PROPOSAL

1. TITLE	Quality Improvement in Primary Care
2. BACKGROUND	**2.1 Summary** City and Hackney GP Confederation has been requested by the City and Hackney CCG to submit a proposal, in line with the General Practice Forward View, to deliver a Quality Improvement approach to the development of resilient, systematic and continuously improving general practice in City and Hackney. The CCG is required to find £3 per head of population from within its existing allocation to provide transformational support funding to stimulate development of at scale providers for improved access and to stimulate implementation of the 10 High Impact Actions to free up GP time and secure sustainability of general practice. Building quality improvement expertise is one of the 10 High Impact Actions to free up GP time. In order to achieve the transformation and sustainability that the local healthcare system requires, practices must work systematically to improve their resilience (including financial sustainability) and reduce unwarranted variation in quality of service delivery. **2.2 Key Issues** • Nationally demand for appointments has risen by 13% over the last 5 years, with a 95% growth in the consultation rate for patients aged 85-89. Primary care is therefore under unprecedented strain; • Over half of 3,000 GP respondents to the latest BMA workforce survey consider their current workload to be unmanageable or unsustainable. Over half rated their morale as low or very low; • As identified in our Primary Care Workforce and Buildings Time-Bomb report in 2015, the current City and Hackney GP workforce is aging and facing a retirement crisis which will put the system under even greater strain; • The report further highlighted the ongoing concerns regarding recruitment and retention, particularly of clinical staff locally; • Whilst great strides have been made, there remains unnecessary variation in outcomes between practices locally, with little standardisation of service delivery. We therefore propose the application of a Quality Improvement Collaborative (QIC) model to support general practice to not only develop greater resilience to address these issues but to also equip our practices with the necessary skills and tools to embed a clinically and locally led culture of continuous and systematic improvement to the challenges they face. **2.3 Why is Quality Improvement (QI) important?[1]** The terms 'Quality Improvement' and 'Improvement Science' describe a commitment to continuously improving the quality of health care, focusing on the preferences and needs of people who use services. They encompass a set of values (which include a commitment to self-reflection, shared learning, the use of theory, partnership working, leadership and

[1] A collaborative project to improve the capacity and capability of general practice teams in Newham to use systematic quality improvement methods, UCLP

understanding context) and a set of methods (which include measurement, understanding variation, cyclical change, benchmarking and a set of tools and techniques). QI differs from quality assurance because it is formative rather than summative in nature. It is a method of management which generates professionalism in a supportive no-blame environment, stimulating curiosity and learning. Its objective is to continuously improve health care processes in a ways that will lead to improved outcomes[2].

By engaging with and leading the development of the science of improvement, general practice has an opportunity to further build its reputation as a leader in the field of quality, and to more effectively influence the ways in which the health service is structured and delivers patient care. This requires a number of issues to be addressed. People who work in primary care will need to be better trained in the science of improvement. Practitioners will increasingly find that expertise in the clinical sciences, the clinical method, and the patient–doctor relationship is no longer enough if they want to deliver the highest quality of care for their patients. In the future, they will need to have a working understanding of the published evidence relating to how health services are organised and delivered, an ability to apply this evidence in practice, to use theory and conceptual models to guide change, and to commit to rigorously evaluating the impact of their work. They will also want to know how to work with the public, health service managers, and academic colleagues to deliver improved care. This is a significant commitment but there is growing evidence that those organisations which invest in building the capacity and the capability of their workforce for systematic improvement achieve better results than those which fail to do so[3].

The general theory behind collaboratives is that by cooperating with each other and comparing practice, professionals and teams will be motivated to do things differently, which in turn improves patient outcomes and ultimately improves service use and costs. They have been used increasingly in many countries to achieve large-scale improvements in performance and to provide specific remedies to overcome the typically slow diffusion of medical and healthcare innovations.

Collaboratives require teams/ experts from different healthcare departments or organisations with a clear vision for ideal care in the topic area, and a set of specific changes that may improve system performance significantly.

The potential of quality improvement collaboratives (QICs) to improve the quality of healthcare is widely recognised[4] though collaboratives have not been much used in the primary care sector.

2.4 Case Studies

- Bedfordshire QIPP[5] – achieving impact from clinically led challenge of unwarranted variation in primary care
  - An evidence based, clinically led analysis of practice based public health was undertaken;
  - This identified areas for practice based education;

[2] Goldstone J. The role of quality assurance versus continuous quality improvement. J Vasc Surg 1998;28:378-80
[3] Marshall M, et al. What can science contribute to quality improvement in general practice? Br J Gen Pract. 2014 May; 64(622): 254–256
[4] Schouten LMT, et al. Evidence for the impact of quality improvement collaboratives: systematic review. BMJ 2008;336:1491
[5] PA Consulting

	o Standardised protocols and pathways were developed and embedded in practices; o Benchmarks of future performance agreed; o Led to an 11.8% reduction in GP referrals and top decile antibiotic prescribing • GP Practice, Tameside and Glossop[6] – reducing the number of prescriptions for strong opiate medication issued per month o Tested two ideas, one to write to all patients on repeats (excluding those coded as palliative or end of life care) explaining the long-term problems that can be caused by the medication and possible benefits of reducing/stopping the drugs and one to reduce the quantity of medication issued the first time a prescription was prescribed to 50 tablets (attaching a leaflet setting out the value of the drug for acute pain, its addictive potential and withdrawal symptoms. o A run chart was established to monitor monthly data on strong opiate medication prescribing. A baseline for the 10 month period prior to the project was established for comparison purposes. o Over the course of 10 months, the practice saw a steadily reducing number of prescriptions issued on a monthly basis, with the patient letter being felt to have had the most significant impact. o The practice now monitors these prescriptions monthly and, having seen a sustained reduction in prescribing, send an annual letter to patients. **2.5 Aims and Objectives** • To support GP practices to improve the quality and safety of the care for their patients by using the philosophy and methods of the science of improvement; *and in doing so:* • To help build a culture of shared learning in the community; • To improve outcomes for patients with complex health problems and to reduce the unplanned use of primary and secondary care services This proposal directly links to the Confederation's aims which are to improve services to patients, support our member practices to become more resilient and to think about new ways of delivering primary care that improve the service that patients receive.
3. PARTNERSHIP	We propose partnering with UCL Partners (UCLP) in the delivery of this proposal. UCL Partners are a unique academic health science partnership that brings together people and organisations to transform the health and wellbeing of the population. In particular, UCL Partners focus on areas of work to support health systems, organisations, and individuals to improve quality, increase efficiency and support leadership that enables transformation in line with the *Five Year Forward View*. UCLP will run two collaboratives in Year 1, lead by their own QI expert. During year 1 four local QI Fellows will be fully trained and they will then run a further two collaboratives in year

[6] GP practice in Tameside and Glossop

	2. Year 2 provides for a further four QI Fellows to be trained, thereby creating a local resource of up to 8 QI Fellows.
4. QUALITY IMPROVEMENT IN PRIMARY CARE - METHODOLOGY	The ethos underpinning Quality Improvement is to work smarter, not harder. Our approach has therefore been developed to support this and will ensure that identified changes/improvements required are sustainable in the long term (as habits) rather than seen as short term projects. In addition, we will work to embed a positive culture of learning and improvement across the 43 City and Hackney practices, ensuring that an environment of leadership and innovation is cultivated to deliver patient-centred and population-focussed care. Quality improvement will be a natural progression from the work of the Practice Support Team, which will focus on stabilising practices in the short to medium term. In addition, the Confederations role in workforce development, provision of leadership capabilities and current review of potential "back office functions" that can be offered to practices will provide further medium to long term support in developing sustainable primary care. By extending this remit and focussing on embedding quality improvement, all City and Hackney practices will be able supported to focus on system performance and reductions in the unwarranted variation between practices in the long term. This will deliver: • Reduced variations in the quality of clinical care and improvement on the variables in the CCG's PCQ dashboard – metrics non-related to other CCG Contracts with the GPC • Improved capacity and capability within practices, to ensure they remain resilient and sustainable; • Improved performance across all national and local requirements; • Increased patient satisfaction; • Increased staff morale through improved systems and processes; • Improved recruitment and retention through improved practice performance, increased staff capability and skill mix and sustainability also no unplanned practice closures Together and building on our programme of Workforce Development, led by Mary Clarke, these improvements will highlight City and Hackney as a work location of choice for practice staff, both clinical and non-clinical. **QI Improvement Facilitators/Advisors (QI Fellows)** A group of City and Hackney staff (practice clinical and non-clinical staff) will be trained to become QI Fellows by UCLP. This training will focus on the methodology and models UCLPs use to support quality improvement work, covering all areas necessary to understand and participate in QI initiatives. On-going mentoring and support will be provided to the QI Fellows by UCLP to enable the Fellows to lead change locally. This training will cover:

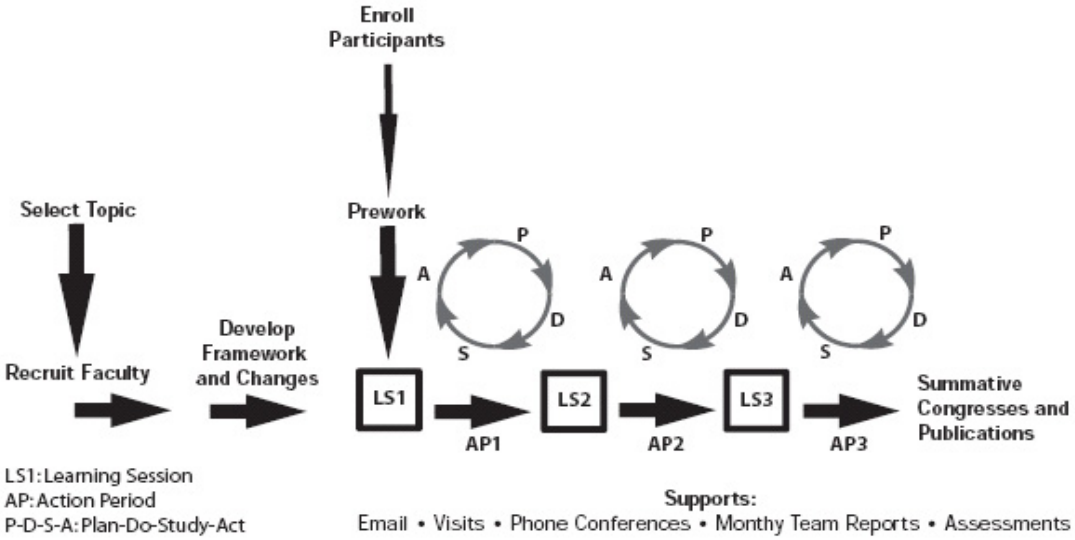
- The 'Model for Improvement' and Plan, Do, Study, Act (PDSA) cycles
- Driver Diagrams
- Measuring for improvement
- Reading and using Statistical Process Control charts
- Planning and carrying out tests of change

This will become the City and Hackney QI team taking forward the programme over the two years and beyond to ensure its sustainability.

INTERVENTION

The improvement collaborative methodology is based on the Institute for Healthcare Improvement's (IHI) Breakthrough Series collaborative model (Figure 1), the key elements of which are joint learning events and practice-level action periods.

Fig. 1: Breakthrough Series collaborative model for achieving breakthrough improvement, Institute for Healthcare Improvement, 1995



Multi-professional practice teams, including service users, come together to work on a system in their practices where there is perceived to be room for improvement.

Over 12 months, 6 action learning sets (run every 6 weeks) and a concluding summit event are held. The sessions support improvement teams to exchange ideas, present findings and learn new QI methods.

In between these sessions, practices use PDSA (Plan, Do, Study, Act) rapid improvement cycles to collect data and to test and apply changes.

Topic Selection

Topic selection should be clinically led and ideally cover challenges of varying degrees. For instance, a more advanced practice may consider a wholescale system review, a less confident practice may focus on one particular area that is proving challenging to them.

Faculty Recruitment

A steering group is then formed comprising QI experts (from UCLP), Confederation liaison, CCG liaison, a lay member and the project team (made up of the Confederation Programme Manager and QI Fellows (those at practice level who have undertaken QI training)).

Enrolment of participants
Engagement events will be organised to introduce QI to the City and Hackney practices and to seek those wishing to sign up for participation. Practice MDTs should comprise a mixture of GPs, practice managers, administrators and ideally pharmacists.

Individual teams are encouraged to ring-fence time weekly in the surgery to meet and discuss project progress.

Learning sessions
6 face-to-face meetings each 4-6 weeks apart are then held during the collaborative, bringing together all of the MDTs participating, patients and the faculty members in order to exchange ideas.

During these sessions faculty members present a vision for ideal care in the topic areas chosen. To drive the improvements and ensure safe and reliable care, evidence-based bundles of care are used. These were developed and tested by Dr Neil Houston and his team at Health Improvement Scotland[7]. A care bundle is a structured way of improving processes of care to deliver enhanced patient safety and clinical outcomes, and should take into account the following criteria:

- 4-5 elements
- All or none compliance
- Measurement done by a clerk if possible
- Should encourage local definition/customisation
- Mix of easy and hard
- Spread over patients journey / functions
- Designed for 95% reliability
- Backed by scientific evidence
- Creates teamwork and communication
- Multiple functions of care essential for desired outcome

For example, a care bundle for pathology results asks:

1. Are the individual test(s) REQUESTED by the clinician clearly recorded?
2. Are the individual test(s) TAKEN clearly recorded?
3. Were results sent to a clinician for review within 2 days of receipt in the practice?
4. Was a definitive decision recorded by a clinician on ALL test results within SEVEN calendar days of receipt by the practice?
5. Have decisions for ALL test results been 'actioned' by the practice (including the patient being informed as instructed)?
COMPOSITE: Have all measures been met?

The key measure in a care bundle is the composite score which measures the level of compliance with all measures for all patients. The care bundle data collection tool is a way of sampling whether optimum care is being delivered. This approach is different from traditional

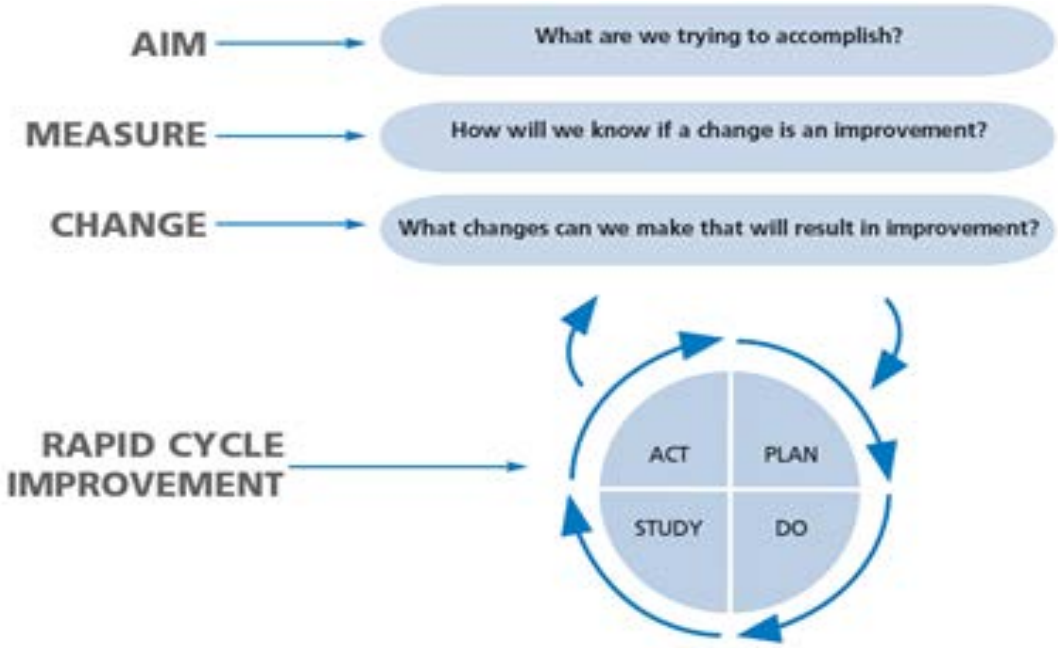
[7] Houston N, et al. Safety Improvement in Primary Care. 2012 http://www.health.org.uk/node/308

auditing approaches which are designed to identify whether individual measures are being implemented for all patients.

The teams also learn from the QI Fellows the Model for Improvement [Fig.2] – described below – which enables teams to test the change ideas within their surgeries, then reflect, learn and refine these tests. The tools for teams to individually create specific changes (change packages) to improve the system's performance are also outlined.

Fig. 2: Model for Improvement

Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*, 2009

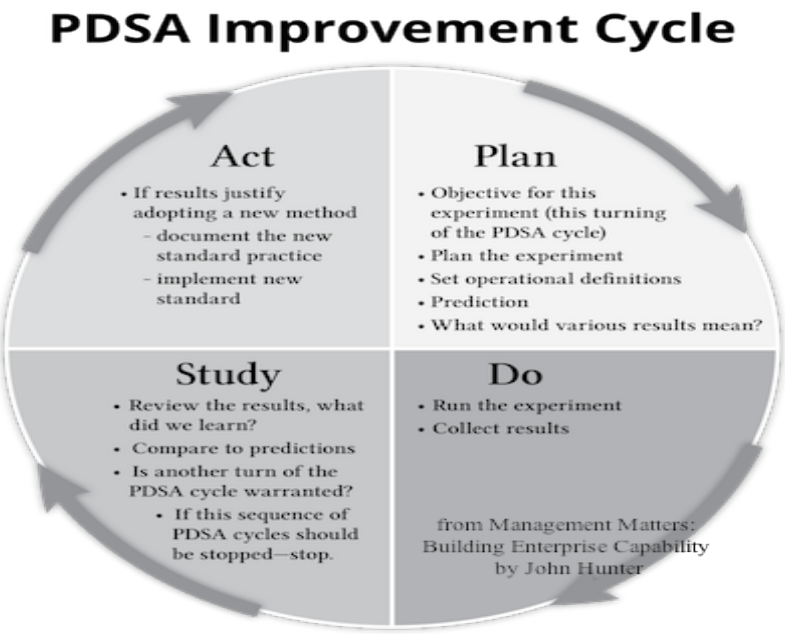


The Model for Improvement requires collaborative teams to ask three questions:

- What are we trying to accomplish? (Specific and measurable aim). Participants determine which specific outcomes they are trying to change through their work.
- How will we know that a change is an improvement? (Measures) Team members identify appropriate measures to track their success.
- What changes can we make that will result in improvement? (Changes) Teams identify key changes that they will actually test.

Key changes are then implemented in a cyclical fashion using the 'Plan-Do-Study-Act' (PDSA) learning cycles. [Fig. 3]

Fig. 3: PDSA improvement cycle, Deming, 1994



As the learning sessions progress, the team members learn more from each other and from the patient group as they report on successes, barriers and lessons learned. These exchanges take place as presentations, workshops and informal dialogue.

Action Periods
Between the learning sessions teams test and implement changes. They submit 4-6 weekly progress reports for the collaborative to review, and are supported by conference calls, peer site visits and web-based discussions using Google Basecamp and email to enable them to share information and learn from experts. The aim is to support the practices and build collaboration as they try out new ideas.

Summit Event
Held at the end of the 12 month project to allow practise to present their progress and improvement journey to members of UCL Partners, the Confederation and the CCG.

MEASUREMENT

Data collection
Practices submit data on a monthly basis [Fig.4], using EMIS searches, to their nominated QI Fellow.

Fig. 4 Data collection spreadsheet, adapted from Houston et al. for a pathology care bundle

	Bundle measure	Patient 1		Patient 2		Patient 3		Patient 4		Patient 5		
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Number out of 5
1	Are the individual test(s) REQUESTED by the clinician clearly recorded?											
	Comments/discrepancies/actions											
2	Are the individual test(s) TAKEN clearly recorded?											
	Comments/discrepancies/actions											
3	Were the results sent to a clinician for review within 2 days of receipt in the practice?											
	Comments/discrepancies/actions											
4	Was a definitive decision recorded by a clinician on ALL test results within SEVEN calendar days of receipt by the practice?											
	Comments/discrepancies/actions											
5	Have decisions for ALL test results been 'actioned' by the practice (including the patient being informed as instructed)?											
	Comments/discrepancies/actions											
6	Have all the above measures been met?											
	Overall compliance											

Run charts (used to identify and display trends in data over time) are created at individual practice level to present ongoing progress versus the agreed standards. To emphasise the shared learning element of the collaborative, composite run charts are also produced and available to the teams as data is collected. This allows teams to track their progress against their peers.

5. TIMEFRAME

Each improvement cycle consists of 12 months of dedicated QI support for practices. As such we propose two complete cycles of QI support to ensure that as many practices as possible can participate.

Those participating in the first year (2017/18) will be able to demonstrate during year two (2018/19) the sustainability of changes undertaken, to encourage greater uptake of remaining practices.

The model of developing QI expertise locally will also ensure that QI is sustainable beyond year two.

Please see Appendix A for a month by month breakdown of how each collaborative will be delivered over a 12 month period.

6. LESSONS LEARNT FROM OTHER UCLP PROGRAMMES OF QI

Lessons learnt from UCLPs QI work elsewhere shows[8]:

- Practices are interested in learning about systematic quality improvement methods and if a conducive environment is created there is a clear appetite for sharing learning in a positive and collaborative manner.
- Participation in QI collaboratives can lead to measurable improvements in clinical care and service performance. For example, in Newham where practices worked on a pathology care bundle, patients were informed of pathology results earlier and more reliably. This led to an improved patient experience and also freed up administrator time. Time between hospital discharge and GP medication changes was

[8] A collaborative project to improve the capacity and capability of general practice teams in Newham to use systematic quality improvement methods, UCLP

	both reduced and welcomed by affected patients. • The current workload crisis is a massive challenge to the engagement of practices. UCLP employed a range of tactics to get and keep practices on board, with a variable but mostly a good level of success: o Focusing the topics to align with current priorities for the practices and for the CCG o Emphasising transferable benefits to other mandatory requirements e.g. annual appraisal, revalidation, CQC visits o The use of small financial incentives to help cover the costs of practice engagement o A variable level of hands-on support from the core QI team to help the practices to deliver their agreed objectives o Ensuring that the learning sets are organized to be convenient and fun for the participants • Some practices lack the necessary IT skills to undertake technology-enabled quality improvement. • The non-doctors in the team (e.g. pharmacists and patient reps) can provide much energy and expertise for the wider team. • Patients can play a key role but much effort is required to keep them central to the work. • QI collaboratives require investment of time and money if they are to succeed. Of interest: 1. Although this demonstration project focused on engaging individual practices, future work might more effectively be organised at the level of clusters or groups of clusters which have clear common interests. This is of particular interest for the Confederation. • The CEG has much to offer as a future partner in improvement collaboratives, assisting with automating data collection and creating advanced searches. • Effective collaboratives need high quality facilitation and leadership. A significant investment needs to be made in building a larger cadre of QI experts to work across the CCG area. These leaders are most effective when they come from, and have a deep understanding of, the local community. Patients and the broad range of different health professionals and service managers should be core members of this leadership group. • There should be a significant expansion in training opportunities for practitioners and patients to learn about systematic QI methods. Learning about QI should be a core requirement on training programmes such as the GP VTS. It should also become part of the culture of the CCG, using every opportunity (education events, bulletins) to promote a culture of shared learning.
6. FUTURE DEVELOPMENT	Once established in year one, we would like to further develop QI expertise across City and Hackney in year two, with the development of a **City and Hackney Improvement Academy**. This would bring together current improvement-related activities (for example learning about systematic improvement approaches and leadership, carrying out improvement projects and programmes, promoting innovative approaches to service improvement and evaluating improvement interventions) and to act as a focus for future investment.
7. COMMUNICATION	A range of approaches will be required to engage practices including: • Aligning chosen work areas to those which practices already need to do;

	• Identifying ways in which participation can help other 'must-dos' e.g. annual appraisal, revalidation, CQC visits; • Financial incentives; • Hands on practical help in many practices.
8. PATIENT INVOLVEMENT	Involving patients in quality improvement is essential in ensuring that the work of the practice can be seen through the eyes of those that access and use the practice's services and the care it provides. Patients are therefore ideally placed to help practices redesign systems and processes, generating new ideas for quality improvement approaches. As such, we propose working collaboratively with Healthwatch Hackney and Healthwatch City of London and our practices to develop ways in which patients can be effectively engaged in quality improvement. This will include: • Patient participation groups; • Focus groups; • Patient stories / case studies; • Patient interviews; • Patient journey maps.
9. STAKEHOLDER ENGAGEMENT	All stakeholders will need to be engaged with quality improvement, not just a practice's patients. We will therefore support practices to identify their stakeholders at the outset of their change project, via a stakeholder analysis exercise. As an example, improvements to the way tests are requested and handled is likely to benefit from involving a manager from the path lab in the quality improvement process.
10.OUTCOMES	The expected outcomes from this programme of quality improvement in general practice are: • A local team of Quality Improvement "Fellows", fully trained by UCL Partners, with the confidence, capability and capacity to lead and drive improvement locally; • Clinical leadership roles across the local health system, thereby maximising what can be achieved through collaborative working across practices and other local health and social care providers; • An embedded culture of continuous staff development; • Increased staff retention; • Primary care across City and Hackney that is seen as the work location of choice for clinicians; • Clinical service delivery that is clearly delivered using a population / public health approach; • Optimised use of existing resources; • Consistent and high achieving quality of service delivery as evidenced by performance data and patient/professional feedback; • Standardised processes, systems and protocols that minimise waste of resources, meet the needs of patients and are sustainable; • Improved patient satisfaction;

	• Individuals in practices with the capability and capacity to undertake quality improvement research and innovation roles to continue to help shape the future resilience of primary care across City and Hackney.
11.STAFFING / TRAINING	A total of four QI Fellows will be trained to develop expertise in QI methodology at local level, over 2 years, to enable them to then run their own collaboratives. This training will consist of attendance at UCLP training sessions and on-going UCLP support. In addition, each practice that participates in a collaborative will develop in-house skills in quality improvement and running their own quality improvement projects. We would also wish to train a small number of Confederation staff to become QI Fellowes. Whilst acknowledging that the work should be clinically led and practice driven, in order to ensure that the QI programme is implemented in a co-ordinated and sustainable way, we propose the following roles in addition to individual practice teams: **QI Expertise (UCLP)** • QI expert consultant **Programme Support (Confederation)** • Quality Improvement Project Manager • Quality Improvement Project Administrator **Delivery Support** This will consist of sessional time of the trained local QI Fellows (1 day per week). In addition, the following roles will also support as required: • Practice Support Team GP • Practice Support Team Practice Manager • Director of Workforce Development (Confederation) • Professional expertise as required, e.g. finance, HR, IT • EMIS facilitator / data support (CEG)
12.COSTINGS	Please see Appendix B for the detail of the costings associated with delivery of this proposal.
13.BARRIERS TO QUALITY IMPROVEMENT	It should be acknowledged that there are a number of barriers to implementing quality improvement in general practice, which we will work to mitigate through a range of approaches including early engagement, communication strategies which emphasise the benefits of collaboration and sharing of successful case studies[9]: • many GPs are reluctant to engage with ideas that they perceive as belonging too much to the domain of the professional manager. Those who object to a suggested new way of working derived from the improvement world often refer to it pejoratively as 'management speak'; • when GPs are first introduced to the details of some improvement approaches, they often have difficulty accepting the premise that small and practical changes to

[9] Quality Improvement in General Practice, The King's Fund, 2010

	seemingly mundane aspects of care can achieve anything worthwhile. Doctors' training and daily experience appears to lead them to expect effective solutions to be complex, often depending on highly specialist knowledge and uncommon individual effort; • Despite the drive to improve quality in health care and in general practice, some GPs still hold an ambivalent attitude to the notion of further advances in assessing and improving quality – particularly to the idea that new opportunities to improve should continually and proactively be sought; • Unmet learning needs relating to how to engage and lead colleagues in new ways of working; • it is vital for quality improvement activities to involve the whole practice team, with visible support from doctors. However, studies of introducing these methods to general practice have encountered hierarchical, doctor-dependent cultures that can stifle improvement. Lack of support from just one GP can have a devastating effect on an improvement effort; • non-GP members of the practice team who are unused to being involved in planning or assessing improvement may be anxious about assuming greater responsibilities.

ACKNOWLEDGEMENT:
We would like to thank UCLP for their input to this proposal.

Appendix A – Month-by-month breakdown of proposed collaborative activities across 12 months

Month 1	• Identify and recruit local QI leads. • Set up an engagement event where all practices are invited to sign up. • Identify CCG priorities. • UCLP GP QI Lead and Project Manager work with local data to identify clinical gaps. • Evaluation for the whole programme is designed.
Month 2-3	• Run practice engagement event. • Up to 10 practice teams who sign up to participate in the collaborative are invited to the learning sessions. Practices have to agree to send a multi-disciplinary team to learning sets which are half day long events. Practice multidisciplinary teams, charged to learn from the collaborative process, comprise of a mixture of GPs, practice managers, administrators and pharmacists. Individual teams are encouraged to ring-fence time weekly in the surgery to meet and discuss project progress. • Collaborative evaluation is developed for implementation along with the learning sets.
Months 3-10	Learning sessions: 6 face to face meetings every 6 weeks bringing the 10 multidisciplinary teams together. Other stakeholders like patient groups will also be engaged in the learning sessions based on the need of the programme. The faculty present the vision for ideal care in the topic areas. Practices self-selected their chosen focus areas based on the priority list identified in month 1. To drive the improvements and ensure safe and reliable care, evidence-based bundles of care or other such approach is used. Change packages are shared with team that they have to use locally to implement and monitor change. Experts are brought into sessions to support development of the teams. Action periods: Aim is to support the practices and build collaboration as they try out new QI ideas. These are between the learning sessions where teams test and implement changes. They submit 4-6 weekly progress reports for the collaborative to review, and they are supported by conference calls, peer site visits and web-based discussions to enable them to share information and learn from experts.
Month 11-12	Summit event: held at the end of the collaborative period where practice teams present their improvement journey and results. An Evaluation is designed and runs throughout the collaborative to understand the process, quality and outcome measures that the collaborative helped the locality achieve. The evaluation report will support the design and implementation of the next collaborative by the newly trained local QI leads. A Project close out report will also be submitted to the funder/commissioner in month 12 when the project will close.

Important information:	UCLP QI experts offer support and advise throughout the 12 month period. They attend/provide input into events and support the design and development of local collaborative. QI training is provided to teams who sign up for the collaborative and they are taken through the PDSA cycles between learning sessions (learning by doing). Each GP team who participates in the collaborative completes a local project and presents the experience at the Summit. The local QI leads are recruited against a Job Description to ensure they are the right resource for the locality. They attend QI 'train the trainer' classes and then are supported over the 12 month period by the UCLP GP QI lead. They are given hands on training and encouraged to take on active role in the locality. The aim is that at the end of the collaborative the local QI leads would be able to run a local collaborative independently using the training toolkit provided.

Appendix B: Costings

Year 1	Two collaboratives (max of 11 practices per collaborative)		£		Comments
	UCPL QI Lead		£209,424.00		Per collaborative this includes:
					1 day per week for 1 year, 6 active learning sessions, 1 end of programme summit event, individual practice visits, running train the trainer courses, ongoing local QI lead advice, guidance and supervision, programme materials and evaluation of programme outcomes
					cost includes VAT
	Project management		£12,000.00		1 day per week for 1 year (includes on-costs)
	Administrative support		£7,500.00		1 day per week for 1 year (includes on-costs)
	Data analysis (CEG)		£15,000.00		
	Backfill - GP		£52,000.00		1 day per week, per collaborative to train as local QI lead
	Backfill - Manager		£12,000.00		1 day per week, per collaborative to train as local QI lead
	Venue hire for learning sessions		£1,855.00		Tomlinson Centre (7 half day sessions)
	Catering for learning sessions		£3,000.00		Tomlinson Centre (7 half day sessions)
	Cost for two collaboratives		**£312,779.00**		
	Confederation overheads (10%)		£31,277.90		
	TOTAL - YEAR 1		**£344,056.90**		
Year 2	**Two collaboratives (max of 11 practices per collaborative)**				
	Local QI Lead		£52,000.00		Per collaborative this includes:
					1 day per week for 1 year, 6 active learning sessions, 1 end of programme summit event, individual practice visits, running train the trainer courses, ongoing local QI lead advice, guidance and supervision, programme materials and evaluation of programme outcomes
					cost includes VAT
	Project management		£12,000.00		1 day per week for 1 year (includes on-costs)
	Administrative support		£7,500.00		1 day per week for 1 year (includes on-costs)
	Data analysis (CEG)		£15,000.00		
	Backfill - GP		£52,000.00		1 day per week, per collaborative to train as local QI lead
	Backfill - Manager		£12,000.00		1 day per week, per collaborative to train as local QI lead
	Venue hire for learning sessions		£1,855.00		Tomlinson Centre (7 half day sessions)
	Catering for learning sessions		£3,000.00		Tomlinson Centre (7 half day sessions)
	Cost for two collaborativeS		**£155,355.00**		
	Confederation overheads (10%)		£15,535.50		
	TOTAL - YEAR 1		**£170,890.50**		
	OVERALL TOTAL		**£514,947.40**		

Proposal by the City and Hackney GP Confederation for the development of a GP Practice Support Team

1. Title	Development of a GP Practice Support Team
2. Introduction	The purpose of this proposal is to detail the support that the Confederation can provide to those GP practices in City and Hackney who, for a variety of reasons, find that they are struggling. Nationally, many GP practices are finding themselves highly vulnerable. A combination of reducing income, poor CQC ratings, poor buildings that are unfit for purpose and an inability to recruit and retain staff mean that practices are at risk of closure. The increasing complexity of general practice also means that practice management and systems and processes are ever more challenging. In City and Hackney, to a degree, practices are in a relatively strong position. They have a well-established Confederation and a CCG willing to invest in additional roles in primary care. However, we know that many of our practices are struggling with cash flow, that recruitment and retention of staff is a key clinical issue and recruitment of GPs is at an all-time low. Low staff morale and burnout are also key risks for future sustainability and resilience. The GP Confederation is established not only to win and deliver contracts, but to overtly support the development and sustainability of primary care. We would view the closure of any GP practice as a failure and this proposal intends to ensure that this does not happen. Collectively, as a Confederation, we have a duty to ensure that all core GMS/PMS contract services are delivered across the whole of City and Hackney. However, we would like to use this opportunity to additionally support practices with wider, generic issues such as clinical coding, clinician recruitment or appointment booking systems that require review. Crucially, the Practice Support Team will provide an essential role in helping practices to increase their ability to be resilient in the face of the many challenges being experienced by general practice. This support will comprise of four stages: • Identification of priority practices; • Initial diagnostic audit undertaken in the practice; • Development of an action plan in partnership with the practice; and • Ongoing advice and guidance to support implementation of the action plan This support will provide a particular focus for practices on establishing robust systems and processes that enable them to operate efficiently and effectively. The support will also build on the highly successful model we ran for a limited number of practices in 2015, so we are able to evidence its success. A core team of Confederation staff and clinicians provided 1:1 support to those practices who were at high risk of not achieving contractual requirements, which would then have

	impacted negatively on all 43 City and Hackney practices. As a result of this intensive period of support, all practices were successful in achieving contractual requirements.
3. Delivery Model	Our proposal is to develop a Practice Support Team, whose core membership will consist of sessional time of: • A GP • A Practice Manager • An IT / EMIS expert The above will be supported by the CEG where required, but at no extra cost. This team will provide dedicated support to those practice who have been identified as requiring advice, guidance and support in order to meet their core GMS/PMS requirements. This will be enhanced support, above and beyond that currently provided to all City and Hackney practices by the Confederation Contracts and Practice Support Managers. The process will be as follows: **Stage 1: Identification of priority practices** We will undertake a review of current practice performance and this, together with evidence from Confederation team members on those practices who may be struggling, will inform the development of a schedule of practices who we believe require enhanced support. We will also seek views from: • the Confederation Board; • the CCG primary care leads; • a review of patient feedback; • CQC reports; • The outputs from the CCG Quality Dashboards These practices will then be approached by the Confederation to seek their acceptance to engage with the Practice Support Team and undertake the three stages highlighted above. **Stage 2: Diagnostics** An initial practice visit will be conducted by the Practice Support Team. This visit will cover, but not be limited to: • A review of existing systems and processes, clinical and non-clinical; • A review of existing EMIS searches utilised by the practice to support achievement of core GMS/PMS requirements; • A review of prevalence and standards that the practice is finding it hard to achieve: • A review of appointment booking systems; • A review of all call and re-call processes; • A review of workforce, both clinical and non-clinical; • A review of how the practice wishes to develop for the future. The exact activities will be dependent on each individual practice circumstances.

	As a minimum, those participating at the practice in this initial, diagnostic visit should be the lead GP, practice manager and lead practice nurse. **Stage 3: Action Planning** Following the visit, the Practice Support Team would draft a report in partnership with the practice, detailing those areas identified for improvement and/or change. A further meeting would then be held with the practice to develop, in partnership, an action plan to implement the areas that are agreed require improvement/change. This plan would detail roles, responsibilities and timeframes for each identified area together with a schedule of regular joint meetings between the practice and the Practice Support Team to review progress. **Stage 4: Ongoing support** Once agreed, the action plan would be implemented, with the Practice Support Team providing the agreed level of support. It is anticipated that at this stage of the process, additional resources may be required by practices to implement the plan. For instance, the Director of Workforce at the Confederation may assist those practices where clinician recruitment proves to be a concern. In addition, the Confederation Contracts and Practice Support Managers will provide support as required to assist practices in implementing their agreed action plan. Once the action plan is fully implemented, practices will be able to seek ongoing advice and guidance via the Confederation's Contracts and Practice Support Managers in the same way as all other member practices.
4. Links to other Confederation work	This proposal links directly to other work underway or planned in the Confederation, as follows: • A review of potential back office roles that could be provided through the Confederation for practices, such as HR and finance support; • A possible larger QI initiative; • CEPN and HEENCEL work on recruitment and retention and new workforce roles; • The organisational development and facilitation skills of the Confederation Deputy Chief Executive.
5. Timeframe	It is anticipated that the work required to undertake all stages across all identified practices will take up to 2 years to complete. Identified practices will be prioritised based on the urgency of their needs and activities scheduled across the 2 year period. Therefore the roles identified as forming part of the Practice Support Team are based on sessions, which will be utilised on a "call-down" basis over the 2 year period.
6. Finance	Please see Appendix A for our proposal costings

Appendix A – Proposal Costings

			£	Comments
Stage 1	**Identification**			
	Confederation staff time		£1,000.00	To review data, identify priorities etc
Stage 2	**Diagnostics**			
	Project administrative support		£7,500.00	£125 per day for a maximum of 60 days
				To project manage the overall visit process, scheduling, assit with reporting, collation of data etc. To be provided by existing part-time Confederation staff via an increase in working hours as required.
	Sessional support (cost per 4 hour session)			
		GP	£6,500.00	£325 per session x 1 session per practice
		Practice Manager	£3,000.00	£150 per session x 1 session per practice
		IT/EMIS support	£2,500.00	£125 per session x 1 session per practice
	Total		**£19,500.00**	
Stage 2	**Action plan development**			
	Sessional support (cost per 4 hour session)			
		GP	£32,500.00	£325 per session x 5 sessions per practice
		Practice Manager	£15,000.00	£150 per session x 5 sessions per practice
		IT/EMIS support	£12,500.00	£125 per session x 5 sessions per practice
	Total		**£60,000.00**	
Stage 4	**Ongoing advice and guidance**			
	Sessional support (cost per 4 hour session)			
		GP	£13,000.00	£325 per session x 2 sessions per practice
		Practice Manager	£6,000.00	£150 per session x 2 sessions per practice
		IT/EMIS support	£5,000.00	£125 per session x 2 sessions per practice
		Contracts or Practice Support Manager	£8,000.00	£200 per session x 2 sessions per practice
		Director of Workforce	£12,000.00	£300 per session x 2 sessions per practice
	Total		**£44,000.00**	
	Confederation Overheads		£12,450.00	
	Grand total		**£136,950.00**	