

# **Transforming Primary Care in Barking and Dagenham**

**Our strategy 2015 – 2020**



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## 1 Executive summary

For patients, primary care and their relationship with their local GP form the foundation of the NHS service they expect and receive. If the NHS is to be clinically and financially sustainable in the years ahead, primary care and the rest of the system need to be transformed. If this can be done right, primary care can be a rewarding place to work for the professionals working in it, now and in future.

Nationally, the NHS faces significant future challenge in the form of the increasing health needs and expectations of the population; changes in treatments and technologies; and increasing pressures on finances, both from reduced spending growth in the NHS and cuts to social care budgets. Current projections from Monitor and NHS England estimate that the NHS will face a £30 billion funding gap by 2020/21. To tackle these challenges within Government funding limits, the *Five Year Forward View* sets out a transformational change agenda for the NHS that involves:

- Reducing variation in care quality and patient outcomes
- Increasing the emphasis on preventative care
- A shift towards more care being delivered in primary care
- Breaking down the barriers in how care is provided through the introduction of new models of care spanning current organisational boundaries
- Action on demand, efficiency and funding mechanisms to improve financial sustainability.

Barking and Dagenham, along with the wider Barking and Dagenham, Havering and Redbridge (BHR) system, has a greater commissioning challenge than the national average in the form of a system-wide budget gap of over £400m. The BHR system needs to be transformed to:

- Meet the health needs of the diverse, growing young population in one of the most deprived areas in England where an increasing number of people are living with one or more long-term condition in its local communities
- Improve health outcomes for these populations and reduce health inequalities overall
- Meet national and regional quality standards for care
- Close a £400m budget gap.

To achieve this, commissioners agree that acute hospital care should be reserved for acutely ill patients and the majority of care should be delivered nearer home. Key themes for the development of primary care are that it should be accessible, coordinated and proactive.

So what is the current state of primary care in Barking and Dagenham and how does it need to be transformed to meet commissioners' requirements and the needs of local people?

Significant progress has been made in improving access to general practice, with the establishment of hub-based urgent GP appointment evening and weekend services. However, local GPs and stakeholders have told us that the current model in primary care is unsustainable. The workforce is stretched, with recruitment and retention of staff challenging. Workload is increasing, and will do further with an ageing population, and practices cannot deliver the quality of care their patients need without becoming financially unsustainable. While national funds are available for clear, coherent transformation strategies, there is no additional ongoing funding available in the system beyond funding potentially released through a proportional reduction in acute hospital care. Primary care

needs to change to better meet demand and be a rewarding place to work and attractive to future potential recruits.

The CCG's vision is to combine primary care with other community-based health and social care into a place-based care model with productive general practice at its foundation and GPs overseeing care for their patients. Each of the three existing localities in Barking and Dagenham where neighbouring GP practices work together will be a 'place', and the vision is therefore to establish locality-based care across all health and social care services for the populations within those geographical localities.

Locality-based care will be proactive, with a focus on prevention, support for self-care, active management of long-term conditions and the avoidance of unnecessary hospital admissions. Patients will have a more joined-up care experience, be enabled to take more control of their care, and more of their treatment will be closer to home.

The locality-based care model has at its foundation highly productive GP practices working collaboratively to deliver care, free up GP time and reduce administrative costs, making best use of available IT solutions. General practice will lead a highly effective extended locality team of community, social care, pharmacy, dental and ophthalmology professionals and the voluntary sector providing local people with the majority of their care. With input from local patients, this team will decide local pathways, how the care workload is shared, and where care delivered from, in line with standards set and common assets managed at the BHR system level.

In configuration terms, locality teams will initially be virtual teams. General practice will have the opportunity to lead and shape the way locality provision develops, learning from the experience of joint working. In 2021, provision may continue in the form of an alliance of individual GP practices who operate autonomously. Alternatively, by then, general practices may consolidate into a larger scale provider, or join with community and other providers into a multi-speciality community provider.

A system-wide programme will be established to refresh the roles and mix of professionals needed for locality-based care and to develop the career packages needed to sustainably attract and retain the GPs, nurses and healthcare assistants needed.

With the balance of care delivery shifting away from hospital care, a commensurate share of the existing funding envelope will fall to general practice and fellow locality team providers. In time, it is likely that contractual arrangements will change to incentivise population-level outcomes rather than reward provider activity.

Locality-based care aims to be fully operation within two years. Key changes will be:

1. GP practices will work more productively and free up GP time to provide and oversee patient care.
2. Collaborative working between GP practices in localities and with the extended team of care professional will become established, raising quality and increasing capacity for locality care services and helping reduce the cost of administration.
3. Clear boundaries between primary care and acute hospitals, with good handovers between teams.
4. A programme will be put in place to recruit, develop and retain a primary care workforce suited to delivery in a place-based model in Barking and Dagenham.
5. Increasingly, reliable IT solutions will enable joined-up patient care and the automation of administrative tasks, and locality-based providers will adopt and use them with confidence .

## 2 Introduction

This strategy sets out a future vision for primary care in Barking and Dagenham in the context of wider change in Barking and Dagenham and the Barking and Dagenham Havering and Redbridge (BHR) health system, defines the overall scope and approach for the associated transformation programme and provides a detailed plan for 2016/17.

The strategy addresses the future roles, form and sustainability of general practice specifically, given the role of the CCG in commissioning primary medical services. It also considers the future role of other primary care services such as community pharmacy, dentistry and ophthalmology as participants – along with community health, social care and voluntary sector providers – in integrated local care services.

Section 3 describes the drivers for change, summarising the commissioning agenda at national, London and local levels and the presenting a thematic analysis of the issues and opportunities raised at grass roots level by local stakeholders.

Section 4 assesses the strategic options for a future primary care model, making the case for change, and Section 5 describes the future vision and how it addresses the drivers for change.

Section 6 describes what will change over the first two years of the programme and Section 7 presents the detailed 2016/17 plan.

In developing this strategy, we have engaged extensively with stakeholders with a role in the Barking and Dagenham health and care economy: patient representatives, patient groups, general practitioners, practice managers, pharmacists, nurses, community and mental health services provided by North East London NHS Foundation Trust (NELFT), acute services provided by Barking and Dagenham, Havering and Redbridge University Hospitals Trust (BHRUT), the Partnership of East London Co-operatives (PELC), the Local Medical Council (LMC), the London Borough of Barking and Dagenham, NHS commissioners and Care City. We have also consulted with primary care and workforce leads at NHS England London level. Thanks are due to individuals who have provided their time and perspectives.

In formulating the vision, programme and plan we have worked closely with the BHR primary care transformation programme board. Many of the issues that have been identified in the

development of this strategy are local and specific to Barking and Dagenham. Others we share with our neighbouring boroughs in Redbridge and Havering and where we believe that a collaborative approach can be taken to addressing them, we will.

We have also consulted BHR commissioning colleagues responsible for parallel strategic work on planned care, mental health and urgent and emergency care to ensure alignment of vision and clarity on programme scope where proposals overlap.

## 3 Drivers for change

### 3.1 The commissioning context

#### 3.1.1 National

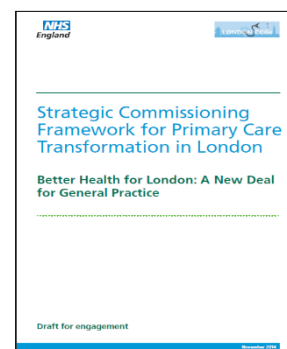
Nationally, the NHS faces significant future challenge in the form of the increasing health needs and expectations of the population; changes in treatments and technologies; and increasing pressures on finances, both from reduced spending growth in the NHS and cuts to social care budgets. Current projections from Monitor and NHS England estimate that the NHS will face a £30 billion funding gap by 2020/21. To tackle these challenges within Government funding limits, the *Five Year Forward View* sets out transformational change for the NHS to be driven by commissioners and realised by providers. This involves:



- Reducing variation in care quality and patient outcomes
- Increasing the emphasis on preventative care
- A shift towards more care being delivered in primary care
- Breaking down the barriers in how care is provided through the introduction of new models of care spanning current organisational boundaries
- Action on demand, efficiency and funding mechanisms to improve financial sustainability.

#### 3.1.2 Regional

At a London level, the *Better Health for London* report from the Mayor's Office contained a range of recommendations that related to primary care. In particular, it called for significant investment in premises, developing at scale models of general practice and the need for ambitious quality standards. This vision for primary care was further articulated by the publication of the Strategic Commissioning Framework for Primary care in London which outlines a key set of specifications (service offers) aligned to the areas that patients and clinicians feel to be most important:



- **Accessible care** – better access to primary care professionals, at a time and through a method that's convenient and based on choice
- **Coordinated care** – greater continuity of care between the NHS and other health services, including named clinicians and more time with patients as and when needed
- **Proactive care** – more health prevention by working in partnerships to improve health outcomes, reduce health inequalities, and move towards a model of health that treats causes and not just symptoms.

The 17 indicators under these themes will be used across London to ensure a consistent, high quality service offer is available across the city.

### 3.1.3 Local

Barking and Dagenham, along with the wider BHR health system, has a greater commissioning challenge than the national and London average - the system-wide budget gap for BHR is over £400m, as seen in Figure 1, below.

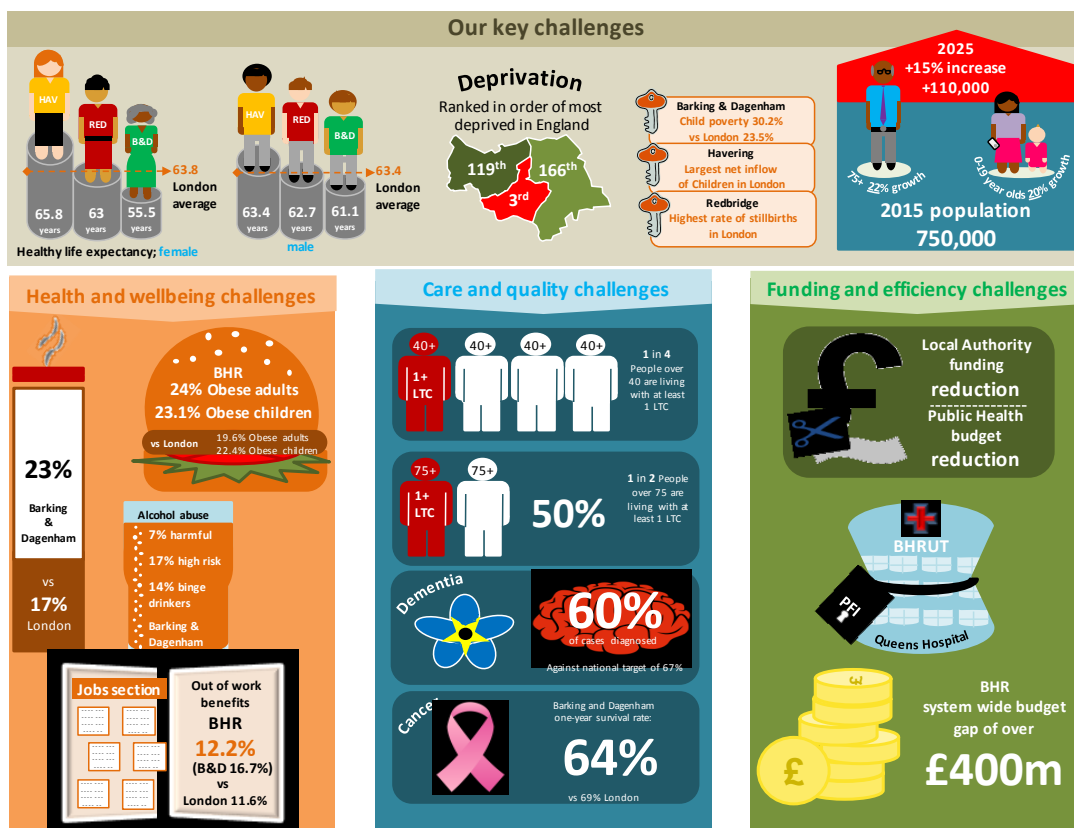


Figure 1 Key challenges for BHR CCGs

The BHR system needs to be transformed to:

- Meet the health needs of the diverse, growing and ageing populations in its various local communities
- Improve health outcomes for these populations and reduce health inequalities overall
- Meet national quality standards for care
- Close a £400m gap.

To achieve this, commissioners and local providers agree that acute hospital care should be reserved for acutely ill patients and deliver the majority of care nearer home, and that more emphasis is needed on prevention to improve outcomes and contain demand for care.

#### Local strategies

Within BHR, strategies are in development that will have a large impact on the transformation of primary care, both in terms of future service configuration and contracts, supporting infrastructure and work that must be coordinated to achieve maximum benefit across the local health system (e.g. workforce development). These include:

- A new model of urgent and emergency care, which will radically transform local urgent and emergency services, removing barriers between health and social care and between organisations. Urgent care will be simple for people to use and services will be consistent,



no matter where people use them (i.e. by phone, online or in person). This will be enabled by the use of the latest technology to make care records accessible to patients and clinicians.

- The mental health and planned care strategies, which are in early stages of development.
- The preventative care strategy, which aims to allow all Barking and Dagenham residents to have the support needed to improve their health and wellbeing and to reach their full potential. This involves primary, secondary and tertiary preventative interventions and services to help people get the right care, in the right place, at the right time, enabling them to live independently and at home for as long as possible.
- The BHR partnership is currently drawing up a business case to develop an Accountable Care Organisation (ACO) pilot. If implemented, it would deliver structural changes in the local health economy that align incentives and payment mechanisms to enable common goals and integrated working. The creation of an ACO locally would be a further demonstration of local ambition and see a large part of the budget currently controlled by NHS England and Health Education England devolved to the new body to spend on local needs. No decision to form an ACO has yet been taken by BHR partners.

Services within the scope of primary care include:

<b>Preventative care</b>	Health and wellbeing advice: healthy eating, physical activity, mental health, kicking bad habits
	Screening
	Immunisations
<b>Planned care</b>	Self-care, self-management with coaching, education and support from primary care to manage their condition and to have a plan for escalation/emergency
	Planned and preventative case management
	Pharmacy services: Dispensing, medicine reviews, prescribing
	Enhanced services
	Specialist input
	Transitions between secondary care/reablement
<b>Urgent and emergency care</b>	Urgent care - holistic assessment, streaming, booking
	Minor ailments advice and treatment
	Planned GP appointment

### 3.2 Performance and future sustainability of the current primary care model

Our analysis shows that current performance is mixed and the current model will not be able to cope with higher demand and meet care quality expectation. The headlines are:

- Our primary care workforce is already stretched
- Demand is growing due to a growing and younger population, with high levels of migration in and out of the borough, and more patients having more than one long-term condition
- A high proportion of GPs are nearing retirement, and recruitment and retention is challenging
- There is too much variation in primary care quality
- Substantial progress in improving the accessibility of general practice, but more to do
- There is too much variation in patient satisfaction, particularly around access
- Some of our premises are poor quality

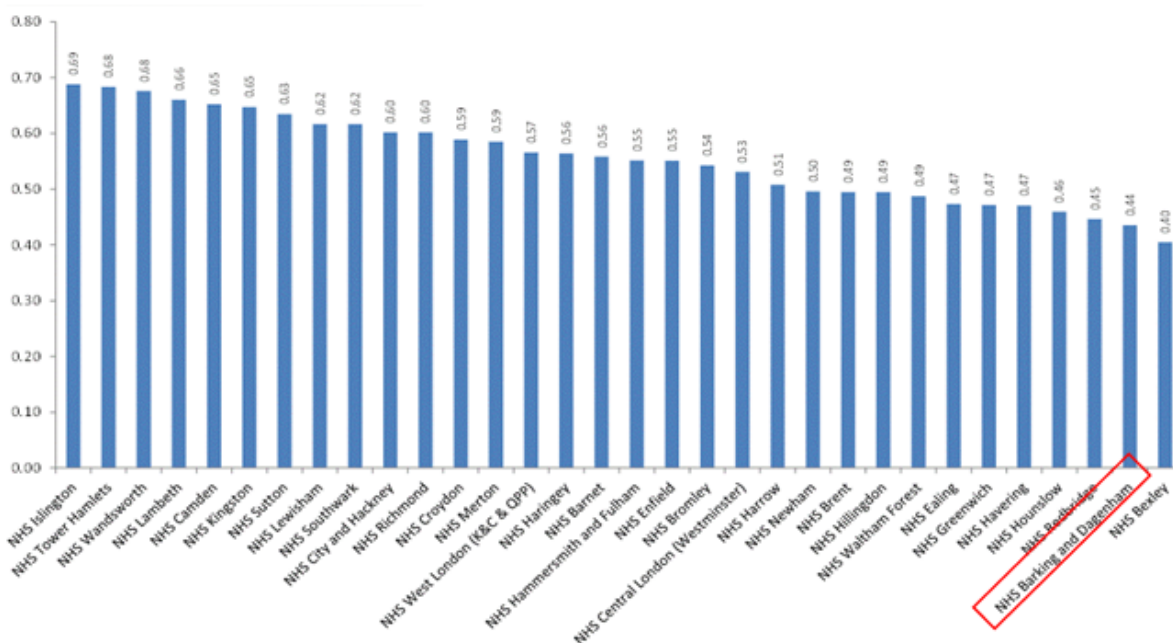
- Patients are being seen in a hospital setting for conditions that could be better managed in primary care.

More detail is provided below.

### 3.2.1 Workforce

#### **Our workforce is stretched and recruitment & retention is challenging**

Barking and Dagenham has some of the lowest rates of GPs per 1,000 population in London, with 0.44 GPs for every 1,000 registered patients compared to a London average of 0.55. The number of Practice Nurses only just meets the London average (0.22 Nurses per 1,000



population compared to a London average of 0.2). See Figure 2, below.

Figure 2. London CCGs rate of full time equivalent (FTE) GPs (exc. Registrars and Retainers) per 1,000 patients.

Traditionally, outer London has found it harder to attract newly qualified GPs than inner London. It is difficult both to recruit and retain salaried GPs and to attract GP partners in Barking and Dagenham, as well as other members of the primary care workforce. Stakeholders identified the following reasons:

<b>Isolated GPs</b>	Salaried GPs and long-term locums feel disenfranchised and isolated. High numbers of single handed GPs.
<b>Older GPs</b>	High proportion GPs reaching retirement age
<b>Older nurses</b>	High proportion nurses reaching retirement age
<b>Overworked GPs</b>	Lowest quartile of GPs per head of population in the country
<b>Nationwide shortage of GPs</b>	Shortage of medical students going into general practice despite Health Education England mandate. Training posts remain unfilled

<b>Cost of living in London</b>	Inner London posts attract Inner London Weighting pay whereas Outer London posts attract lower band Outer London weighting
<b>Brand and reputation</b>	Other parts of London are further ahead in marketing themselves and adjacent opportunities e.g. career development, research opportunities, honorary positions

### High proportion of GPs nearing retirement

In addition to the current challenges faced by the shortage of GPs working in Barking and Dagenham, the age profile of the GP workforce signals that this challenge will be greater in future years. Barking and Dagenham has more than twice as many GPs over the age of 60 than the national average: 30% of GPs are over 60, compared to 15% in London and 9% nationally (Figure 3). With potential retirements in this already stretched workforce, this is clearly a local priority.

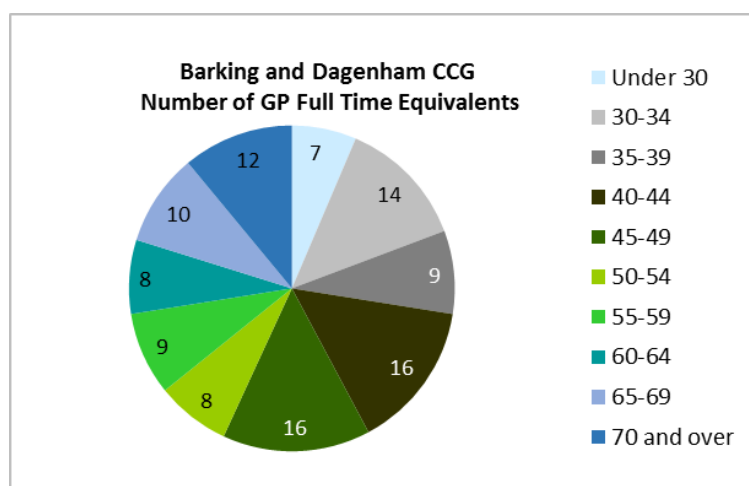


Figure 3. GP age profile, (Practice Reported): HSCIC General and Personal Medical

### 3.2.2 Workload

Local stakeholder interviews provided us with a consistent narrative of increased demand, increased workload and, especially, increased time spent on bureaucracy and administrative tasks. Barking and Dagenham’s GPs find their current workload unsustainable. Many are overworked, and feel they are spending too much time on administrative tasks and chasing information, with not enough time for patient care. This work can be from external sources (e.g. patients who are discharged from secondary care with increased demands from primary care) as well as work generated within their practices (e.g. time spent on repeat prescriptions). Delegating care to other healthcare professionals/services can be difficult, with uncertainty over resources and capacity elsewhere in the system. Lack of information sharing between services makes it difficult for all members of the primary care team to know what other professionals are doing. This means work may be duplicated and confidence in the whole system working in an integrated way is reduced.

Patient behaviour also contributes to GP workload. Many patients find the primary care offer around urgent care confusing and will seek an appointment with their own GP, on top of contact with GPs/other professionals in urgent care, to ‘check’ their treatment is correct. Others still feel

they need to see their GP for minor illnesses such as coughs and colds when another professional such as a community pharmacist could provide that care.

**Population growth and demographic change - growing population and a rise in the number of patients suffering from one or more long-term condition**

The population of Barking and Dagenham is growing and the local healthcare needs are changing.

- Barking and Dagenham has seen a significant overall population increase of 13.4% to 185,911 (2011 Census). This is 22,000 more people since 2001, including a 50% increase in 0-4 year-olds. Within Greater London, Barking and Dagenham had the fourth biggest percentage population increase (2%) of all London boroughs between 2012 and 2013.
- 30% of the population are children, placing a huge pressure on school places, housing and social care including on workloads across key agencies working with the borough's families.
- The population is projected to rise from 190,600 in 2012 to 229,300 in 2022. This is a 20.3% increase and is the second largest in England after Tower Hamlets.
- Barking and Dagenham has a population churn of 189 per 1000 or 19% which is significantly higher than the London rate of 9%.

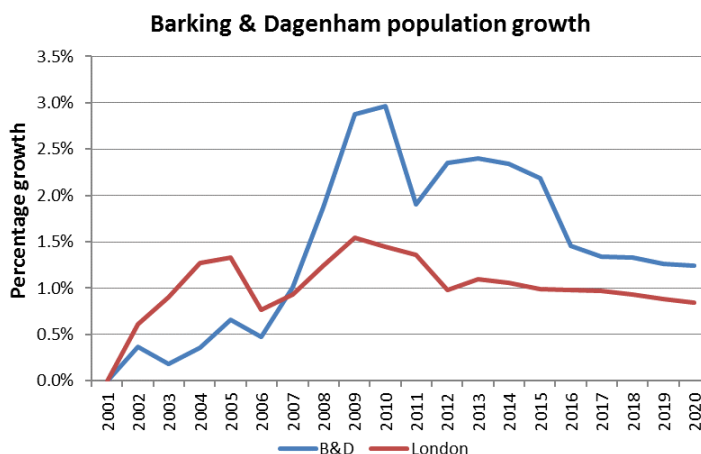


Figure 2. Projected population growth in Barking and Dagenham, GLA 2014

The Barking and Dagenham Independent Growth Commission report <sup>1</sup> sets out a 20-year vision for the London Borough of Barking and Dagenham to deliver Barking and Dagenham's growth opportunity. The Commission proposes at least 35,000 new homes and 10,000 new jobs will be created over the next 20 years, the most high profile development being at Barking Riverside. The council will publish its detailed response to the Commission's report and strategy for transforming the borough and transforming the way in which the council is organised in April 2016.

Barking and Dagenham has also seen a rapid shift in the proportions of various ethnic groups across the borough, with a large decrease in the white British ethnic group and a large increase in the black African ethnic group. The most recent ethnic breakdown is shown in Figure 5. By 2020, the expectation is that black and minority ethnic community will make up approximately 50% of the population.

The borough is the 7th most deprived in London and 22nd most deprived nationally which is also reflected

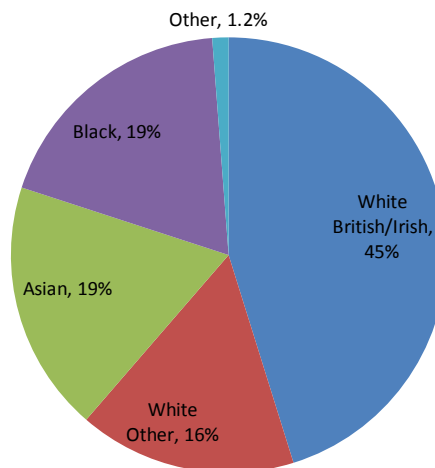


Figure 3: Barking and Dagenham ethnicity profile, community mapping 2015

<sup>1</sup> No-one left behind: in pursuit of growth for the benefit of Barking and Dagenham Independent Growth Commission [www.lbbd.gov.uk](http://www.lbbd.gov.uk)

in the relatively poor standard of health - life expectancy for both men and women is lower than the England average. Over half of the borough's population live in the 20% most deprived areas in England and around one third of children in the borough are living in poverty.

### **Long-term conditions**

In addition to the growth in our population, we are seeing a growth in the number of people living with one or more long-term condition.

- Diabetes prevalence is higher in Barking and Dagenham than the London and England average and the burden of disease from long-term conditions is likely to increase in primary care. The number of people recorded with diabetes in Barking and Dagenham increased from 10,625 in 2013 (6.4%) to 11,418 (6.8%) 2014 and is projected to increase further.
- About 10% of the population has caring responsibilities for someone who is ill, frail or disabled.
- Of the over 75 year olds living alone in the borough, almost 4,100 (41%) are living with a long-term condition and 1,317 have dementia.
- A population such as Barking and Dagenham is likely to have particularly high mental health needs and it is known that the rate of mental health disorders in children and adolescents in Barking and Dagenham is significantly higher than the national averages.

General Practice has a key role in the identification, treatment and management of long-term conditions and mental health. These trends impact on the demand on GPs and the primary care team.

Improved care coordination is central to the model of care provided to patients with long-term conditions. It has been shown to deliver better health outcomes, improve patient experience and is vital for people living with multiple conditions. Better care coordination is key to delivering an integrated health service. However, care coordination is complex and requires a shared approach across the healthcare system.



### **3.2.3 Quality**

There is variation in the patient outcomes across Barking and Dagenham. General practice makes a significant contribution to improving the health of the population and influencing patient health outcomes. Across Barking and Dagenham there are examples of excellence in practice. We need to learn from these examples of excellence to reduce the variation that currently exists.

Quality outcome framework (QOF) achievement in Barking and Dagenham is an indicator GP practices will be familiar with that highlights the needs for reducing variation in the quality of care between Practices in the borough. The variance in QOF achievement in 2014/15 ranged from 458 to 559 (maximum). Lower QOF scores affect both the care of patients with long-term conditions and practice income.

Table 1. BHR CCGs QOF achievement, 2014/15

CCG	Average achievement (559 maximum)	Lowest score	Highest score
Barking & Dagenham	530	458	559
Havering	516	282	559
Redbridge	522	443	559
London	521	139	559
England	530	139	559

Achievement against the general practice outcome standards (GPOS) allow us to see how GP practices perform against a set of 26 indicators for quality improvement agreed with GP leaders, clinicians, the London-wide LMCs, commissioners and other health care professionals, think tanks and patient groups. Barking and Dagenham CCG has a slightly lower proportion of GP practices rated as ‘achieving’ or ‘higher achieving’ against GPOS as London. The proportion of

Breakdown of GP practices by General Practice Outcome Standards achievement, BHR CCGs and London, Q4 2015/16

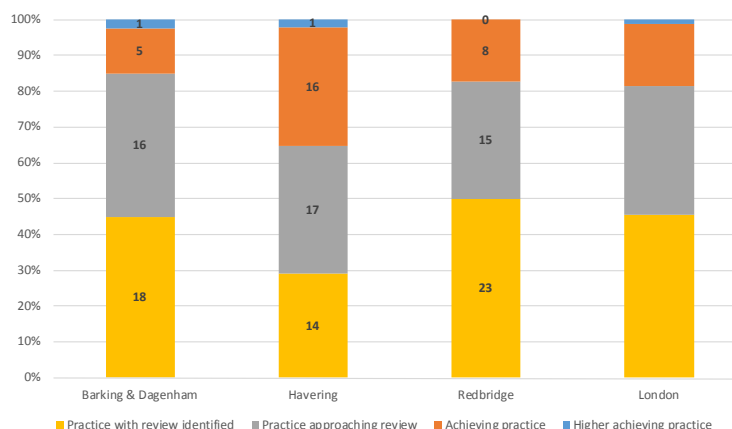


Figure 4: Breakdown of GPOS performance by BHR CCG

practices in the lowest performing category of ‘review identified’ is 45% (18 practices), similar to average of 46% in London. Practices in this category have nine or more triggers in total, or three or more level two triggers (where they are well below target/England average). For more detail on individual indicators where comparison to the England average is possible see Figure 7, below.

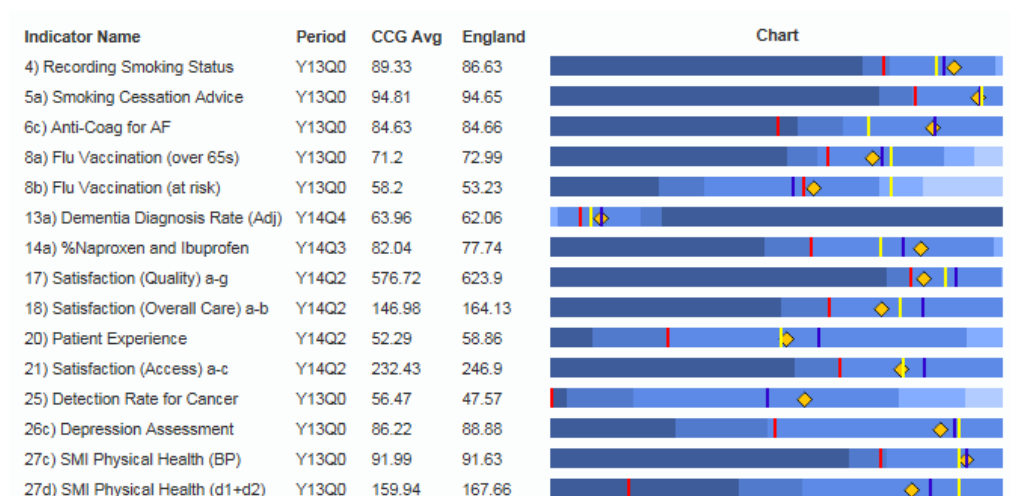


Figure 5: Barking and Dagenham CCG compared with national performance in general practice outcome standards

Key: Yellow diamond represents the CCG value; blue line the national average for the standard; yellow line the level one trigger value; red line the level two trigger value.

**Some of our premises are of poor quality and need further investment**

To ensure that patients receive high quality, accessible and safe care it is fundamental that general practice is able to deliver care from buildings that are fit for purpose and have the relevant facilities. Investment in primary care estates and IT has lagged behind investment in secondary care. Some general practices are working from inadequate buildings with limited facilities. This creates a poor environment for patients and staff. Much of the primary care estate is out-of-date, under-developed and cannot provide the facilities needed to deliver high quality care.

In Barking and Dagenham there has recently been significant investment in the health estate over the last decade, with one new community hospital and seven large LIFT centres but there is still a very mixed picture across primary care. Much of the primary care estate is in poor condition, with a large number of single-handed practices operating out of old houses.

Barking and Dagenham have invested in a DDA and infection control compliance programme for a portion of their primary care estate in 2010 and continuing this improvement in primary care premises must continue to remain a focus. This improvement needs to be coupled with opportunities presented through the new modern estate, which now needs to be fully utilised with extended opening hours. Most is generic space that would benefit from sessional booking and use. This will allow for rationalisation of the remaining NHS Property Services sites, a lot of which is in poor condition and not fit for purpose.

An additional consideration for the primary care estates picture in Barking and Dagenham is the number of regeneration schemes planned in the borough. The council's local housing strategy for Barking and Dagenham identified dense areas of regeneration such as Barking town centre and Barking Riverside. The borough is situated in the Thames Gateway growth area and has the potential to develop 15,000 new homes over the next ten years. Barking Riverside will be the most significant of these developments, leading to the creation of a major new community in the borough, with approximately 10,800 new homes. There is an opportunity to improve our primary care estate through the funding available through London Borough of Barking and Dagenham and housing developers to support public infrastructure as a result of these developments.



**There are variable levels of patient satisfaction, particularly in terms of access**

Improving access to primary care professionals, at a time and through a method that's convenient and based on choice is outlined as a key priority for the delivery of primary care services in London. General practice core hours of operation are 8.30am to 6.30pm, Monday to Friday. The direct enhanced service for access incentivises practices to open additional hours outside of this core offer. Across Barking and Dagenham there are eight practices, one in five, that are not open during core hours impacting on the amount of access available to their patients

As part of the engagement on the development of this strategy a survey was circulated to patients, carers and their representative groups to seek

More receptionists to answer the phones when the telephones are busy in the morning

It needs to be easier to get an appointment on the day

their views on local primary care services. Access to services was highlighted as an issue for some respondents and highlighted as an area where things could be improved. These are a selection of comments captured that relate to patient satisfaction in relation to access.

Access has been a key priority for primary care development over recent years and work has begun to develop the strong foundations for opening up access to patients across Barking and Dagenham. In collaboration with Redbridge and Havering CCGs integrated primary care services through access hubs during evenings and weekends are being offered across the network. Provided by the local GP Federations, this new model of extending access has so far achieved a 90% patient satisfaction rate and has opened up an additional 5,000 urgent care slots a month.

GP services are getting worse, unable to make an appointment by phone, nearly always engaged. Shorter hours than previously

### **Patients are being seen in a hospital setting for conditions that could be better managed in primary care**

As the usual first point of contact for patients when accessing the healthcare system, primary care plays a crucial role in preventing unnecessary hospital attendances and admissions.

Across Barking and Dagenham a high proportion of patients attend A&E. It may have been appropriate to treat some of these patients in primary care. Figure 8 reflects the attendance rate per thousand registered patient at each practice in Barking and Dagenham in 2013-14:

- In Barking and Dagenham the average attendance rate is 426 per 1,000 registered patients, one of the highest rates in London;
- The London average in in 2012-13 was 312 per 1,000 population which itself was the highest in the country;
- Variation locally in A&E attendance rate by Practice range from approximately 320 to 680 per 1,000 and is unlikely to be as a result of population factors alone.

This suggests that more can be done to treat patients in primary care, ensuring they have access to the care closer to home.



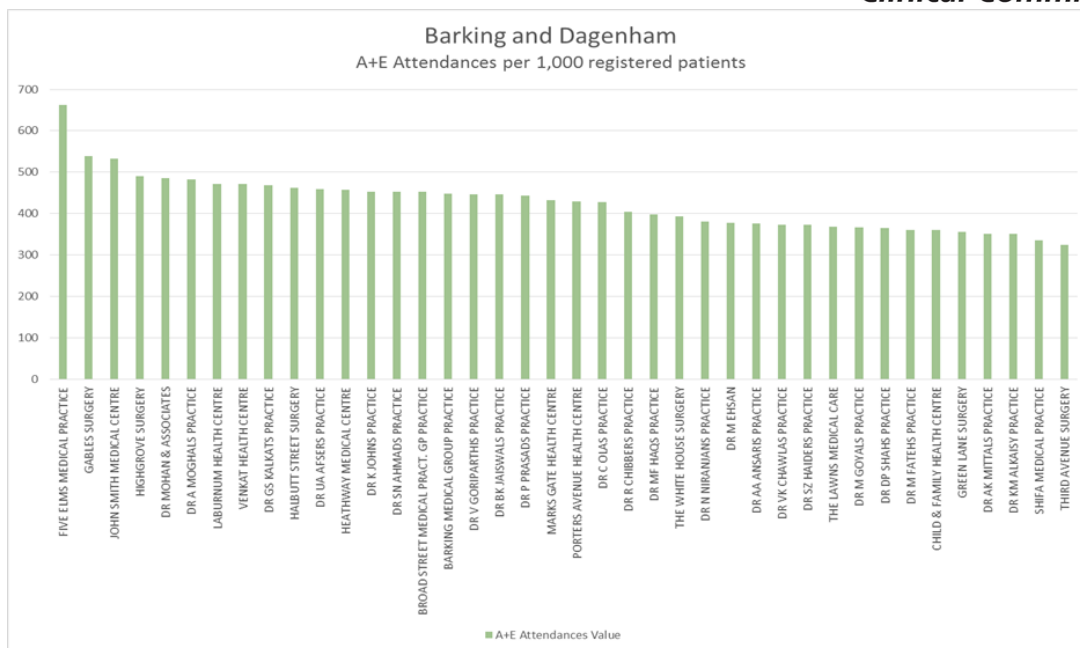


Figure 6: A&E attendance by practice per 1,000 population

Out-patient referrals show a similar trend with variation in referral rates varying across practices, see Figure 9.

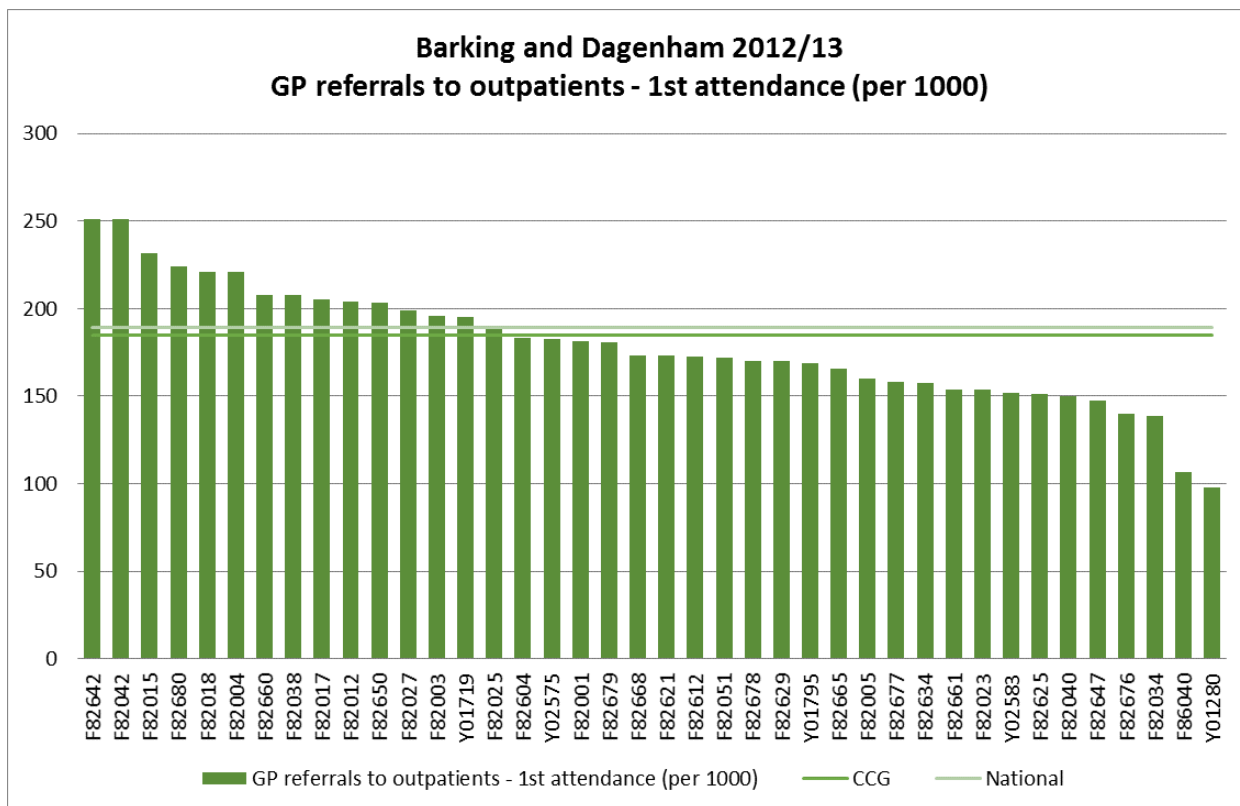


Figure 7. GP referrals to outpatients, first attendance by practice per 1,000 population

**[Drafting note: Information request in progress. GP practice codes to be replaced with practice names prior to strategy finalisation]**

### 3.3 GP and stakeholder perspectives

We have consulted with patient representatives, general practitioners, practice managers, pharmacists, nurses, community and mental health services (NELFT), acute services (BHRUT), the London Borough of Barking and Dagenham, NHS commissioners and Care City. We have also had conversations with primary care and workforce leads at NHS England London level. Local stakeholders have identified issues with primary care as it is now, and potential solutions. There is wide recognition that transformation in primary care is both necessary and desirable.

A full thematic analysis of feedback is available from the primary care transformation team. The key themes are shown below.

Challenge	Aspiration	Solutions offered
The system is fractured – we work in silos and there is a lot of inefficiency and duplication	We want integrated health and wellbeing services that meet our populations' physical, mental and social care needs	<ul style="list-style-type: none"> <li>• We want more focus on prevention</li> <li>• We need to help patients to self-care</li> <li>• Care should be close to home</li> <li>• Links and handovers between primary, community, secondary and social care should be seamless</li> <li>• To improve quality and reduce costs we should align incentives across providers.</li> </ul>
Demands and expectations of GPs are too high	We need to re-define the role of the GP in relation to the rest of the primary care team	<ul style="list-style-type: none"> <li>• GPs want to retain overall responsibility for their patients but not feel like they have to do everything</li> <li>• We want GPs to be able to delegate work/decisions to other members of the primary care team where appropriate</li> <li>• We want GPs to have more time for complex, planned and preventative work</li> <li>• We want the benefits of collective working but also need to balance that against the desire for GP autonomy.</li> </ul>
Our workforce is stretched and the workload is getting bigger	There are ways we could tackle our workload and workforce challenges	<ul style="list-style-type: none"> <li>• We could share staff</li> <li>• We could pilot new care pathways and ways of working</li> <li>• By enhancing peoples' skills we could enable more sharing of the workload</li> <li>• Shared education and training would help team working and build relationships between professionals</li> <li>• We could train hybrid health and social care workers</li> <li>• Building communities of practice and support across professions would reduce feelings of isolation and allow us to share knowledge</li> <li>• Sharing back office functions would cut down on work.</li> </ul>
We are	We want to build on	<ul style="list-style-type: none"> <li>• We want to roll out the successful pilots we</li> </ul>

committed to our patients and do some things really well	what already works	<p>already have</p> <ul style="list-style-type: none"> <li>• We want to keep what works well.</li> </ul>
Poor use of technology and low quality facilities makes our work harder	To do our jobs well we need fit for purpose buildings and good IT	<ul style="list-style-type: none"> <li>• We need good IT and digital platforms to improve self-care and access for patients</li> <li>• We need integrated IT to improve quality and reduce workload.</li> </ul>

## 4 Primary care strategic options

### 4.1 Requirements

In summary, the drivers for change described in the previous section give us a set of requirements a new primary care model must aim to meet. These are:

#### Delivery

- Meet the health needs of the diverse, growing and ageing populations in its various local communities
- Contribute substantially to the improvement of health outcomes for these populations and the reduction of health inequalities overall
- Meet national and regional quality standards for primary care, ensuring care is accessible, coordinated and proactive
- Increase capability/capacity to deliver the majority of patient care – planned, mental health and urgent – out of hospital with a focus on prevention, reducing demand for acute care and enabling savings of £400m across BHR.

#### Patient Experience

- Patients can continue to benefit from a relationship with their local GP
- Patients receive a joined-up, cost-effective care service with unnecessary duplicate assessment and treatment avoided.

#### General Practice

- Productive GP practices can retain their autonomy and have a financially sustainable future
- GPs have the time they need to provide quality patient care
- The time and effort spent by GPs and practice colleagues on administrative tasks is minimised
- The respective roles and responsibilities of GP practices and all local care providers in delivering care are clearly defined and consistently applied day-to-day by all parties

#### Workforce

- The career offer and working environment for GPs in Barking and Dagenham are sufficiently compelling to retain existing GPs and attract new enough recruits.

#### Infrastructure

- GPs and their fellow professionals can rely on IT to present the information about their patients that they need at the point of care to make the best decisions for patients
- Care is delivered in premises that are fit for purpose in a way that makes the best use of existing assets.

## 4.2 Strategic options

We have identified five possible options for the transformation of primary care in Barking and Dagenham over the coming five years:

1. “Do nothing” – retain the existing model at current levels of funding
2. Retain the existing model and increase funding
3. Invest in improving the quality and productivity of general practice and make it sustainable
4. Extend primary care incrementally to become a place-based model of care, whereby general practice and other primary and community-based providers collaborate to deliver proactive, joined-up care out-of-hospital for a local population
5. Building on the Five Year Forward View, move directly to merging the provision of general practice and community-based care and create a new form of provider, such as a multi-speciality community provider.

Our analysis in Section 3 demonstrates that option one is not sustainable.

Option two is neither clinically sustainable nor financially viable. BHR has a system wide budget gap of over £400m, and there is no additional funding available in the system beyond funding potentially released through a proportional reduction in acute hospital care.

The current primary care model therefore needs to change. A focus on improving general practice (option three) meets a number of the requirements above, but is not sufficient to create the capability and capacity needed to deliver the majority of patient care, or to transform care so it is joined-up and cost-effective with unnecessary duplicate assessment and treatment avoided. This would require closer integration of general practice with other primary and community-based care (option four).

Our recommendation is a vision which combines the strengthening of general practice (option three), maintenance of the patient-GP relationship and the continued autonomy of practices, with the extension of primary care to become place-based care (option four).

Experience of collaborative working in a virtual team may, in time, build a case to move to new forms of provider configuration (option five), but change should be made incrementally by local care professionals with a focus on what will improve services for patients.

## 5 The vision for primary care in Barking and Dagenham

### 5.1 Vision for primary care

The CCG's vision is to combine primary care with other community-based health and social care into a place-based care model with productive general practice at its foundation and GPs overseeing care for their patients. Each of the three existing localities in Barking and Dagenham where neighbouring GP practices work together will be a 'place', and the vision is therefore to establish locality-based care across all health and social care services for the populations within those geographical localities.

Locality-based care will be proactive, with a focus on prevention, support for self-care, active management of long-term conditions and the avoidance of unnecessary hospital admissions. Patients will have a more joined-up care experience, be enabled to take more control of their care, and more of their treatment will be closer to home.

The locality-based care model has at its foundation highly productive GP practices working collaboratively to deliver care, free up GP time and reduce administrative costs, making best use of available IT solutions. General practice will lead a highly effective extended locality team of community, social care, pharmacy, dental and ophthalmology professionals and the voluntary sector providing local people with the majority of their care. With input from local patients, this team will decide local pathways, how the care workload is shared, and where care is delivered from, in line with standards set and common assets managed at the BHR health system level.

Collaborative working will include GPs deciding how GP practices will work collectively across localities to offer services to patients, both within routine and extended opening hours, as defined by the strategic commissioning framework standards, and how collective working to manage workload will create more time for extended appointments. Localities will also decide what blend of services best meet local need and standards, for example the number of appointments available with GPs and other health professionals, and where those appointments will be offered (e.g. GP practices, hubs). To see how locality-based care will meet each strategic commissioning framework standard, see Appendix A: Transforming primary care live SPG delivery plan.

In configuration terms, locality teams will initially be virtual teams. General practice will have the opportunity to lead and shape the way locality provision develops, learning from the experience of joint working. In 2021, provision may continue in the form of an alliance of individual GP practices who operate autonomously. Alternatively, by then, general practices may consolidate into a larger scale provider, or join with community and other providers into a multi-speciality community provider.

A system-wide programme will be established to refresh the roles and mix of professionals needed for locality-based care and to develop the career packages needed to sustainably attract and retain the GPs, nurses and healthcare assistants needed.

With the balance of care delivery shifting away from hospital care, a greater share of the existing funding envelope will fall to general practice and fellow locality team providers. In time, it is likely that contractual arrangements will change to incentivise population-level outcomes rather than reward provider activity.

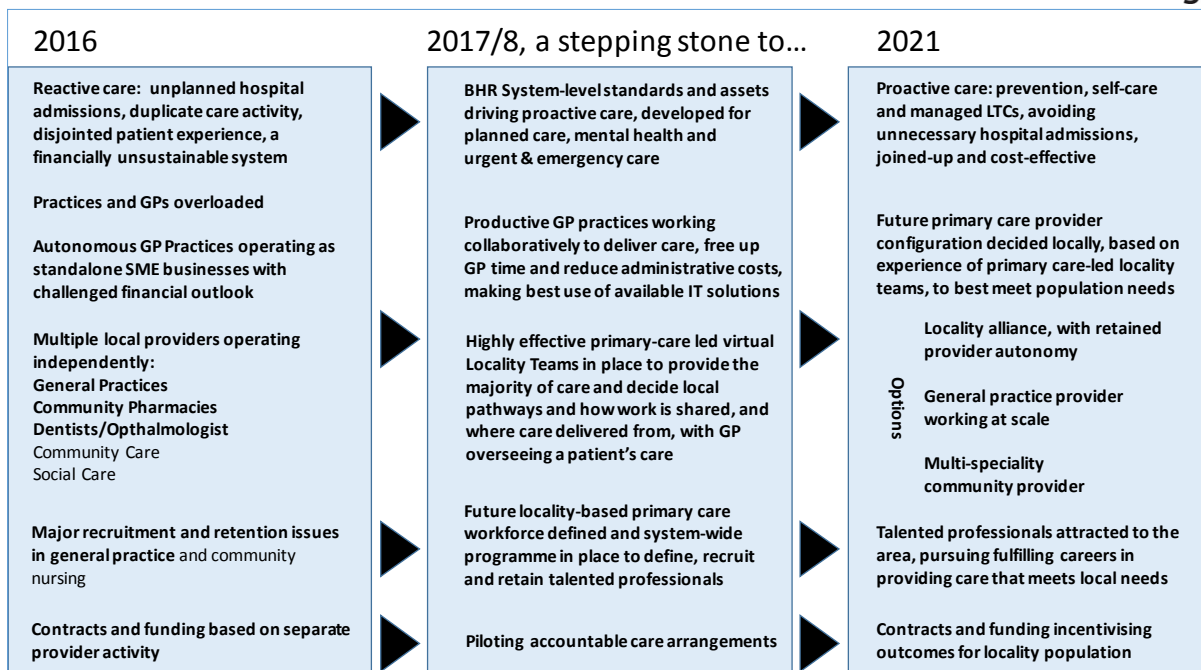
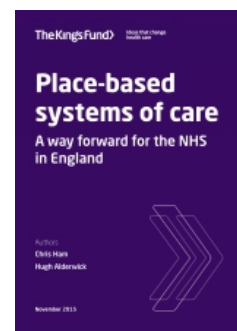


Figure 10. Milestones in journey towards achieving the vision

## 5.2 What is place-based care?

The King's Fund proposes place-based care as a way to create an environment where health care organisations can effectively work together towards improving health outcomes for the populations they serve. By pooling their resources, providers are freed from the pressure to focus on their own services and organisational survival to the potential detriment of other organisations within the health economy. In place-based care, providers collaborate to manage pooled resources, enabling them to consider the whole health economy when making decisions and to better use resources to meet their local populations' needs. Place-based care is not about top-down change, it's about enabling local systems of care to develop ways of working that effectively meet population need. The King's Fund's framework for developing place-based models of care will be used to develop the model in Barking and Dagenham. More details on this framework are in Section 0.



Evidence advanced by the King's Fund, drawing on examples from New Zealand, Chenn Med, is that place-based care works best with a population of 50-70,000 people. As Barking and Dagenham has a history of working in localities which contain populations of this size (see Appendix B: Current localities), it is proposed that place-based care be established within these boundaries.

## 5.3 How will place-based care in a Barking and Dagenham locality work?

The vision for general practice-led, locality-based care is summarised in the Figure 11, below. As now, it is founded on GP practices.

### Providers and professionals working collaboratively

The locality-based care model comprises multiple layers, operating in parallel:

- Individual GPs, supporting, treating and referring patients on their list, taking, where appropriate, oversight of their care across the system, equipped with the information they need to do so
- Productive GP practices, effective at managing and prioritising their workload, using the full resources of the practice and making best use of IT solutions to free up GP time for patient care
- GP practices working within collaborative arrangements to deliver primary medical and additional services and to manage administrative activity more cost-effectively; existing federation arrangements may offer a starting point for this
- General practice leading an extended multi-professional team of community, social care, pharmacy, dental, ophthalmology and voluntary sector services.

The team in a locality will be sufficiently small (averaging circa 100 team members) to allow the formation of trusted working relationships between clinicians and care workers from different organisations and professional backgrounds, which will be important in improving care quality, patient experience and productivity. The inclusion of patients in that team of 100 will be key for the co-design of services with the population they serve.

It is assumed, initially, that general practice and fellow providers will come together in a virtual team, with the option to evolve into more formal organisational structures for collaborative working based on experience from delivering care collaboratively.

### General practice-led locality-based care

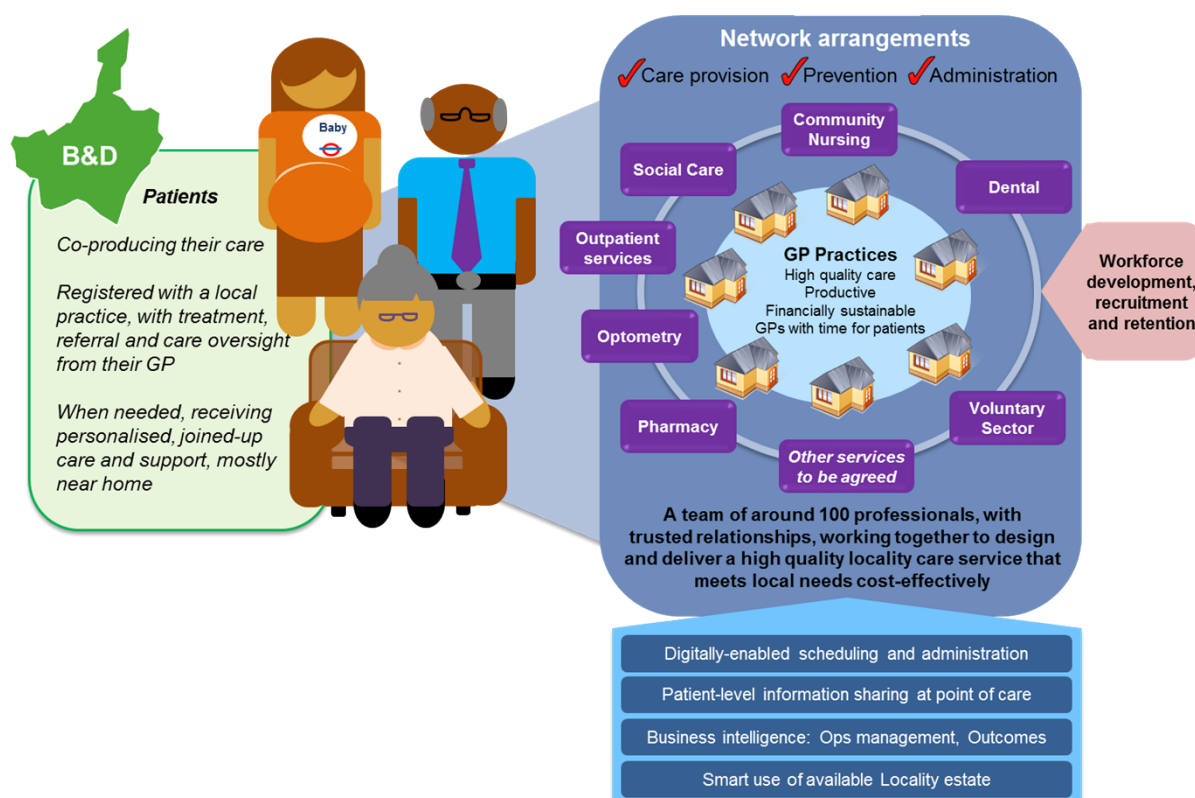


Figure 11. General practice-led locality-based care

### Building a locality strategy and plan

To ensure equity and quality of care, localities will need to provide services which meet NHS England's strategic commissioning framework quality standards, and with BHR ambitions set

within a formal quality improvement framework with evaluation via the system's agreed primary care transformation dashboard (Appendix C – Primary care transformation dashboard). Within this framework, locality teams will develop a shared strategy and plan to meet the needs, priorities and preferences of the population they serve. They will decide what resources will best meet local health needs, and the specific health outcomes they want to target and track.

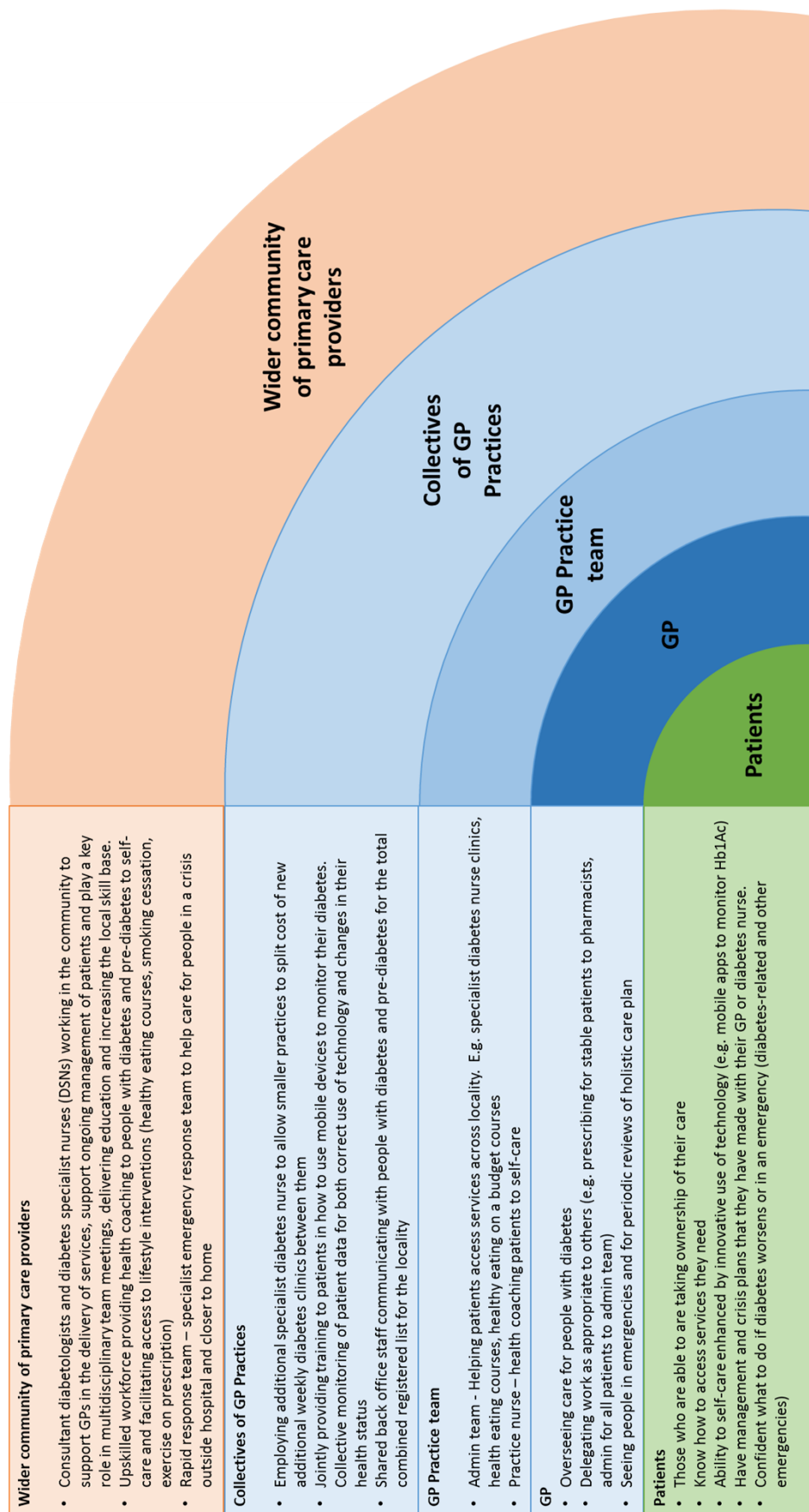
### **Localised pathway design**

Pathway design within each locality will be informed by BHR standards for pathways for preventative, planned, urgent and mental health care. Within these standards, localities will be supported to design the pathways that work best for their population. Pathway design at locality level will include:

- Deciding the division of responsibility for delivery of primary care services across GP practices individually, GP practices collectively and the extended team
- Thresholds and protocols for referral to, and discharge from local hospital services
- The relative proportion of GP practice appointment time to be made available for prevention, planned and unplanned care.
- How the locality will utilise the planned urgent and emergency care 'click, call, come in' capacity as part of their urgent care offer
- How care across providers is joined up around the patient
- How providers all play to their strengths
- How quality is assured.



Figure 12. Example of how the mix of services might be distributed across the locality team





## Enablers and support

The CCG will provide investment and support in the enablers of this vision for primary care-led locality working. BHR will:

- Provide each locality with dedicated resources to support the development of locality working.
- Identify solutions for the recruitment, retention and development of the GP workforce, as well as nursing, pharmacists and practice management. Other roles, including primary care healthcare assistants, may need to be developed (details below).
- Develop funding and contractual arrangements for primary care and the wider system to incentivise joined-up care, prevention and avoidance of avoidable hospital admissions.
- Enable GPs and the extended primary care team to operate from fit-for-purpose premises, making best collective use of local public service estates.
- Support both patients and their care providers to be confident users of information and IT solutions that enable self-care, care scheduling, joined-up care planning and management, and safe clinical decision-making.

At the same time, the financial sustainability of the system will be enhanced through the de-duplication and appropriate automation of administrative functions, releasing more patient-facing time.

## Local authority contribution

- Social care services will make up a core part of locality-based primary care teams
- Public health will contribute in a number of ways:
  - input into needs assessments for each locality
  - map the current social capital available within each locality
  - commission services that focus on prevention of ill health
  - evaluate the impact of prevention on care capacity.

## Evolution of the way providers are organised and work together

In configuration terms, locality teams will initially be virtual teams. General practice will have the opportunity to lead and shape the way locality provision develops, learning from the experience of joint working. Provision may continue in the form of an alliance of autonomous health and social care providers. Alternatively, by 2021, general practices may consolidate into a larger scale provider, or join with community and other providers into a multi-speciality community provider.

## 5.4 What is the vision for workforce in general practice and the locality?

Throughout our stakeholder interviews, there was a shared vision of integrated primary, community and social care working at a locality level with the patient and GP in the centre.

This strategy, therefore, makes recommendations for the primary care workforce for the first two years whilst the landscape becomes clearer with other strategies and initiatives. These recommendations will create the framework for a more engaged, mature and agile locality-based primary care team empowered to 'sense and respond' in a fast-changing world.<sup>2</sup> This will allow benefits from working as part of the CCG but also be locally driven.

<sup>2</sup> Frederic Laloux: Reinventing Organizations: A Guide to Creating Organizations Inspired by the Next Stage of Human Consciousness (Nelson Parker, 2014). [www.reinventingorganizations.com](http://www.reinventingorganizations.com)

As the vision is very much about empowering localities to co-design and deliver locally appropriate solutions, we have set out a range of potential options proposed by stakeholders for workforce development within locality settings. Localities can choose to adopt solutions that suit their population's and workforce's needs. These are set out in Appendix D – Workforce development in primary care.

### 5.5 What would locality-based care mean for a GP practice in 2018?

Different ways of working will develop within each locality, but GPs will see key changes in their day to day working across Barking and Dagenham take place over the next two years.

#### 1. GP practices will work more productively and free up GP time to provide and oversee patient care

*I'm a Practice Manger for quite a big practice (9 FTE GPs). I did a bit of work with one of our partners looking at the activity in our practice using a tool developed by the RCGP, which we found out about at one of the locality support sessions. I found the tool really helpful, not least because while everyone at our practice feels stretched and that things could be more efficient, they all have different opinions about what the problem is! Having the information about how we were spending our time in black and white made it a lot easier to agree what we should focus on, and ways we could change it.*

*We realised that a lot of GP time was spent on patients that could be seen by someone else in the practice. For example, GPs were doing routine blood pressure checks that could have been done by the nurse; hospital referral chasing that could have been done by reception; repeat prescriptions could have been done by our admin team. We talked through a couple of options that we'd gone through at a locality workshop and decided we would try 'process triage' at our practice. That means getting reception to ask what appointments were for and directing the routine checks, repeat prescriptions, coughs etc to alternative members of staff or the pharmacy. Of course, if a patient doesn't want to say why they want a GP appointment, we don't push them to say, it's just where they are happy to give that information. It's also not infallible, sometimes patients do reveal they have another problem which needs GP attention during their nurse appointment. Even taking all that into account, we managed to move about 10-15% of our GPs' workload onto other members of the practice team. That frees up about a day a week of GP time that can be spent on more valuable work.*

#### 2. Collaborative working between GP practices in localities and with the extended team of care professional will become established, raising quality and increasing capacity for locality care services and helping reduce the cost of administration

*I'm a partner in a small practice and, like many practices, we have a lot of patients with diabetes. A specialist nurse helping to care for these patients would really improve these peoples' care, but we don't have the resources to employ a full-time specialist nurse, and have never been able to recruit one on a part-time basis. Because the practices in our locality have all outsourced our payroll and HR through the same company, it's been easy to join up with two other small practices to create a full-time role for a specialist diabetes nurse that we share between us. We share the cost of her salary, and all our patients get the benefit of specialist nursing. Our nurse likes the variety and was attracted by the full time job close to home. Our practices are close together so it's similar for her in terms of travel, and she's never working too far away from her son's nursery either.*

*We don't just outsource as a locality though; we also share work between our existing staff. We realised there are a lot of tasks that we didn't want to outsource, but that didn't make sense for every practice to do its own. Our practice managers have divided up this work we all do between them and now focus each team on doing one thing (e.g. call-recall) really well for the whole locality.*

### **3. Clear boundaries between primary care and acute hospitals, with good handovers between teams**

*I used to spend hours chasing up information about my patients that had been discharged from hospital, making sure I knew what care needed to be in place and that it was happening. It was very often reactive, non-medical work, that was draining and frustrating. Having better information flows with our local hospital has improved things a lot. Joined-up IT means I have much more of the information I need to manage patients post-discharge. Reducing the administrative burden associated with discharged patients means I have more time to focus on planned care. For example, working on emergency plans with those patients who are likely to require acute care when their condition deteriorates. By having those plans in place with patients, and other services they will need, we can make the transition between primary and secondary care much better for those patients.*

### **4. A programme will be put in place to recruit, develop and retain a primary care workforce suited to delivery in a place-based model in Barking and Dagenham**

*After years of trying, six months ago I finally recruited a new salaried GP to my practice and it's made a huge difference. Before she started I'd been reliant on locums and working myself into the ground. I used to regularly think to myself 'I'm a GP in my prime, I'm highly skilled, do I really want to do this for another 20 years when I could have a much, much nicer life in Australia?!'. Having another full time GP that's committed to the practice and the patients has really helped take some of that pressure off.*

*I think the recent changes have helped make our borough an attractive option for newly qualified GPs, when they wouldn't have considered it a few years ago. Now we're getting a reputation as the top place in London for innovation, what with the Vanguard and work on integration. She wanted to work somewhere where she would definitely be developed, on top of getting experience in all the multiprofessional working. It also helps that the CCG have got a bit slicker at marketing the area - good house prices compared to the rest of London and so on – as well as the work we do.*

### **5. Increasingly, reliable IT solutions will enable joined-up patient care and the automation of administrative tasks, and locality-based providers will adopt and use them with confidence**

*I knew that joined-up IT would release a significant amount of time that my receptionists*

*used to spend printing and scanning paper documents. What I hadn't really expected was the difference it's made in terms of building trust in my colleagues outside my practice, and the benefits that has brought me in my job as a GP. It's not just that I started to build relationships with them in joint IT training sessions, or during Skype MDT meetings. Having shared records where we can access the information we need means I can easily see what community nursing, pharmacies, social care etc are doing to care for my patients. For example, if a patient needs a home visit after coming out of hospital, I can see when it's happened, what the outcome was and who is doing what. I don't have to hunt for that information, or call to double-check. It's just there. It means that I can really focus on what I need to do as a doctor for my patients, keep an overview of their care, but not feel like I have to do everything myself to be sure it will get done.*

## 5.6 What would be the benefits of locality-based care for patients?

Across primary care there will be an overall improvement in quality of primary care in Barking and Dagenham, and a reduction in the variation of quality between GP practices. Patients will benefit from care that is more proactive, accessible and coordinated, as outlined in the patient offer of the strategic commissioning framework. Their experience will be of an integrated service that supports and improves their health and wellbeing, enhances their ability to self-care, increases health literacy, and keeps people healthy. Primary care will be personalised, responsive, timely and accessible, and provided in a way that is both patient-centred and coordinated.

Practices across Barking and Dagenham will show improvement in the quality of treatment for key cancer, COPD, diabetes, mental health and patient satisfaction indicators (including four patient access indicators), as measured by progress against baseline in the primary care transformation dashboard (Appendix C – Primary care transformation dashboard)

Issues around patient access will be addressed by providing seven-day primary care, with integrated IT allowing appropriate sharing of their records between services so that they receive high quality care no matter where they are. Joined-up services and shared records will enhance patients' confidence in primary care, reduce their reliance on their GP where other professionals could help them, and reduce their frustrations around having to repeat their story to different professionals.

The locality model will also allow patients that would previously have been treated in secondary care to be treated closer to home, for example by bringing consultants out of hospitals and into community clinics hosted in hubs.

Localities will actively engage with the population they serve, with the priorities and preferences of patients feeding into the locality vision and patients involved in the co-design of services with professionals.

## 6 The transformation needed in primary care

### 6.1 What is the transformation needed?

Within the next five years, care for Barking and Dagenham residents will move from reactive to proactive, with a focus on prevention, support for self-care, active management of long-term conditions and the avoidance of unnecessary hospital admissions. Patients will have a more joined-up care experience, be enabled to take more control of their care, and more of their treatment will be closer to home.

As illustrated in Figure 13 below, this will be achieved by

- Improving the productivity and financial sustainability of GP practices through better management of workload and use of IT, freeing up GP time for patient care
- Introducing/extending collaborative working between GP practices on care delivery and administration
- Transforming further how care is provided and organised in each locality, combining professionals in general practice with those in other primary and community-based health and social care providers into an extended team which provide a joined-up service for the majority of patients' care, with GPs overseeing care for their patients
- Developing BHR system strategies for planned care, mental health, urgent and emergency care and prevention, which establishes common standards and services for the BHR population, including defining standards regarding increasing access for those who are not currently accessing primary care.
- Locality teams working within this framework to decide local pathways, how work is shared and where care is delivered from, to best meet the needs of their population
- Locality teams having the governance, resources and business intelligence to monitor delivery, learn from experience and continuously improve their care quality and cost-effectiveness
- Locality teams are competent at capacity planning, enabling them to effectively design new ways of working taking into account how time spent on secondary prevention can free-up time currently spent on patients who have been discharged after an emergency admission.
- Developing a sustainable workforce for general practice and locality working
- Aligning contractual and funding arrangements with the achievement of population outcomes.

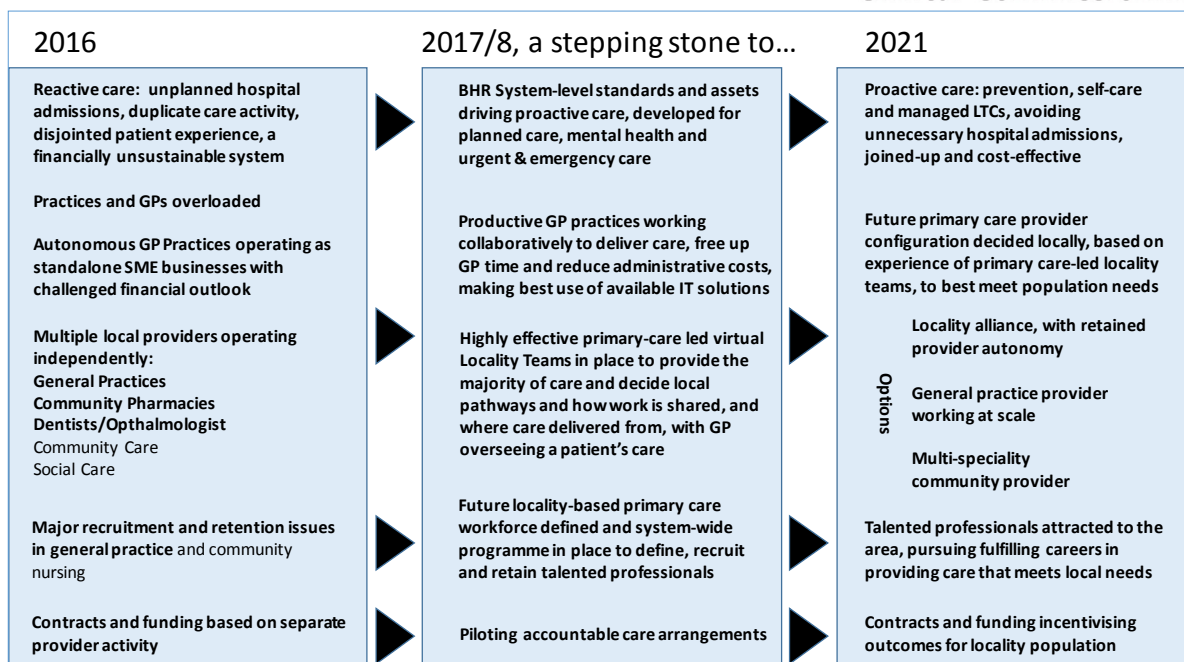


Figure 13: Milestones in journey towards achieving the vision

This agenda draws on the Kings Fund's guidance for establishing place-based care, shown below.

## 6.2 What will be the outcomes of the transformation?

Operating effectively, locality teams delivering the majority of care, working within the BHR standards framework, should achieve a range of outcomes:

- Reduction in unnecessary duplicate assessments and diagnostic tests
- Enhanced outcomes at individual patient and locality population levels
- Better targeting of local resource to locality health needs
- Increased support for individuals' self-management
- Enhanced life expectancy
- Better access to the right urgent care services
- Reduced unplanned A&E attendances and emergency admissions
- Reduced re-admissions to hospital.

In addition, there are outcomes specifically related to general practice:

- Enhanced patient satisfaction with the general practice service
- Continued high levels of access to GP practice services
- Proportional increase in GPs' patient-facing time
- Improved productivity and financial sustainability of GP practices
- Improved morale, teamworking and patient focus amongst locality-based staff
- Quality and financial benefits realised from investment in digital, IT and business intelligence solutions

These will all contribute to improved outcomes for patients, which will be monitored via the primary care transformation dashboard (see Appendix C – Primary care transformation dashboard).



### 6.3 How will implementation of the transformation agenda be organised?

The transformation agenda is multi-dimensional and, as shown in the table below, will be led from locality teams with support from a primary care transformation programme (PCTP) and adjacent planned care, mental health and urgent and emergency care transformation programmes, all at BHR system level.

<b>Transformation theme</b>	<b>Vehicle</b>
Improving the productivity and financial sustainability of GP practices through better management of workload and use of IT, freeing up GP time for patient care	PCTP
Introducing/extending collaborative working between GP practices on care delivery and administration	PCTP
Transforming further how care is provided and organised in each locality, combining professionals in general practice with those in other primary and community-based health and social care providers into an extended team which provide a joined-up service for the majority of patients' care, with GPs overseeing care for their patients	PCTP
Developing BHR system strategies for planned care, mental health, urgent and emergency care and prevention, which establishes common standards and services for the BHR population	Adjacent BHR transformation programmes
Extending access to urgent care services	Urgent and emergency care programme
Locality teams working within this framework to decide local pathways, how work is shared and where care is delivered from, to best meet the needs of their population	Localities, with BHR adjacent programme input and PCTP OD support for first cycle
Locality teams having the governance, resources and business intelligence to monitor delivery, learn from experience and continuously improve their care quality and cost-effectiveness	PCTP
Developing a sustainable workforce for general practice and locality working	BHR System/ CEPN/ Care City
Aligning contractual and funding arrangements with the achievement of population outcomes.	ACO Programme

The primary care transformation programme itself will be primarily about provider development – strengthening individual practices, progressing collaborative working amongst GP practices in localities and developing extended locality teams, bringing together GPs with all local health and social care professionals to provide the majority of care for patients. To bring this to life and establish a learning culture, the approach is to draw on the CCG's strategies for planned, mental health and urgent and emergency care and identify specific local schemes, which can be used to inform development of collaborative governance and working arrangements in localities and as a proving ground in localities, ensuring they are wholly grounded in the business of local providers and the care needs of local people.

The PCTP will be directed by the BHR Director of Primary Care Transformation and governed by the Primary Care Transformation Programme Board who:

- Provide system wide leadership and accountability for the transformation of primary care in BHR

- Recommend the priorities for primary care strategy to the governing bodies of BHR CCGs and the respective health and wellbeing boards
- Oversee implementation of the strategic commissioning framework for primary care transformation in London.

A programme management office will operate at BHR system level to ensure the four BHR transformation Programmes are co-ordinated and aligned so that localities are enabled to deliver the outcomes set out above.

## 6.4 Transformation Plan

### 6.4.1 Five-year programme

Phase 1	Establish effective localities, founded on productive general practice, to provide the majority of patient care	April 2016 to September 2017
Phase 2	Localities deliver care to meet local needs, line with BHR standards, and continue to evolve through learning and trial new contractual and funding arrangements	April 2017 to April 2021
Phase 3	General practice and locality provider configuration and evolves where appropriate from virtual team to alternative provider form	April 2018 to April 2021

#### 6.4.2 Phase one: objectives and plan

The provider development work associated with improved productivity and the design and mobilisation of collaborative general practice and locality working needs to be undertaken with strong drive but at a measured pace to ensure the work is clinically led, that participating clinicians and care workers buy in, that professional relationships form sustainably and there is the opportunity to learn from experience and adapt the model accordingly.

The implementation will need to involve a collaborative partnership between the centralised BHR/CCG team and teams in each locality. A key requirement of the new model is that the ways of working and approach within each local area should be designed by the teams working within that area. There are however some key attributes that will need to be present in all models and additionally there are synergies and benefits that can be delivered through an understanding of the models under development in all localities, which would not be identified and exploited through a purely devolved implementation approach.

The objective is that locality teams should be working at full capacity and across the full scope of primary, community and social care by September 2018, in time for the 2019 contracting found.

Second-level objectives to achieve this are set out in the table below.

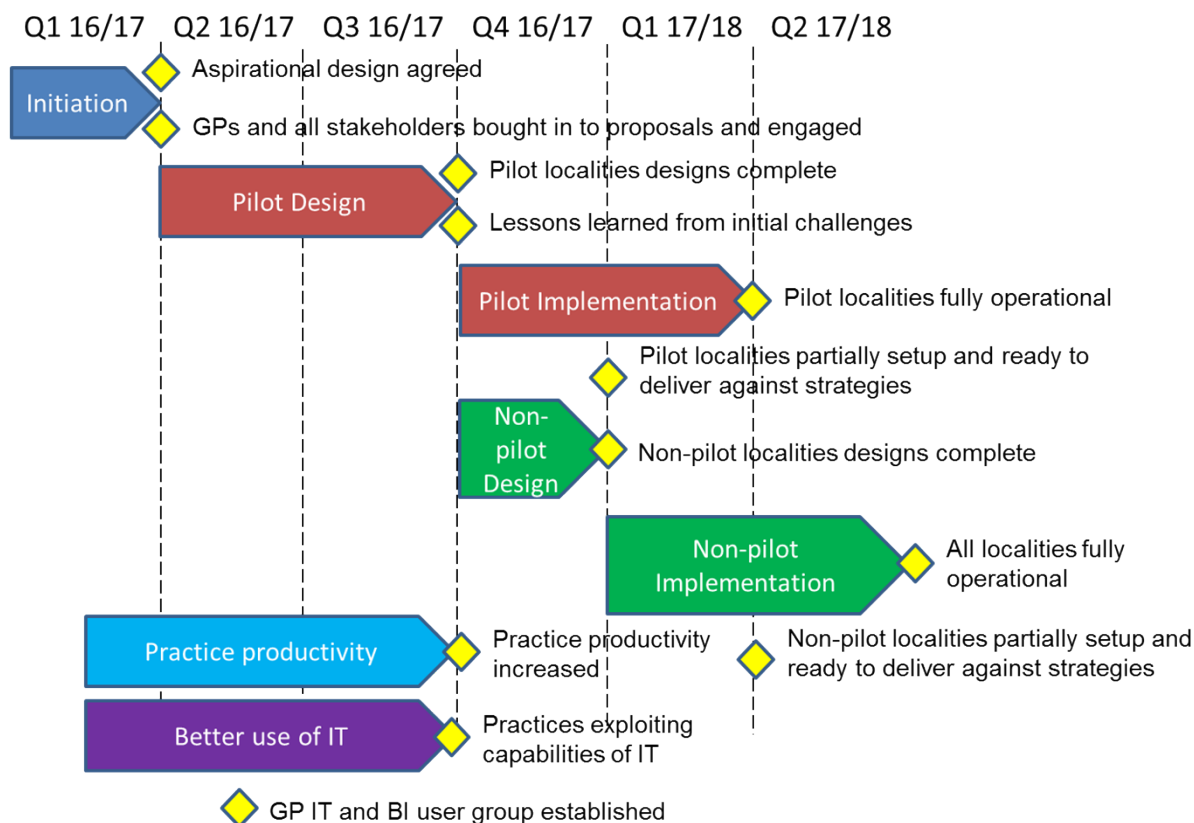
Objectives for primary care transformation phase one	
<b>Provider development</b> :	<ul style="list-style-type: none"> <li>• GPs are able to, and effective in, providing appropriate oversight for all of a patient's care</li> <li>• Individual GP practices are effective in managing their workload and focusing GP time where it adds most value</li> </ul>
<b>Practice productivity, collaborative working and</b>	<ul style="list-style-type: none"> <li>• GP practices are clear what IT and digital solutions are available to improve productivity, have implemented them and realised the associated benefits</li> <li>• In each locality, each GP practice is clear on what primary care</li> </ul>

<b>locality team development</b>	<p>services it delivers and effective at delegating responsibility for other primary care services to other providers</p> <ul style="list-style-type: none"> <li>• Members of extended primary care teams in each locality have formed trusted working relationships with colleagues serving the same cohort of patients</li> <li>• Locality teams are clear what IT and digital solutions are available to enable interoperability, effective collaboration and a joined-up patient experience, have implemented them and realised the associated benefits</li> </ul>
<b>Quality</b>	<ul style="list-style-type: none"> <li>• Individual GP practices sustainably meet and exceed quality standards set out in NHS England Strategic Commissioning Framework for primary care and show progress against baseline in the primary care transformation dashboard</li> </ul>
<b>Locality pathways</b>	<ul style="list-style-type: none"> <li>• Arrangements are in place and used for locality pathways to be jointly designed by a cross-section of patients, GPs and other members of the locality team</li> <li>• Arrangements and protocol are in place whereby locality teams work with the BHR planned care, mental health and urgent and emergency care programme to agree mutual expectations for service design, capacity assumptions and outcomes and to communicate progress, issues and learning</li> <li>• Each locality has developed and implemented a holistic plan for prevention, including the upskilling of clinicians to coach for health and the organisation of screening and immunisation services</li> <li>• Each locality has pathways for frail elderly patients and for those with multiple co-morbidities</li> <li>• Each locality has determined how the CCG's planned 'click, call, come in' urgent care solution will be combined with urgent appointments in GP practices to provide an unplanned care service for the local population. They will have a clear plan for implementing this</li> <li>• Each locality has worked with Barts Health and/or BHRUT to develop and implement a full set of protocols for referral to hospital and discharge.</li> </ul>
<b>Governance, intelligence and learning</b>	<ul style="list-style-type: none"> <li>• Governance and management arrangements are established for collaborative working in general practice</li> <li>• Governance and management arrangements are established for locality working</li> <li>• Business intelligence arrangements are in place and used actively to monitor operational activity across each locality and to monitor the achievement of outcomes</li> <li>• Protected time is available and used by GPs and fellow locality team members to learn and develop together</li> <li>• Successes are identified, shared and celebrated.</li> </ul>

While some work has been done in Barking and Dagenham to establish a GP federation, full implementation of the vision will require a significant change from current ways of working, and therefore it is proposed to start with a pilot. One locality will lead the way for Barking and Dagenham with the designs for the other localities not being started until that for the pilot locality has been completed. This will enable lessons learned from the pilot to be incorporated in the designs and planning for the other localities.

To minimise risk and allow greater chance of success robust project and programme management arrangements will be put in place, and localities will receive significant support from BHR and the CCG. This is not to take away from the responsibilities and ownership of teams in localities, but to provide a support to them in the design and implementation of change.

Key milestones for phase one are as follows:



### 6.4.3 Programme for 2016/17

#### 6.4.3.1 Initiation phase

An initiation phase is required to undertake the following tasks:

- Creation of a set of design principles against which all Locality Models should be designed. These will be based on the King's Fund: 10 principles to guide the development of systems of care in the NHS
- Development of the framework of outcomes that all locality models will need to deliver as a minimum in addition to their locally identified outcomes
- Development of a business case for the implementation of the new model articulating the case (costs and benefits) at all levels - system and borough, locality, GP practice
- Agreement of resources needed for implementation and how these resources will be identified
- Definition of each locality area and agreement of these, including development of locality profiles to enable localities to prioritise and plan around the needs of their populations
- Identification of the pilot locality and working with them to mobilise the project to design their new model

- Communications and engagement to gain buy-in and support from all parties across Barking and Dagenham who need to be involved in the design and implementation of the new model.

#### 6.4.3.2 Practice productivity

A workstream will be initiated to help GP practices increase their productivity. This will be delivered through a series of workshops teaching skills and using real-life data from GPs to drive improvement. These workshops will cover:

- Theory and methods of demand and capacity modelling to support analysis of their own practices. E.g. the RCGP's *3<sup>rd</sup> available appointment*
- Sharing modelling findings and selection of interventions to trial within their practices
- Sharing of impact and learning from changes made within practice

This additional independent workstream will involve working with all members of the extended primary care team to help everyone understand the capabilities and make use of their existing IT.

#### 6.4.3.3 Design phase – collaborative working in general practice and across localities

Each locality designing its new operating model, with the pilot locality taking the lead and lessons learned from the pilot fed into the design of the other localities. This will include work on (but not limited to) the following areas:

- Processes and pathways - including business models of operation for all different areas of the operation and functions (both front and back office), the operational costs of these and the expected performance levels
- Organisation and people – the organisation structure, staffing levels, roles, skill requirements, culture etc
- Estates – how the different accommodation across the locality will be utilised to support the new operating model
- Governance – how the locality will be governed and managed
- Use of IT and information (N.B. the designs for IT and information governance will be completed at a system level to achieve economies of scale and consistency across localities).

To develop this new operating model, practitioners from different disciplines will need to come together and will follow a co-design approach. This approach will play a part in developing the organisation and creating trust and relationships between the different groups of professionals within a locality.

The implementation plan, to be followed through the next phase of the implementation, will also be developed. This will include in detail all of the activity that will need to be completed to move from a design on paper into live operations.

At a system level designs for IT and information governance will be completed incorporating the requirements of the emerging locality models. There will also need to be a re-design of the CCG and system level support and management arrangements so that they are aligned with and fit-for-purpose with the new locality ways of working. This level will also have responsibility for oversight of the designs that are in development to recognise synergies and opportunities for efficiency and collaboration between localities.

#### *6.4.3.4 Implementation phase*

This phase of activity will include all the activity needed to move from a design on paper into live operations. The detail of this cannot be known until the completion of the design phase; however it will touch on all areas of the new operating model.

## 7 Risks and assumptions

### **Risks**

- Insufficient grass roots buy-in from GPs and other primary care professionals
- Insufficient capacity within general practice to participate
- Dependencies on other projects – IT, workforce
- The pace of change demanded vs the time necessary to develop localities sustainably
- Compatibility of the strategy with main providers' strategies
- Insufficient investment in the resources to enable the programme to succeed.

### **Assumptions**

- Improving team working in localities will release significant quality and productivity benefits
- GP practices are receptive to opportunities to improve their practices
- This strategy will have top-level support regardless of whether the ACO proceeds
- Interoperable IT agenda sufficiently advanced to enable localities to provide continuity of care to patients.

## 8 Appendix A: Transforming primary care live SPG delivery plan





## Transforming Primary Care Live SPG delivery plan

**Key:**

- predicted pan London delivery date
- SPG confirmed activity date
- Anticipated activity date subject to SPG confirmation
- SPG Coverage
- ★ SPG specification delivery

		2015		2016		2017		2018		2019		2020		How does the vision for locality-based primary care enable and accelerate cost-effective compliance with the standard?													
		01 April 2015	02 Jul 2015	03 Oct 2015	04 Jan 2016	01 April 2016	02 Jul 2016	03 Oct 2016	04 Jan 2017	01 April 2017	02 Jul 2017	03 Oct 2017	04 Jan 2018		01 April 2018	02 Jul 2018	03 Oct 2018	04 Jan 2019	01 April 2019	02 Jul 2019	03 Oct 2019	04 Jan 2020	01 April 2020	02 Jul 2020	03 Oct 2020	04 Jan 2021	
<b>Proactive Care</b>																											
<b>Delivery of specifications</b>																											
<b>P1</b>	<b>Co-Design</b>																										
	<b>BHR</b>																										
	Focus groups led by the federations with Healthwatch representation	★																									
	H1000 model developed with UCLP and patient groups linked into the design process	★																									
	Development of the new intermediate care model (ICM, CTT, IRS) followed extensive engagement with stakeholders to determine co-design the model	★																									
	Focus group to review central care centre initiative across the federations																										
	CEPM to review workforce planning and training needs																										
	Map dementia services across health, social care and voluntary sector in Havering																										
	Map health services for over 75s to review the pathway alignment																										
	Test impact of new operational resilience schemes																										
	Development of the primary care strategy																										
<b>P2</b>	<b>Developing assets and resources for improving health and wellbeing</b>																										
	<b>BHR</b>																										
	MDoS developed to include local asset database																										
	Work with the local council, community and voluntary services to input into MDoS (this is dependant on LA sign-up which is being sought through ICC and ICSG)																										
	MDoS used by ICM to locate support and care services close to peoples' homes																										
<b>P3</b>	<b>Personal conversations focussed on an individual's health goals</b>																										
	<b>BHR</b>																										
	Risk stratification is in place to support targeting the top 1-3% for conversations	★																									
	Integrated case management (ICM) in place to manage the top 1%																										
	Care co-ordination and Frailty training being commissioned as part of the Locality Training Fund for 2014/15																										
	Review whether to roll out intervention pharmacists pilot as a QIPP scheme																										
	Health1000 pilot in place providing tailored care to patients with 5+ LTC who registered on the Health1000 list.																										
	Everyone counts initiative - GP Practices have been allocated CCG funds based on their list sizes with which to devise new and innovative services to support the >75s within their practice population.																										
<b>P4</b>	<b>Health and wellbeing liaison and information</b>																										
	<b>BHR</b>																										
	MDoS developed to include local asset database																										
	Clinicians use MDoS																										
	Patients are able to use MDoS																										
<b>P5</b>	<b>Patients not currently accessing primary care services</b>																										
	<b>BHR</b>																										
	Patients encouraged at walk in centres & UCC to register at a practice																										
	Homeless patients encouraged to register at walk in centre co-located practices	★																									
	CCG and LA to develop and implement plans to work with local schools and business around healthy life styles																										
	Review London Commissioned services around homeless practice/provision																										
	Primary care strategy developing additional plans to target vulnerable groups																										
	Queens A&E to review patients with 10+ attendances in 12 months																										

Patients and voluntary sector organisations will be part of the locality team and will help co-design services within localities

Locality teams will include colleagues from the Local Authority, voluntary and community, health and third sector organisations and will work together to ensure best use of community resources (including social capital) to improve population health and wellbeing

Localities will design planned care pathways that include opportunities for patients to access coaching for health from a member of the primary care team who will be able to direct them to appropriate local services (e.g. leisure centres, citizen's advice)

Training in coaching for health will be part of workforce development

Locality teams will design ways to use local assets and IT/ Digital to prevent ill health by enabling patients to access information and advice

Localities will collaborate to design ways to reach people who do not routinely access primary care, including a joined-locality approach to working with the unregistered population.

Productive GP practices making best use of IT and Digital solutions will have more time to focus on people on their registered list who do not attend, and processes in place to potentially consolidate that work.

## Transforming Primary Care Live SPG delivery plan

Coordinated Care	2015		2016		2017		2018		2019		2020		How does the vision for locality-based primary care enable and accelerate cost-effective compliance with the standard?	
	01 April 2015	01 Jul 2015	01 Oct 2015	01 Jan 2016	01 April 2016	01 Jul 2016	01 Oct 2016	01 Jan 2017	01 April 2017	01 Jul 2017	01 Oct 2017	01 Jan 2018		
<b>Delivery of specifications</b>														
<b>C1 Case finding and review</b>														
<b>BHR</b>														
Regular engagement with the Integrated Care Coalition (ICC)														
Risk stratification is in place to support targeting the top 1-3% for conversations														
Integrated case management (ICM) in place to manage the top 1%														
Queens A&E to review patients with 10+ attendances in 12 months														
Health1000 pilot in place providing continuity of care to patients with 5+ LTC who registered on the Health1000 list. Patients targeted through a tailored risk stratification tool focused on patients with more than 5 LTCs.														
<b>C2 Named professional</b>														
<b>BHR</b>														
Integrated Case Management in place														
All patients included in the ICM model have a named professional														
Risk stratification tools used to identify further patients at risk														
Unplanned admissions DES in place - optimising coordinated managed care for the most vulnerable patients in their homes														
Health1000 pilot in place providing continuity of care to patients with 5+ LTC who registered on the Health1000 list.														
<b>C3 Care Planning</b>														
<b>BHR</b>														
Integrated Case Management model in place														
Care plans developed and managed with the MDTs in ICM														
Patient records shared across MDTs within the ICM														
Data governance for patient records to enable sharing within ICM agreed														
Pilot Skype MDT with acute geriatrician in Havering														
Joint Assessment and Discharge team in BHR University Hospital Trust to improve discharge and care planning for complex patients														
Care co-ordination training commissioned as part of the Locality Training Fund for 2014/15														
Patient records shared across access hubs & federations														
Shared care summary being developed to pull key clinical information from sources to aid clinical decision making and improve patient experience														
Health1000 pilot in place providing continuity of care to patients with 5+ LTC who registered on the Health1000 list.														
<b>C4 Patients supported to manage their health and wellbeing</b>														
<b>BHR</b>														
Integrated Case Management model in place														
Care plans developed and managed with the MDTs in ICM														
Patient records shared across MDTs within the ICM														
Care co-ordination training commissioned as part of the Locality Training Fund for 2014/15 (training includes cognitive behavioural techniques to support patients to self-care).														
Patient records are shared across the federations and are available at the access hubs														
Health1000 pilot in place providing continuity of care to patients with 5+ LTC who registered on the Health1000 list.														
System wide training / specific workshops through the CEPN e.g. EOL - difficult conversations for secondary care clinicians														
<b>C5 Multi-disciplinary working</b>														
<b>BHR</b>														
Integrated Case Management model in place														
Care plans developed and managed with the MDTs in ICM														
Patient records shared across MDTs within the ICM														
Patient records are shared across the federations and are available at the access hubs														
Health1000 pilot in place providing continuity of care to patients with 5+ LTC who registered on the Health1000 list. Team consists of dedicated: Geriatrician, social worker, physiotherapist, occupational therapist, nurses, GP and key workers														
System wide training / specific workshops through the CEPN e.g. EOL - difficult conversations for secondary care clinicians														

## 9 Appendix B: Current localities

### Barking & Dagenham GP Practices

#### Cluster One



Dr Kashyap & Mehta –  
Marksgate Medical Practice  
Dr Teotia – Green Lane Surgery  
Dr Haider & Dr Finnigan –  
Valence Medical Centre  
Dr Garcia – Highgrove Surgery  
Dr Afser Surgery  
Dr Goriparthi - Tulasi Medical Centre  
SLL: Monga Mafu  
PIL: Stasha Jan

#### Cluster Two



Dr A Moghal – Becontree Medical Centre  
Dr Sharma & Kalra –  
Laburnum Health Centre  
Dr Ola Surgery  
Dr Bila – Heathway/Broad Street Practice  
Dr Ehsan – Oval road Practice  
Dr D Shah - Parkview Medical Centre  
Dr Goyal/Dr Duodu –  
Church Elm Lane Medical Practice  
SLL: Monga Mafu  
PIL: Stasha Jan

#### Locality 1

Clusters 1 and 2

#### Cluster Three



Dr Abaniwo - Five Elms Medical Practice  
Dr Mittal - Markyate Surgery  
Dr Dallas - The Gables Surgery  
Dr Jaiswal - Julia Engwell Health Centre  
Dr Goriparthi - Venkat Health Centre  
SLL: Richard Clements  
PIL: Kam Sahota

#### Cluster Five



Dr K John - King Edwards Medical Centre  
Concordia - Porters Avenue Doctors Surgery  
Dr Kendeel - John Smith House  
Dr Ansari- Ripple Road Medical Practice  
Dr Kalkat - Thames View Health Centre  
Dr Prasad - Faircross Health Centre  
Dr Haq - Abbey Medical Centre  
SLL: Gemma Hughes/ Sarah D'Souza  
PIL: Mary Smith

#### Locality 2

Clusters 3 and 5

#### Cluster Four



Dr Chandra - Broad Street Medical Centre  
Dr Fateh – First Avenue Surgery  
Dr Ahmed & Dr Monteiro – Hedgemans Surgery  
Dr Alkaisy & Dr Islam – Urswick Centre  
Dr Mohan – Urswick Medical Centre  
Dr Adedeji Practice - Halbutt Street Surgery  
SLL: Richard Clements  
PIL: Kam Sahota

#### Cluster Six



Dr Chawla – The Surgery  
Dr Tolia - The Barking Group Practice  
Dr Chibber & Dr Gupta's surgery  
Dr Niranjan - Victoria Medical Centre  
Concordia - Child and Family Centre  
Dr Rashid - Shifa Medical Centre  
Dr Sharma & Dr Rai - The White House  
SLL: Gemma Hughes/ Sarah D'Souza  
PIL: Mary Smith

#### Locality 3

Clusters 4 and 6

## 10 Appendix C – Primary care transformation dashboard

Placeholder – dashboard has not been populated but was finalised mid-March

## 11 Appendix D – Workforce development in primary care

Solutions offered include using a greater skill mix of practitioners in primary care, offering a seamless integrated service with clear opportunities for career development for all members of the primary health care team.

Specific ideas for different members of the primary health care team are summarised below.

### GPs

Attract young GPs	<p>Fourth year fellowships in Barking and Dagenham for GP trainees. Provide “home” (perhaps a BHR-wide employment agency) with identity, peers and support for ongoing learning, personal and professional development, parental leave, study leave, management opportunities to lead small projects and research opportunities, whether a partner, salaried or long-term locum Plurality of provider models to include independent contractors, federations, chambers, super practices, and increased salaried working, to achieve economies of scale in management, infrastructure, and clinical resources, and to provide wider ranges of patient services. Become exemplars of multiprofessional working</p>
Attract returning GPs	<p>By marketing package for returning GPs: ongoing support for personal and professional development, family friendly approach, parental leave and carers leave offer, easy to access Ofsted reports, Rightmove and Zoopla. Clarity on career path and ongoing development.</p>
Attract international GPs	<p>From Eastern Europe (via the IMG scheme) GP profile to match changing population profile. Offer IMGs a registrar-level salary while training (as they do in East Midlands) to enable senior experienced GPs to afford to come to London.</p>
Promote sustainable model of General Practice	<p>To promote fulfilling, rewarding and sustainable career. Become known as <i>the</i> place in London for excellent integrated care with primary, community and social care building on innovation of the Vanguard and ACO. Time to see patients and deal with issues properly Interesting variety of patients Integrated locality model of working with joint learning and co-development of services with other providers and patients. Identify, prioritise, implement and evaluate local models of QI initiatives Social prescribing Pharmacist prescribing Support older GPs with retirement planning</p>
Market Barking and Dagenham as a place to live and work	<p>Effective HASS in Barking and Dagenham with S75 agreements in place between LA and community provider Affordable housing (for London) Good schools</p>

	Range of career development pathways identified
Opportunities in Barking and Dagenham as a GP	To develop as clinical leader - locality lead, clinical lead, committee chair, CCG board member To develop as educator and trainer To develop as a researcher (with Care City, BHRUT, UCL Partners)
Ongoing learning and development	Protected time for learning with peers both in general practice and with rest of the primary health care team Training in coaching for health Training in solution focused conversations Continue to develop skills e.g. joint injections, update on dermatology
Use workforce modelling data	Available from April 2016 from NHS England (London) to identify existing workforce. Match to current and future models of care, identify gaps and plan to address
Identify areas to prioritise and work on collaboratively	Form localities/communities of practice All GPs part of geographical network (including salaried and long-term locums) Find ways to innovate/incentivise joint working e.g. <ul style="list-style-type: none"> <li>• top slice secondary care services and provide network enhanced services</li> <li>• One HV for network of GP practices</li> <li>• Share services across network of practices e.g. phlebotomy, direct access physio, counsellor</li> <li>• Develop care pathways across the locality</li> <li>• Share back office functions e.g one book keeper, IT support, HR support</li> <li>• Autonomy to use delegated budget at locality level to meet the needs of the local population</li> </ul>

## Pharmacists

Upskill community pharmacists	In behaviour change Train as health coaches
Develop role of practice pharmacists	Medicines reconciliation Medication review Prescription management Prescription safety/concordance Acute common conditions Chronic disease management Practice performance Primary care practice research
Develop role of pharmacists to work in urgent care settings	Training in coaching for health Training in common clinical conditions Independent prescriber
Upskill to become independent prescribers	For urgent prescriptions as well as LTCs Career path to develop expertise in diabetes, asthma etc
recruit clinical pharmacists	Have "off the shelf" Barking and Dagenham offer, ready to

	advertise for new clinical pharmacists (London-wide initiative)
Recruit local pharmacists	Through local pharmacy apprentice scheme
Ongoing joint learning	With GPs and other members of the primary health care team Career paths identified
Family friendly	
Introduce Pharmacy First scheme	Free OTC medicines for patients on benefits

### Nurses

Attract young nurses	Multi-agency training: acute, primary and community Key worker housing
Retain nurses	Career development pathways identified Ability to work in primary care and community care Supported by AHPs Part of a learning community of practice Key worker housing
Recruit international nurses	
Train nurse prescribers	To work with patients with LTC
Train nurse practitioners	To work with patients with LTC Career path e.g. community matron, specialist practice nurse
Family friendly	
Life long learning	Ongoing joint learning with GPs, pharmacists and other members of the primary and community health team
Optimise use of pool of nursing resource across a locality	Using practice nurses and community nurses, with links to midwives, health visitors and school nurses.
Develop specialist nurses for non registered population	e.g HV for the homeless develop working relationship with third sector e.g. AA, narcotics anonymous

### AHPs

Recruit physician's assistants	London-wide scheme to train physicians assistants Have a Barking and Dagenham offer "on the shelf" ready to advertise when PAs graduate
Physician associates support doctors in the diagnosis and management of patients. They are trained to	See patients for same-day appointments Review test results Booked appointments with patients with LTC Home visits Cryotherapy



<p>perform a number of roles including:</p> <ul style="list-style-type: none"> <li>taking medical histories</li> <li>performing examinations</li> <li>diagnosing illnesses</li> <li>analysing test results</li> <li>developing management plans.</li> </ul> <p>They work under the direct supervision of a doctor</p>	<p>Teaching Clinical audit Maintaining practice registers Supervision of HCAs Make Barking and Dagenham primary care an attractive place to work by offering apprenticeships (PAs have to find £9,000 tuition fees and loans and grants are not available) NB PAs cannot gain prescribing rights as do not have registration. This is being addressed nationally.</p>
<p>Train generic staff to work across health and social care</p>	<p>Care City to provide mechanism to train generic health and social care workers to work across health and social care. Care City to host peer networks, provide mentorship and facilitate apprenticeships CEPN are developing care navigators</p>
<p>Family friendly</p>	<p>To recruit and retain</p>
<p>Life long learning</p>	<p>Framework for ongoing personal and professional development Career paths identified</p>

## Admin and Clerical

<p>Practice Managers Board</p>	<p>Could be developed to</p> <ul style="list-style-type: none"> <li>help PMs share work between them (QOF, call-recall)</li> <li>develop areas of personal expertise/sub specialisation</li> <li>develop career path</li> </ul>
<p>Receptionists</p>	<p>Develop reception staff skills in signposting Career path as care navigators</p>
<p>Family friendly</p>	
<p>Life long learning</p>	<p>Opportunities to continue to learn and develop Career paths mapped out and supported</p>