse practitioner backfill to release one partner to work with the project manager. Our estimate for this support is c£xxxxx

The practices also recognise that they will need guidance from the Area Team and Bristol CCG.

Organisational structure and key contacts

The five practices have nominated members to a Steering Group to take this federation project forward. The practices are represented on the Steering Group by:

Bedminster Family Practice: Dr Jane Collyer and Gabby Prowse

Gaywood House Surgery: Dr Dolly Weil and Brent Stephen

The Malago Surgery: Dr Andrew Green and John Gibson

Southville Surgery: Dr Barbara Compitus and Andrew Bale

The Wedmore Practice: Dr Cathy Gibbs and Geraldine Eld

BB05 Corby

This paper is being submitted to the Governing Body for amendment and/or approval as appropriate. It should not be regarded, or published, as policy until formally agreed at the Governing Body meeting.

NHS Corby Clinical Commissioning Group Governing Body Meeting – 25 June 2013

Title: Corby Urgent Care Centre	**Number:** CCG-13-20
Author: Nicki Price, Chief Officer	**Contact No:** 01536 400600

Presented by: Nicki Price, Chief Officer

Purpose / Summary:

In October 2012, Corby Urgent Care Centre opened but only started offering the full range of services in February 2013, following the closure of the Corby Minor Injury Unit.

This paper sets out progress achieved to date.

Relevance to Strategic Delivery:

Strategic Objectives	Strategic Priorities: Care Closer to Home	Strategic Priorities: Reconfiguration of Hospital Services	Strategic Priorities: The establishment of a credible and accountable, fit for purpose statutory organisation
	To develop and implement an out of hospital strategy ☐	To commission high quality evidence based services ☐	To comply with all statutory duties and achieve full authorisation ☐
	Develop capacity and capability in primary and community care ☑	To implement the outputs from the Healthier Together programme ☐	To ensure high quality services through increased clinical and managerial leadership ☐
			To deliver all national and local targets ☐
			To work with member practices, public, patients and partners to commission efficient and effective services within budget ☑
Not Applicable to Strategic Delivery ☐			

Recommendations:

The Corby Clinical Commissioning Group Governing Body is asked to note:

- the position against the business case
- the activities taking place to improve public awareness of the UCC

Six Month Review Corby Urgent Care Centre

1. Introduction and Background

In 2011/12, NHS Corby was in the bottom 10% of all CCGs for A&E utilisation. The number of patients being admitted to hospital for less than 24 hours was increasing year on year costing approximately £1.3m pa. The existing community based urgent care services were not effective in curtailing A&E demand or reducing emergency admissions and costs were increasing.

In 2010, as an aspiring CCG, local Clinicians developed a vision for urgent care, which would support clinicians to manage patients in the community more effectively; streamline services and improve cost effectiveness.

At the centre of this vision was a community based Urgent Care Centre (UCC) with a range of diagnostic facilities and an observation area.

The business case set out an ambitious plan to build a new UCC worth £2.6m, decommission all existing community based urgent care services and re-commission an UCC that would initially open from 8am – 8pm, 365 days a year with full diagnostic support during these times.

At the heart of the business case was a £500k annual saving, achieved through a reduction in A&E attendances and a reduction in 24 hour admissions to the local acute Trust.

2. Interim Review of Service

Eight months since the UCC opened its doors, the financial benefits of the project are starting to be realised. There was a 27% reduction in adult and 14% reduction in paediatric 24 hour admissions in first 6 months of opening (see figure 1 and 2)

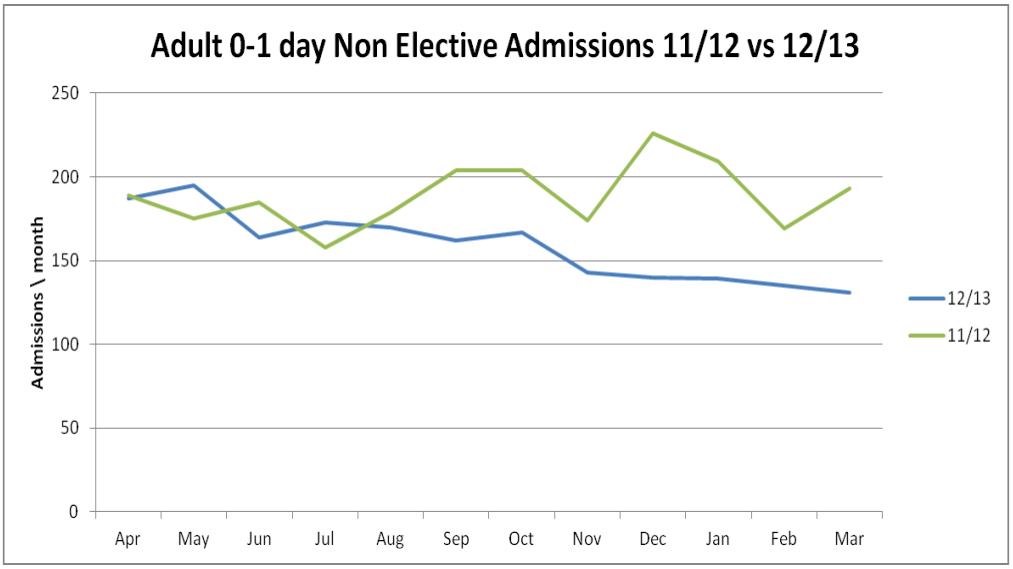


Figure 1

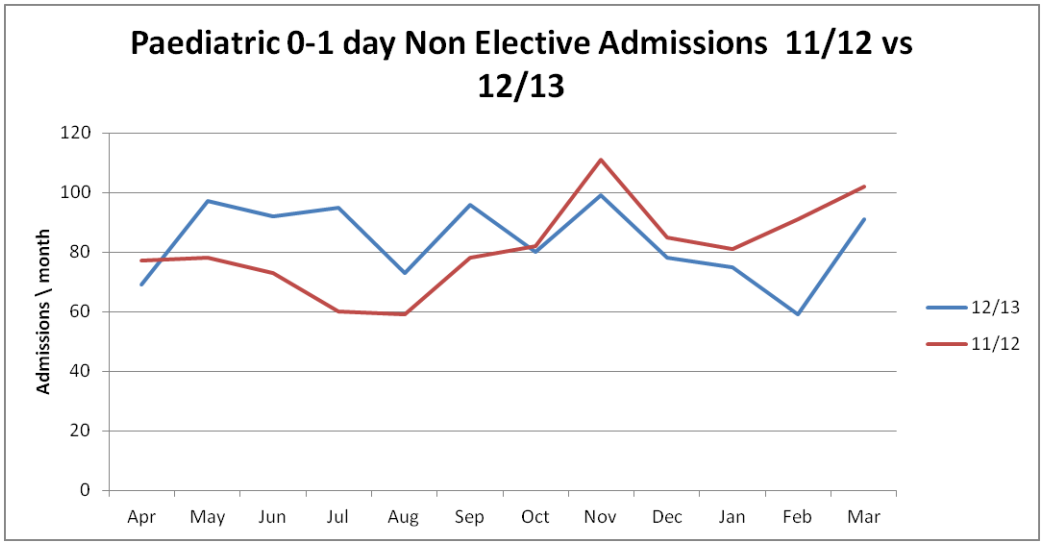


Figure 2

In March 2013 the number of A&E attendances had fallen to around 1,050 per month (see figure 3). Early indications for April and May show that this figure has dropped to below 1,000 which is equivalent to 171 attendances per year per 1,000 registered patients. This places the CCG in the top 10% of CCGs in the country for A&E attendances.

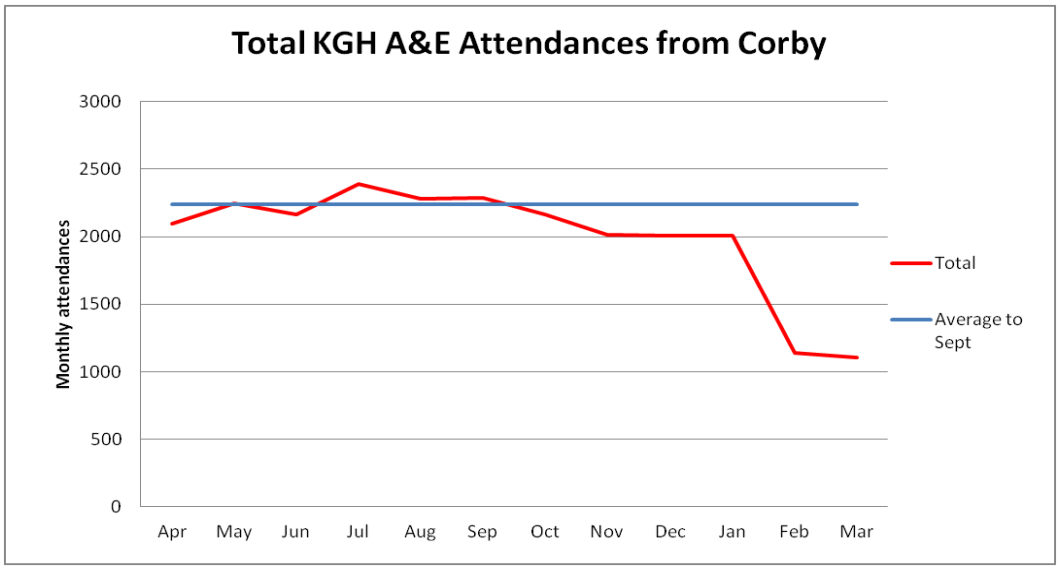


Figure 3

NHS Corby has revisited the original assumptions in the business case and tested that against delivery over the last 8 months (Appendix 1 outlines progress being made against the objectives set out in the business case).

A revised estimate of £685k net savings is now expected in 2013/14, exceeding original expectations (despite activity estimated at being 18% over plan).

Following feedback at NHS Corby Patient Engagement event, a communication strategy aimed at supporting the general public's awareness of the UCC will be launched over the

next month and will continue over the summer. This will include advertising the 'Choose Well' campaign on Corby Radio and the Corby Urgent Care Centre being distributed to 25,000 homes in Corby and surrounding villages.

Appendix 1

Business Case Objective	Current Position (October – March 2012)	Approximate Savings (October – March 2012)
Divert up to 25% of 'Minor' A& E attendances (excluding Corby Minor Injury Unit attendances) in to the UCC Expected Saving: £63kpa	From December 2012 until March 2013, on average there has been a 17% reduction in 'Minor' A&E attendances during the opening hours of the UCC. There has also been a reduction in attendances after 8pm.	Approximate savings between October and March 2012- £101k
Reduce 24 hour emergency admissions by 50% for adults Expected Savings £499k for adults and children(based on 10/11 prices)	For Adult 0-1 day admissions, targeted by the UCC Observation Couches there has been a steady improvement since November. Since October there have been 320 fewer admissions vs 11/12. This is a decrease of 27%	Approximate savings between October and March 2012- £199k
Reduce 24 hour emergency admissions by 25% for children See expected savings above.	For Paediatric 0-1 day admissions, there has been an improvement from November 2012 onwards. Overall in this period there have been 68 fewer admissions than in 11/12. This is a decrease of 14%	Approximate savings between October and March 2012 - £52k

BB06 Invicta

Memorandum of Understanding for Delivery of Primary Care Services as part of the Prime Minister's Challenge Fund

Between

Invicta Health Community Interest Company (IH CIC) AND

G82211 - Aylesham Medical Practice

G82700 - Buckland Medical Centre

G82227 - Lydden Surgery

G82662 - Pencester Health Centre

G82015 - Pencester Surgery

G82128 - Peter Street Surgery

G82002 - St James Surgery

G82117 - The High Street Surgery

G82729 - White Cliffs Medical Centre

1st March 2015 to 31 September 2015

PURPOSE:

This Memorandum of Understanding (MOU) is between Invicta Health and the practices listed above. Each of whom have agreed to work collaboratively to deliver integrated primary care services as part of the Prime Minister's Challenge Fund, and will set out the obligations and expectations on each of the parties to ensure quality and safe practices that meet the aims of this multi-agency working arrangement.

The aim of the service is to deliver integrated primary care services for patients whilst ensuring the following:-

The best possible outcome for the patient

Timely access to a range of community based health and social care services

Optimum use of acute/community and social services resources.

It has, therefore been agreed between Invicta Health and the practices listed above to provide access to primary care services from 8am – 8pm 7 days a week.

Patients who come from and/or are registered with GPs outside of this group will not be excluded from this service, but will only receive immediately necessary treatment.

This MOU supersedes all prior arrangements and understandings between the parties and representations by them, whether written or oral, which relates to the subject matter of this Agreement.

SERVICE

This integrated primary care service will provide routine general practice services for patients registered with the practices who have signed this agreement.

Immediately necessary treatment will be provided for all other patients as required.

The Primary Care hub will operate the EMIS clinical system and have access to the partner practices patient clinical records via clinical system links. It will act as a branch surgery to all practices and patients will be able to book appointments for both routine and urgent care.

The aforementioned practices may book urgent care appointments for patients at the Primary Care hub.

The aforementioned practices are expected to continue to offer the same opening hours and overall consultation hours as they had prior to this agreement, in line with their care contracts, including any Directed Enhanced Services or local Community Contracts they are currently signed up to.

The Primary Care Hub will work alongside, and in partnership with, KCHT, EKHUFT, SECAmb KMPT, KCC (including Social Services), private and voluntary sectors, NHS 111, South East CSU, pharmacies in the local areas, and any other organisations as necessary.

JOINT RESPONSIBILITIES OF INVICTA HEALTH AND THE PRACTICES

Work collaboratively to provide effective integrated working and consistent levels of quality of care, ensuring staff are aware of and follow agreed pathways, protocols and processes.

Use their professional and clinical judgment and practice to ensure the best interest of the patients.

The parties will work together to support the involvement of their staff and partners, including allowing clinical staff from practices to work in the hubs and Invicta Health staff to work in practices.

Each practice will nominate a 'lead' or 'leads' who will be the key contact point(s) and who will communicate regularly to ensure that staff are able to address any queries and/or concerns, and attend any meetings in support of the project.

The practices will provide data in the agreed format to support the delivery of KPI's, which will be collated by Invicta Health. Where outputs are not being met, to work collaboratively to formulate robust action plans and timelines to resolve.

All clinicians will support CCG prescribing initiatives, and will ensure that patients exhibiting drug seeking behaviour are referred back to their usual GP.

For patients registered at the practices listed above any action required as a result of investigations initiated at the hub will be followed up by the practice. This is to maximise the opportunity for continuity of care.

The practices and Invicta Health have a responsibility to ensure that all staff working on their sites are provided with information on Health, Safety and Risk Assessment policies, including

evacuation/fire procedures, together with any other policies relevant to the organisation's operation.

The lead contacts detailed in this MoU are responsible for reporting any incident or accident involving staff whilst working on their site. Where requested, the parties will complete or support the completion of each organisation's Accident/Incident Reporting form.

Where any complaint is made by a patient, either whilst staff are with the Employing Organisation or working within the wider setting, then both parties will work together to respond and will review any occurrences of complaints at review meetings;

Each organisation is responsible for their staff and will follow their own respective disciplinary procedures and assessment of fitness to continue to practice.

COMMUNICATION

All parties are responsible for ensuring the use of robust communication protocols and will undertake to agree and escalate any concerns to all key members of this agreement, in order that a solution can be sought in the most timely and effective manner.

QUALITY STANDARDS

The parties will work to the highest standards of service quality and continuous improvement and use the following codes of organisational practice.

Clinical Governance

Infection Prevention and Control

Patient Information Confidentiality and Governance

Audit

The parties will take account of the key principles of the NHS Constitution and operate within all NHS standards, guidance, protocols, policies and mandates.

The parties will comply with practice recommended by the Department of Health as set out in Health Notices, circulars and other documented guidance as they apply to the services covered in this Service Level Agreement.

The parties comply with all relevant legislation and organisational equivalent policies including Health and Safety at Work etc Act 1974, EU Health and Safety Regulations, the Data Protection Act 1998, Computer Misuse Act 1990, Mental Capacity Act 2005, the Caldicott Report and all other relevant legislation.

All parties will ensure that all information is handled securely and confidentially in line with legislation, organisational policies/procedures and best practice and that all breaches are notified to their organisation's IG Compliance Manager within 24 hours.

The service will be included under the CQC registration of Invicta Health.

REPORTING/INFORMATION REQUIREMENTS

KPIs and the performance will be monitored and reported on a monthly basis to the PMCF Board / NHS England / C&C CCG.

Signatures of Partner Organisations:

Chief Executive: **……..……Date……..**
Invicta Health CIC

G82211 - Aylesham Medical Practice

Partner / Practice Manager……..……Date……

G82700 - Buckland Medical Centre

Partner / Practice Manager ……..……Date……

G82227 - Lydden Surgery

Partner / Practice Manager ……..……Date……

G82662 - Pencester Health Centre

Partner / Practice Manager ……..……Date……

G82015 - Pencester Surgery

Partner / Practice Manager ……..……Date……

G82128 - Peter Street Surgery

Partner / Practice Manager ……..……..Date……

G82002 - St James Surgery

Partner / Practice Manager ……..……..Date……

G82117 - The High Street Surgery

Partner / Practice Manager ……..……..Date……

BB07 Invicta

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BB08 Invicta

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BB09 Waltham Forest CCG

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