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## THE WORKING IN PARTNERSHIP PROGRAMME: FINAL REPORT

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## Introduction

This report has been commissioned by the *Working in Partnership Programme* (WiPP), towards the end of its life, to provide a permanent record of what it has done, what people currently think about what it has done, and what is going to happen next. The programme ends in June 2008.

The aim is to supply an 'auditable account'. In the present context this means a view that is based on independent, systematic work. The writer (brief details at Annex A) had no connection with the Working in Partnership Programme before beginning work and has no personal stake in it. The report is based on standard interviews with 25 stakeholders in WiPP, selected in discussion with WiPP managers and members of its Advisory Group, and listed in Annex B; and on extensive reading of WiPP documents and web materials, to which there has been unfettered access. The report is hopefully independent and systematic, therefore, but it is not a thoroughgoing research evaluation.

In its overall shape, WiPP has been a classic development programme: ringfenced funds were made available nationally to support work on explicit improvement objectives; governance arrangements and programme management were established; a range of practical projects was identified; project management was organised to take them forward; projects were piloted, improved and evaluated; and arrangements were made to secure their future before the programme concluded. There were naturally variations from this model because the projects differed in character, but it is the essence of the approach; and because the approach will no doubt arise again in the future, it is worthwhile to describe what has been done and the lessons that have been learned.

The report is organised into four main sections. Part 1 sets out the programme's history and organisation. Part 2 outlines the thirteen projects conducted by WiPP, which are described in more detail in Annex C. Part 3 summarises the reflections of the key stakeholders interviewed for the report and draws out a number of issues and learning points. Part 4 is about the current status of the programme and the future for its constituent initiatives.

The writer would like to thank everyone who gave up their time, always generously, to discuss the Working in Partnership Programme with him, and in particular Janine Zdziebczok who also made all the meeting arrangements.

## Part 1: Origins and Organisation of the Programme

### Origins and early days

#### *The 2004 General Medical Services Contract*

The 2004 GMS contract (nGMS) is a complex arrangement with many interconnecting elements. It was negotiated in response to the pressing issues and needs of the day and it is easy to forget what they were: serious problems of morale in general medical practice, associated difficulties with recruitment and retention, and large variations in quality with too many under-resourced, inefficient and struggling practices. All of this was happening at a time when, as now, national strategy sought to expand the role of primary care.

The contract set out to make general practice more attractive and effective and, in so doing, to reinforce this foundation of the NHS and facilitate the expansion of its role. Paragraphs 6.46 to 6.48 of nGMS (reproduced as Annex D) outline a programme for England<sup>1</sup> to promote the effective use of clinicians' time and improve patient care. The core issues were to identify circumstances in which patients could be enabled to manage their own conditions and use services more effectively, and in which services could be supplied more easily and cost-effectively by non-medical health professionals. Existing good practice would be disseminated and new improved ways of working developed. The focus was to be 'traditional' general practice and, in particular, the kinds of practice that might find nGMS very challenging. The contract paragraphs set out seven strands of work in more detail.

The nGMS paragraphs also announced the intention to set up a multi-disciplinary group to take the core issues forward, working with relevant external bodies, with patient and public involvement, and holding a programme budget of £10m over three years to sponsor, evaluate and encourage the spread of good practice. This was the genesis of the Working in Partnership Programme.

The programme's title reflects the central emphasis of the new GMS contract on teamwork within general practice and between general practice and others with responsibilities for health, including patients: nGMS is a contract with practices not GPs. Many WiPP documents carry the strapline *Creating Capacity in General Practice*, capturing its purpose from a different perspective: to reduce avoidable demand on general practice and help its staff to manage their workloads efficiently, making space for new roles and activities.

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<sup>1</sup> The Department of Health specified England because WiPP was to be funded from the nGMS allocation for England. This does not prevent WiPP's outputs from being used more widely, as one already is.

### *Early days*

An initial steering group was set up in 2004 with representation from the Department of Health, the NHS Confederation (later NHS Employers) who negotiated the new contract on behalf of DH, and the British Medical Association. At first, responsibility for managing the programme and the associated resources was located with the National Primary and Care Trust Development Programme (NatPaCT), part of the NHS Modernisation Agency. During 2004 the abolition of both NatPaCT and its parent agency was announced and some of their work passed to other host organisations.

This organisational turbulence did not make for a smooth gestation but the Working in Partnership Programme began to gather momentum, in retrospect, quite quickly. The three key developments were the transformation of the small steering group into WiPPAG, the Working in Partnership Programme Advisory Group, the appointment of Clayre La Trobe as Programme Manager from 1 July 2004, and an undertaking in February 2005 by the Greater Peterborough Primary Care Partnership<sup>2</sup> (strictly speaking by North Peterborough PCT at first then the unified Peterborough PCT from October 2006) formally to host the programme.

In her February 2005 report to WiPPAG, the Programme Manager noted that WiPP had slipped a little behind schedule because of the unsettled context in which it had begun work.

### **Governance arrangements**

#### *The Greater Peterborough Primary Care Partnership*

Although it is not in the foreground of people's thinking, the role played by the Peterborough PCTs has been important. The Service Level Agreement (SLA) between the Department of Health as sponsor of the programme and North Peterborough PCT established the PCT's role in employing WiPP staff and holding its funds, and for providing payroll, human resources, IT, procurement and financial services. The PCT's corporate governance arrangements, policies and procedures have applied. The WiPP Programme Manager has had regular meetings with the present Finance Director and a designated Management Accountant.

Why Peterborough? Chris Town was at the time Chief Executive of the Partnership and the two local PCTs. He was vice-chair of the NHS Confederation GMS negotiating team. He became chair of the WiPP Advisory Group. The arrangement with Peterborough made obvious sense and was highly functional as the accountable NHS official was intimately connected to WiPP's work. When Chris Town retired from the PCT in 2006 the existing Finance Director, who had been involved in setting up the SLA, became the new Chief Executive.

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<sup>2</sup> An alliance between the North and South Peterborough PCTs (which merged in 2006) and the local authority.

In everyday terms WiPP has related more closely to WiPPAG, its advisory group, but it is important to record that, through the SLA with the PCT, the main formalities of NHS management have been in place.

*The Working in Partnership Programme Advisory Group and Project Steering Groups*

WiPPAG's membership is given in Annex E. It drew together a wide range of knowledgeable, well-networked and influential individuals and representatives with an interest in WiPP's task. Its terms of reference from the Department of Health (see Annex F) specify that 'the funding, provided by DH as part of the overall allocation to fund the new GMS Contract, will be deployed on the basis of the recommendations of the Advisory Group unless there is a specific and overriding reason of financial propriety, probity or VFM for not doing so'. The DH, as funder of the programme, would remain the ultimate judge of VFM, one assumes, and share stewardship of propriety and probity with the PCT.

WiPPAG therefore was not only powerful by virtue of its membership but empowered by its remit.

The Advisory Group set out to meet approximately quarterly. As the programme has evolved, it has needed to meet less frequently. Its most significant moments arguably came at the end of 2004 and the beginning of 2005, when the direction of travel was being established.

Although WiPPAG has made its key decisions in plenary sessions, the parties to the nGMS negotiations - the Department of Health, the British Medical Association's General Practitioners Committee and NHS Employers (the NHS Confederation) - have maintained a particularly keen interest as major stakeholders. This is reflected in the membership of a small Executive of WiPPAG members with links to these organisations.

An Evaluations Sub-Group was formed to appraise project proposals.

WiPP's directly managed projects (see Part 2) were managed by a Project Manager with the support of a Steering Group. Steering Groups were normally chaired by a WiPPAG member, or jointly by two, with membership chosen to reflect the key interests in a project and exercise positive external influence. Two pairs of 'sister' projects shared Steering Groups. Memberships are given with WiPPAG membership in Annex E. The importance of the Steering Groups is discussed in Part 3.

*Management structure*

WiPP's organisational structure is given in Annex G. There are three core staff: the Programme Manager (Louise Jarvis, appointed initially as the Communications Lead in May 2005, and then as Programme Manager in March 2006 when Clayre La Trobe left to take up another appointment), the Programme Administrator (Janine Zdziebczok, appointed in May 2005) and

the Communications Lead (Sarah Wrixon, who from May 2006 has been contracted on a consultancy basis). The management team comprises these three plus the five National Project Managers: Janet Bell, Sue Cross, Helena Jordan, Anna Lynall and Paul Vaughan.<sup>3</sup>

The organisation has been described as 'virtual' because people work from their homes with good IT networking, but meeting regularly and frequently.

### *Team development*

The team members worked with an external facilitator to develop their individual and team capabilities. A series of workshops was organised with a focus on process and functioning rather than business issues. These 'offline' occasions for reflection and feedback were valued highly. Each member of the team used the 360° feedback tool associated with the NHS Leadership Qualities Framework to support one-to-one coaching and personal development planning. By giving team members a safe environment in which to discuss their individual and collective performance and feelings, the development programme certainly contributed to people's positive experience of WiPP, discussed again later, and probably to the quality of their work.

### *Communications and the website*

WiPP has seen communications as central to its work, not a bolt-on function but an integral part of the general management of the programme. The work has been guided by well-documented and thoughtful communications strategies.

The communications effort has been directed at multiple audiences using multiple media. The WiPP website has been a dominant factor (more below) but there have been WiPP conferences, WiPP stands at others' conferences and exhibitions, keynote speaker opportunities, road shows, extensive contact with a wide range of press and professional publications, media packs, regular news releases, e-bulletins and mailings. A WiPP year planner was sent to every general practice, PCT and Strategic Health Authority in England. There have been communications audits and audience research, and systematic work on identity and branding.

The programme reaches its consumers and delivers its material mainly via the web. The site ([www.wipp.nhs.uk](http://www.wipp.nhs.uk)) has been managed, under the oversight of the Communications Lead and Programme Manager, by Kevin Holdridge and his colleagues at Kent House. The site is good by any standards. As well as standard home pages, the site gives each individual project its own 'landing page', in effect a mini-homepage, with extensive links to WiPP resources and other related sites.

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<sup>3</sup> ...and Eleanor Thomas, who provided maternity cover, and Mark Gatfield who managed the Good Practice Project in the early days

The site is notable for its interactivity and its use of multimedia resources (podcasts and videocasts) and 'push and pull' technology, which enables the site, in effect, to visit or email people and other sites as well as being visited itself. Work is underway on the migration of materials to new host sites (more on this later) and the design of the 'legacy' site that will remain between the closure of the programme in June 2008 and March 2009.

The penetration of web-delivered materials is quite difficult to assess in detail. However, there have been around 100,000 page viewings per month, so it is clearly substantial.

Through Doctors.Net the management team has carried out and repeated a simple survey of GPs to assess their knowledge of WiPP. In 2006, 29% (of 200 GPs) had heard of WiPP, 21% had visited its web site and 20% said they intended to use WiPP resources. This year, 41% (of 507) said they had heard of WiPP.

### *Finance*

The initial allocation to WiPP was £10 million, with £5.0 million in 2004/05 and the same in 2005/06. The money was part of the allocation made by DH to fund the new GMS contract.

The programme underspent in its first two years, reflecting a slower start than anticipated and the time it took most projects to develop. Employee contracts have been extended accordingly.

An additional sum of £850k was made available by DH for 2006/07 to allow projects to be completed and the programme to be reviewed.

The programme will finish in June with a near-nil balance and no funding will pass to organisations hosting WiPP resources for the future.

More detail will be given in a detached annex to this report (Annex H) when the programme has closed. It will show actual year-by-year spending including spending on overheads (surprisingly modest, reflecting the virtuality of the team) and communications (quite significant, reflecting the essential priority given to them). It will show the initial allocations to WiPP projects and their actual total spend. WiPP's audited accounts will also be included.

## **Part 2: The WiPP Projects**

This part of the report outlines the project work that has been done under the auspices of WiPP, the main business of the programme. It starts with the process for selecting projects and its outcome. The individual projects are then outlined. Finally it shows how the projects together served the programme's strategic objectives.

Annex C describes the projects in more detail.

### **Project selection**

The key decisions about WiPP's portfolio of projects were made towards the end of 2004 and in the first months of 2005. The final thirteen were selected from a larger number of proposals and possible projects, and support for externally managed projects was generally conditional upon clarifications, modifications and adjustments to funding bids. There was therefore much to decide.

Two particular process issues presented themselves. The size and character of the WiPP Advisory Group (in practice the decision making body, supported by an Evaluations Sub-Group) meant firstly that several members would inevitably have been involved in developing proposals or have vested interests in them, and secondly that its meetings would have the potential to be complicated to manage.

The most important single WiPPAG meeting was probably the one held on 10 December 2004 to consider a number of initiatives for funding. A tightly structured approach was devised to ensure propriety and to manage the business to its conclusions. The Chair and Programme Manager prepared unusually detailed paperwork for the meeting which included clear rules about the management of time, declarations of interest and voting rights, and also voting papers which reminded members of the key nGMS paragraphs and asked them to judge proposals' 'fit' and value for money.

In all, thirteen projects, several of them very substantial, have been managed or supported by WiPP. They are listed and summarised below.

Projects 1, 2, 3, 4, 7 and 8 have been managed directly by WiPP with the support of steering groups with a WiPPAG-appointed chair or chairs.

It was decided at an early stage that WiPP should support work led by other organisations that closely fitted the nGMS framework of objectives. On that basis it funded projects 5, 6 and 11, which were already under development when WiPP began work, and projects 9, 10, 12 and 13.

Very early in the process, WiPPAG commissioned research from York University on the likely cost effectiveness of the projects in the event of their national roll-out.

## **The individual projects**

### *Project 1: The Workload Analysis Tool (WAT) (directly managed)*

The Workload Analysis Tool was developed in association with Apollo Medical Systems. The software extracts data from routine practice clinical systems and supplies practices with a range of reports designed to help them match the skills of the healthcare team more closely with patients' needs. WAT has been evaluated by the Health Services Management Centre at the University of Birmingham.

### *Project 2: The Database of Good Practice (directly managed)*

The Database of Good Practice captured relevant experience of successful development from practices and PCTs around the country and produced case studies accessible on the WiPP website. The database differs from many others in its scrutiny process, which is akin to peer review of material for publication.

### *Project 3: Self Care for Primary Care (directly managed)*

This is one of four projects (3, 4, 5 and 6) aimed at promoting and supporting appropriate self care as a means of moderating demand on general practice. Project 3 produced self care development and training materials, and other related resources, for PCTs and individual health and social care workers. Leeds Metropolitan University was chosen to evaluate the pilot.

### *Project 4: Self Care for People (directly managed)*

This project was unique amongst WiPP initiatives in addressing itself to the general public directly, not through an institutional vehicle. Its aim, through self care skills training, was to improve people's ability to understand, manage and avoid minor conditions confidently and safely, improving their quality of life and measurably reducing unnecessary demand on general practice. Leeds Metropolitan University was asked to evaluate this project also.

### *Project 5: Making Sense of Health*

Making Sense of Health is the brand name for a set of self care-related resources developed with funding from WiPP by DPP2000. The resources are for use in schools across all key stages and link in with the national curriculum. They aim to engage young people and their families with issues of health and wellbeing, improving self care and influencing avoidable demand for primary care. The Open University has evaluated the programme.

### *Project 6: Joining Up Self Care*

The Proprietary Association of Great Britain (PAGB), with financial support from WiPP, managed a project to see whether a coordinated PCT-wide health education and promotion programme would be effective in changing the

public's self care habits and behaviour. The pilot, essentially a demonstration project, ran in Erewash PCT. It involved interventions to support and promote self care in three clinical areas: CHD, asthma and minor ailments. PAGB commissioned PMSI Consulting to describe and evaluate the project.

*Project 7: General Practice Nursing (directly managed)*

This is one of four projects (7, 8, 9 and 10) concerned with developing the non-medical workforce in general practice. With its sister project on health care assistants, Project 7 promotes the shift of appropriate work from GPs to other clinical staff, in this case general practice nurses. It has created training resources for improving standards in general practice nursing, enabling the substitution of nursing for medical skills in a wide array of services and freeing GPs to concentrate on more complex cases.

*Project 8: Health Care Assistants (directly managed)*

General practice teams increasingly include health care assistants (HCAs). HCAs take on less complex tasks that have traditionally been performed by nurses. They also work alongside GPs helping with administration. As with the GPN project, the core resource is a Toolkit which defines good practice and promotes it through workshop resources. This project was assessed by the Academic Unit of Primary Care at Sheffield University.

*Project 9: Vocational Training Scheme for General Practice Managers*

This development project, one of two projects directed at management in general practice, was run by the Institute of Healthcare Management (IHM) with funding and other support from WiPP. Its aim was to improve the effectiveness of general practice management by developing a competency-based assessment framework for practice managers and offering a training and mentoring scheme and a career pathway for new entrants. The VTS pilot was evaluated by the Collingham Healthcare Education Centre.

*Project 10: Primary Care Management Development Programme*

This programme was developed and piloted by the National Clinical Governance Support Team and the National Primary Care Development Team (now the Improvement Foundation) with financial and other support from WiPP. It is an interactive online course covering a number of management areas. It is delivered using a range of methods including web-based learning, action learning sets and facilitator support and is assessed by national examiners. This programme was evaluated by the Collingham Healthcare Education Centre.

*Project 11: Alternatives to Sickness Certification*

This project, managed by Developing Patient Partnerships with support from WiPP, set out to explore and evaluate alternatives to the current system of sickness certification and absence management, with a focus on occupational

health services and the role of occupational health advisers, avoiding or reducing calls on GPs. The pilot was reported on and evaluated by the Centre for Primary Healthcare Studies at the University of Warwick.

#### *Project 12: Mental Health Collaborative*

The Improvement Foundation launched the initial two-year phase of the National Primary Care Mental Health Collaborative in February 2006 to improve the primary care of adults of working age with common mental health disorders. It had financial support from WiPP and others.

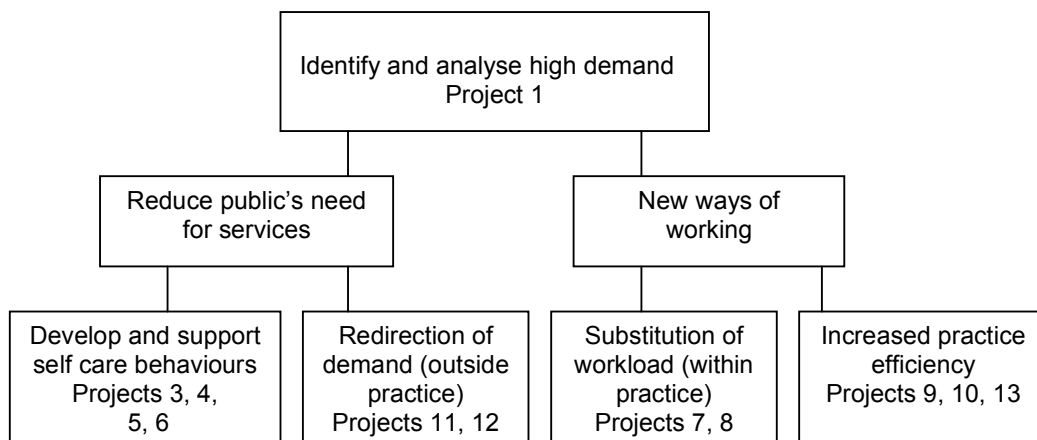
#### *Project 13: Repeat Medication*

This project was managed by the National Prescribing Centre and carried out in Bath and North East Somerset PCT. WiPP provided financial and professional support. The aim was to produce a resource pack of tools that could be used to reduce GP/practice workload by improving the repeat medication process.

### **Strategic fit**

It is possible to map the thirteen initiatives in a number of different ways. One approach related them to Public Service Agreement targets; or they could be organised around WiPPAG's terms of reference, which include high-level objectives. The grouping used here is slightly adapted from a 2006 overview of the programme. It reflects the basic nGMS aim of creating or freeing capacity in general practice by appropriately reducing or diverting demand and using general practice resources more efficiently and effectively.

The diagram indicates only the *main* area of contribution by projects. More complicated analysis is possible but unnecessary here: for example it is clear that the Workload Assessment Tool (Project 1) - and several others - contribute to a number of domains and that The Database of Good Practice, not identified with any specific domain here, could easily contribute to all. The point of the chart is to show that there is strategic fit between WiPP's remit and its projects.



### **Part 3: Overview and Learning Points**

This part of the report gathers together some of the views expressed about the programme by those interviewed. It cannot reflect them all but it does pick up most of the common areas of accord. The writer's own interpretations or additional thoughts are identified as such.

#### **Success?**

Looking first at WiPP as a human enterprise, everyone has said how much they have enjoyed being part of it. Quite a few, including some of the most senior figures, feel it is one of the best professional experiences they have had. Several say they found it highly developmental in personal as well as professional terms. The 'passion' and 'trust' words have been used quite a lot and there has been a strong sense of team membership amongst the senior managers, and also in the small executive sub-group of WiPPAG. There is a tangible WiPP culture. People feel proud to have made their contribution to something challenging and worthwhile, that they have gone the extra yard and not let their colleagues down. There is clearly some sadness that the programme is coming to its close and that it may be a work experience very hard to follow.

People believe the programme has been successful on the whole, as well as enjoyable - 'stonkingly good' as one put it.

Several of the individual projects have been judged independently and by those associated with them to have performed well and generated concrete, practical resources capable of making a lasting impact. They include the Workload Analysis Tool (subject to the final HSMC report), Self Care for Primary Care, Self Care for People, Making Sense of Health, the General Practice Nurses and Health Care Assistants projects, the VTS for Practice Managers and the Management Development Programme. The legacy of the Joining Up Self Care project is different: not so much a practical resource as a useful and credible account of a demonstration project, certainly not a failure. Equally, the Alternatives to Sickness Certification project can be viewed as a sound analysis of a good idea that turned out to be extremely difficult to implement; the lessons are valuable.

Judgements about the overall success of the programme should start with perceptions of its purpose, where the writer senses there may be some slight differences of emphasis. Its job sits somewhere between two alternative interpretations: first, to develop tools and interventions that have been widely used and shown through research to be effective; and secondly, to develop tools and interventions that have been tested and assessed to be useable and have potential. If its true role is more like the former, WiPP has only just started to demonstrate success, with the roll-out or mainstreaming of some of its training resources and toolkits. If it is more like the latter, it has done what was required of it, and more.

The latter seems to the writer the more plausible interpretation, that WiPP's core function has been to create opportunities and promote them, showing how well they might work, rather than to fully implement new tools and resources and deliver actual change.<sup>4</sup> Indeed, it is hard to see how a programme originally set up with a limited timescale could have been for any other purpose. WiPPAG's terms of reference required it 'to coordinate and facilitate the development of schemes....' Responsibility for the long-term use, improvement and evaluation of its products is passing now into other hands, and WiPP can only really be held to account for what it is passing on and how carefully (more of this in Part 4), not for what happens in the longer term.

WiPP can be judged a success against the preferred yardstick and in fact it has overachieved in some projects, beginning the mainstreaming process. This has helped to maintain momentum and reinforced the attractiveness of materials to potential future hosts.

### **Success factors**

Interviewees were asked what factors had contributed to the perceived successes and these are some of the suggestions made.....

A common observation is that the programme has been unusual in bringing together clear policy objectives, adequate financial resources and managerial freedom. Much more often than not in the NHS, one or more of these three key ingredients is missing or compromised by ambiguity, underfunding, bureaucracy or performance micromanagement. The terms of reference for WiPPAG encapsulate the point. This seems to the writer, who has experienced this same confluence of resources, policy and empowered management with similar results in a different context, to be a crucial point for the future.<sup>5</sup>

WiPPAG itself is seen to have been a potent entity. Its membership included many of the most prominent people in and around primary care at the time. Their collective knowledge, skill, experience, connectedness, credibility and influence were exceptional. Moreover, they mainly knew and even trusted each other and were able to bypass at least some of the storming and norming rituals of newly convened groups. In other words, they hit the ground running, so WiPPAG was at its strongest when it needed to be, at the beginning. The Programme Manager has felt very well supported by several individual WiPPAG members, including the Chair.

The Project Steering Groups enjoyed similar advantages and by all accounts have played a crucial role. Projects of these kinds, working at the leading edge, inspire passions but not necessarily consensus: there have been many very engaged debates. It seems clear however that the Groups have come

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<sup>4</sup> This raises the interesting point that the extent of WiPP's penetration into the hearts and minds of healthcare professionals may not be the right test. Outstanding resources could be developed with a lowish profile. High profile may be a measure of success in longer term roll-out.

<sup>5</sup> The All Wales Strategy for People with Learning Disabilities, in the 1980s.

together around decisions, once made, even if they had not had unanimous support. Open debate within and ownership of outcomes when looking outwards, cabinet style, is a mighty management tool when it works well. If it has done so here, it is a reflection on the leadership and positive culture of the programme as a whole and the qualities of the people involved.

By universal agreement, the programme has been managerially well led. It has had two very able Programme Managers and their respective strengths and styles were exactly those that the programme needed when it had them.

Care has been taken with the recruitment of other staff and subsequently with their individual and team development. It is significant that the team has remained intact throughout the life of the programme, despite the knowledge that it was time-limited. Care has also been evident in the systematic selection of pilot sites, collaborators, evaluators<sup>6</sup> and host sites for the future.

### **With the benefit of hindsight...**

Interviewees were asked what might have been done differently, what lessons might be learned.

The discussion of purpose raises an issue about the appropriateness of some of the independent 'evaluations' commissioned by WiPP. It is framed here as a question not an assertion. Large-scale studies have been undertaken of the Self Care for People and Primary Care projects which border on evaluations of the effectiveness of the resources rather than tests of their quality and viability. Would reviews of materials by a panel of independent experts, more akin to the Sheffield assessment of the HCA project, have been more to the point (and cheaper) than the Leeds studies? And was it not inevitable that the effectiveness evaluations would generate ambiguous results so early in the life of the resources under scrutiny?

Defining appropriate evaluation or review arrangements is one of five areas where different steps might possibly have been taken in the early stages. A second and third arise from the differing relationship between WiPP and its projects.

Six projects (1, 2, 3, 4, 7 and 8) were managed directly by WiPP. Five of them are perceived to have been very successful, with mixed views in play about Project 2. Of the 'external' projects, some are regarded as having been very successful, others as less so. In some cases, not necessarily the less successful projects, it has proved difficult for the WiPP team to exert influence or even stay in touch. It was as if WiPP were merely a grant-giver. This could inhibit the recognition and exploitation of the synergies between projects. And how can WiPP ensure and demonstrate value for money in its investments if it operates at arm's length?

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<sup>6</sup> But not necessarily evaluation *models*; see below.

Two points arise: first, if there is a choice between an in-house piece of work and outsourcing, the odds of success *may* be higher with direct management to ensure that all the success factors are in place.<sup>7</sup> Secondly, the odds may also be increased, where outsourcing or grant support clearly *is* appropriate, by establishing a contractually agreed protocol for access, reporting and influence at the very outset, before a commitment is made. Even then, however, external organisational fragility and change may defeat the best of agreements.<sup>8</sup>

A fourth potential learning point arises from the Making Sense of Health project, arguably one of the most promising of them all. It cost far more than any other project, accounting for a quarter of WiPP's total resource. Yet it sits there now with no clearly identified way forward. A mechanism is needed to train teachers in using MSoH resources and achieve national roll-out. It has been suggested that the commitment and planning stage could have included more thorough analysis of options for achieving eventual large-scale implementation so that the way could be prepared during the development period. Would a closer WiPP involvement in the project have made a difference? Hopefully, it is not too late for something to be worked out.

The final hindsight issue is that the complexity of the work required was underestimated at the beginning of the programme. As a result, spending slipped and timescales had to be extended. Financial as opposed to time resources seem to have been set more robustly, although this may have been through good instinct rather than good planning. The issue in broad terms is that attitudinal and cultural change have been involved in developing and trying resources as well as technical and professional management, and these are often the hardest challenges. In terms of the nature of the work, this would clearly apply to the HCA and self care projects. In terms of professional cultures, so many interviewees have said that GPs themselves have been relatively hard to reach and engage that it would be unconscionable not to say so here.

It is easy with hindsight to suggest imperfect foresight. The fact is that when WiPP got underway there was nothing but a few words in the nGMS contract, some funding and a room full of well-motivated people. Yet most of the judgements made then have proved to be sound and productive and a great deal has been achieved as a result. It may then seem churlish to suggest imperfection, but it is part of the learning process.

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<sup>7</sup> Interestingly, the team dispensed with the services of external events organisers and communications consultants at a fairly early stage and set up internal arrangements which have since proved very effective.

<sup>8</sup> Several organisations involved with WiPP have changed or been abolished: NatPaCT, NCGST, NPDT and DPP.

## **Part 4: Now for the Future**

### **Principles and process**

The Working in Partnership Programme comes to an end in June 2008. This short final part of the report summarises the steps that are being taken to relocate WiPP resources for their future with other organisations. The focus is mainly but not only on the directly managed projects.

A typically thorough, transparent and fair process was designed to ensure an outcome good for WiPP, the receiving organisation and above all the end-user of resources.

Selection criteria were drawn up, some applicable to all initiatives, some to specific initiatives. The core criteria included fit between WiPP resources and an organisation's business objectives and ethos; the presence of infrastructure, capacity, capability and determination to maintain resources; appropriateness to end-users, and good access to and for them; and a credible history and a long-term future.

An independent consultant was engaged to identify potential organisations. Those selected were approached and face-to-face discussions have been held.

Like almost everything about the Working in Partnership Programme, this has been well done.

### **Destinations**

This is the emerging picture:

*Workload Analysis Tool* – the tool is still under refinement and work is funded until March next year; it is hoped that WAT will form part of a national data extraction service.

*Self Care for Primary Care and Self Care for People (including the Self Care Connect website)* – destined for the Expert Patient Programme.

*Making Sense of Health* – future uncertain, awaiting the outcome of continuing discussions about implementation.

*General Practice Nursing and Healthcare Assistants* – adopted by the Royal College of Nursing.

*Vocational Training Scheme for Practice Managers* – now successfully accredited and located with IHM with a view to its establishment as one of its ongoing programmes.

*Primary Care Management Development Programme* – the PCMDP will now be developed and delivered on a national basis by the Open University.

## **Annex A: The writer**

**David Martin** BA DipAppPsych PhD

Director, **facilitate**

Senior Associate, Health Services Management Centre, University of Birmingham

David Martin worked as a clinical psychologist and then in the personal social services, including a period as Deputy Director of Social Services in West Glamorgan. He was the first Chief Executive of Bradford Family Health Services Authority and then Assistant Regional General Manager/Regional Director of Planning and Performance Management at Yorkshire Regional Health Authority. After a period as a Director at Trent RHA, developing health authority work and managing the RHA/Regional Office transition, he joined Sheffield University's School of Health and Related Research (SchARR) in 1996 as Director of Health Policy and Management. The link with SchARR continued until 2005 when he was appointed a Senior Associate of the Health Services Management Centre at Birmingham University.

He has a personal consultancy practice.

## Annex B: Interviewees

<b>Name</b>	<b>WiPP role</b>	<b>Organisation</b>
Kate Ansell	Self Care Focus Group member	Patient Participant
Richard Armstrong	WiPPAG WAT Steering Group member	Department of Health
Angela Bailey	CEO of NHS host organisation	Chief Executive Officer, Peterborough PCT
Janet Bell	Pilot Project Manager, Workload Analysis Tool	WiPP
Debbie Bodhanya	Pilot site for VTS and GPN	Business Manager, The Limes Medical Practice, Epping
Professor Alison Blenkinsopp	Self Care and Good Practice Steering Groups	School of Pharmacy, Keele University
Dr John Chisholm CBE	WiPPAG WiPPAG Executive member Chair, WAT Steering Group Member of most other WiPP Steering Groups	General Practitioners Committee, British Medical Association
Sue Cross	National Project Manager, General Practice Nursing	WiPP
Dr Ayesha Dost	WiPPAG Self Care Steering Group	Department of Health
Sandy Gower	WAT Steering Group Member Project Lead for VTS Pilot site for WAT	Practice Partner, Bennetts End Surgery, Hemel Hempstead
Kevin Holdridge	Web provider	Kent House
Dr Philip Leech OBE	WiPPAG WiPPAG Executive member WAT Steering Group Member	Independent Advisor
Louise Jarvis	National Communications Lead, June 2005 to March 2006 Programme Manager, from March 2006	WiPP
Helena Jordan	National Project Manager, Self Care for Primary Care	WiPP
Clayre La Trobe	Programme Manager, July 2004 to March 2006	WiPP
Anna Lynall	National Project Manager, Self Care for People	WiPP

Tracey Martin	WAT Pilot site	Practice Manager, St Andrew's Medical Practice, Spennymoor, Co Durham
Gopa Mitra MBE	WiPPAG JUSC Project Lead Self Care Steering Group Member	Proprietary Association of Great Britain
Eleanor Thomas	Training Manager, Self Care for You Pilot Site for Self Care for Professionals Pilot Site Workload Management Tool	WiPP  Central Cheshire PCT  Central Cheshire practices
Chris Town	WiPPAG Chair WiPPAG Executive member WAT Steering Group member	Former Chief Executive, Greater Peterborough Primary Care Partnership
Paul Vaughan	National Project Manager, Health Care Assistants Initiative	WiPP
Sarah Wrixon	National Communications Lead	WiPP
Lynn Young	WiPPAG Joint Chair, GPN/HCA Steering Group	Royal College of Nursing
Janine Zdziebczok	Programme Administrator	WiPP

## **Annex C: The individual projects in more detail**

### *Project 1: The Workload Analysis Tool (WAT)*

The Workload Analysis Tool, developed in association with Apollo Medical Systems, is central to WiPP's purposes. The software extracts data from routine practice clinical systems, principally Read codes which describe patients' conditions and clinical activity carried out with them, and the type of clinician involved. The Tool supplies practices with a range of reports designed to help them match the skills of the healthcare team more closely with patients' needs. This can involve routing or allocating work differently and taking opportunities to change skillmix in the team. The Tool is highly relevant to the WiPP projects focusing on general practice nurses and health care assistants.

Increasingly, practices using the tool also find it helpful to benchmark their work patterns against those of other practices, with the support of a centrally placed analyst. It can be useful too in practice based commissioning, providing the practice with high quality information as a basis for its commissioning proposals.

The Workload Analysis Tool has taken longer to develop to a satisfactory level than expected. There have been three phases of piloting and implementation, with changing frequencies of reporting and pilot duration. Around 100 practice sites have used the tool with the support of regional coordinators. Lessons have been learned continually. There were for example early problems with the accuracy and consistency of Read coding and the unreliable classification of clinical roles. Standardisation is essential for meaningful comparisons within and between practices. There is still room for improvement.

WAT has been evaluated by the Health Services Management Centre at the University of Birmingham. Questionnaires were sent to practices at three stages and followed up with visits and interviews. Key points from the draft report are that 78% of respondents thought WAT could in principle help practices with workload and skillmix issues and 57% thought it actually had helped them. The HSMC team noted the use of the tool by practice managers as a 'lever' or 'catalyst', or as 'evidence'. The final report is awaited.

### *Project 2: The Database of Good Practice*

The Database of Good Practice captured experience of successful developments from practices and PCTs around the country and produced case studies accessible on the WiPP website. Each case study had to go through a systematic process in order to be included in the database. Sites firstly had to demonstrate that their initiative contributed in at least one of three ways related to skillmix and workload management: making better use of clinicians' time, reducing demand for consultations in general practice or reducing workload for members of the general practice team. The second stage was an in-depth, structured telephone interview, on the basis of which a

case study was written for evaluation by the project's Steering Group (whose membership is on the website). Approved case studies were included in the database.

The database differs from many others in its scrutiny process, which is akin to peer review of material for publication. This means that its users have reason to be confident about the value of the initiatives on the database and the potential for learning.

The aim was to consider about 50 initiatives and publish 15-20 reviewed initiatives on the website to demonstrate what could be done. Forty six schemes were offered and 19 are currently on the database. Work on the project was completed in June 2006.

No formal evaluation has been undertaken.

### *Project 3: Self Care for Primary Care*

This is one of four projects (3, 4, 5 and 6) aimed at raising levels of knowledge, understanding and skill amongst professionals and members of the public as a means of promoting self care and moderating avoidable demands on general practice. Project 3 is focused on health and social care workers. Project 4, with which it shares a Steering Group, is focused on patients and the public. Project 5 is aimed at school children and Project 6 is about PCT coordination of work in supporting and promoting self care.

The projects, taken together, are highly consistent with government health policy, as expressed for example in the White Paper *'Our health, our care, our say'* and it is likely that they have helped to raise the profile of self care, and confidence that it is viable policy.

In broad terms, Project 3 set out to produce and test self care development and training materials in PCTs and practices.

Four PCT pilot sites were recruited competitively in May 2005: North Bradford and Airedale PCT (a 'dual intervention' site, as it was also a pilot for Project 4), Central Cheshire PCT, Southwark PCT and Lambeth PCT. Professor Ruth Chambers of Staffordshire University and colleagues were appointed to write working materials, again following a competitive process.

The main resource, *'Supporting self care in primary care – a training package for health and social care professionals'*, includes materials to enable PCTs and other care agencies - and, with separate materials, general practices - to run three workshops.

The first PCT workshop covers the development of a vision for self care and the benefits of promoting and supporting it, and an approach to prioritised planning. The second is focused on designing specific interventions and identifying barriers and how they might be addressed. The third involves reviewing progress and adjusting plans and actions.

The series for practices is similar in its overall shape but built around eight specially constructed self care patient pathways in disease areas (eg back pain, asthma). Around 30 practices have mounted workshops across the four pilot PCTs.

The initiative also supplies PCTs and practices with high quality training materials and tools for facilitation, analysis, modelling and planning.

The toolkit includes a 264 page paperback book: Chambers R, Wakley G and Blenkinsopp A (2006) *Supporting Self Care in Primary Care*, Radcliffe Publishing.

Since the toolkit became freely available in February 2007, following the pilot and initial evaluation, it is thought that around 60 PCTs have been involved in some way, either using the toolkit or attending WiPP workshops or conferences.

This project and the other WiPP self care initiatives have generated many valuable spin-offs, for example a *Commissioning Framework* designed to support the local commissioning of self care services by providing advice and support to PCT and practice based commissioning. This can be found at *Self Care Connect* ([www.selfcareconnect.nhs.uk](http://www.selfcareconnect.nhs.uk)), a new website, itself an output of WiPP's self care projects, which gathers together information on courses, materials, tools, devices, facts, figures and opinion which support and promote self care, and links those with an interest in self care in a virtual community.

Leeds Metropolitan University was chosen to evaluate the pilot. The study team observed that this was 'an initiative that would take some time to be fully realised'. The successful introduction of self care into primary care would require 'the very culture of GP practice to alter and this was a challenge that would take more time and resources than this current pilot could call on'. Nevertheless there were 'promising signs that.....practices were influenced by the training package and many were now engaged in examining their systems for supporting self care within their patient population'.

#### *Project 4: Self Care for People*

This project was unique amongst WiPP initiatives in addressing itself to the general public directly, not through an institutional vehicle. Its aim, through self care skills training, was to improve people's ability to understand, manage and avoid minor conditions confidently and safely and to help promote lifestyle change, improving their quality of life and measurably reducing unnecessary demand on general practice.

Analysis of practice data suggested a focus on particular conditions thought to be amenable to the approach - crying babies, coughs in children, adult coughs and back pain. Accordingly it was decided to target parents with

young children and men in the workplace. In due course the aim widened to women in the workplace and fathers' groups.

Three PCT areas were recruited to act as pilots: North Bradford and Airedale PCT (the dual intervention site mentioned above), Oldham PCT and South Tyneside PCT.

With their help, a Self Care Skills Training Course was prepared with six modules. Each module takes two trainers around ninety minutes to deliver to between ten and fifteen people from single workplaces or community groups (etc). Modules are generally spread over three or six weeks. Courses are run interactively and therefore vary in content, but with a standard framework and learning outcomes. Under more formal titles, the six modules cover:

- the way beliefs about health and ill-health affect behaviour and thus health
- how changes in beliefs can empower people to change their behaviour and improve their health
- how social factors (eg confidence and self esteem) affect the ability to change
- how psychological factors (eg stress and anxiety) affect the ability to change
- how diet affects health
- how exercise affects health.

Facilitated follow-up group meetings were held after three, six and twelve months. The course was supported by the production of local directories of self care resources.

Around 900 individuals attended courses as part of the project evaluation. Demand increased, partly because an impact on sickness rates was perceived in workplaces.

The website now provides open access to the course materials and also, under password control, to materials used to train trainers, a major role of the project. Over 100 people have been trained as trainers to date.

Leeds Metropolitan University was asked to evaluate this project also and the study team's report is awaited.

#### *Project 5: Making Sense of Health (MSoH)*

MSoH is the brand name for a set of self care-related resources developed with funding from WiPP. The website and the resources are owned by DPP2000 Ltd, an offshoot of the former charity Developing Patient Partnerships (DPP). The resources are for use in schools across all key stages and link in with the national curriculum. They aim to engage young people and their families with information about health and wellbeing, improving self care and influencing avoidable demand for primary care. It is a high level, strategic, and potentially extensive and effective programme in its own right.

MSoH is an educational and community health resource for teachers and students in primary and secondary education and also for parents and public health professionals. It works by developing the skills of teachers and health professionals in health education, providing them with training and resource materials.

The following award-winning resources are available:

- a series of nine BBC television programmes for ages five to sixteen
- printed resource and support materials for teachers and health professionals
- a printed and online health book for children and young people, *Health Problems and How to Deal With Them*
- an interactive website with further resource materials.

The programme has been piloted nationally. Between July 2005 and January 2006, 350 teachers were trained around the country and across all key stages.

The Open University has evaluated the programme and concludes: 'The Making Sense of Health Resources have been very well received by teachers who overwhelmingly report that they need more of this type of resource. The evidence reported here suggests that either in a science or PSHE<sup>9</sup> context the MSoH resources may amply meet their aims..... (they) are effective in increasing students' motivation to engage with science; to pursue health related careers; and importantly to begin to make the small, sustainable changes in behaviour that will lead to long-term health benefits.'

WiPP has been less involved in managing this programme than most of the others. Its main roles in practice have been to agree the initial funding in recognition that the work had a good strategic fit with other self care work and WiPP's overall remit, and to provide communications support, particularly during the latter stages.

A delivery mechanism is now required to ensure that Making Sense of Health resources are available to all schools in England and Wales.

#### *Project 6: Joining Up Self Care (JUSC)*

Like Making Sense of Health, JUSC was in the early stages of development before WiPP began work in earnest. Its management relationship with WiPP has however been closer.

The Proprietary Association of Great Britain (PAGB), with financial support from WiPP, managed a project to see whether a coordinated PCT-wide health education and promotion programme would be effective in changing the public's self care habits and behaviour. The distinctive feature of this work amongst WiPP's self care projects is that it looked at the potential of

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<sup>9</sup> Personal, Social and Health Education.

coordinating a range of interventions across a single (NHS) organisation rather than the impact of specific interventions across several.

The pilot – essentially a demonstration project - ran in Erewash PCT, which has since become part of Derbyshire County PCT, from January 2005 to April 2006. It involved interventions to support and promote self care in three clinical areas (CHD, asthma and minor ailments). Some interventions were directed at health care professionals, others at organisational issues.

PAGB commissioned PMSI Consulting to describe and evaluate the project and a full report was made to WiPPAG in October 2006.

There was some evidence of helpful behavioural change in patients in the three target areas, and by the end of the programme more than three quarters of the health professionals surveyed believed that the wider promotion of self care would help in achieving health gain targets.

The pilot has shown how PCTs can go about setting a self care strategy. The report emphasises the importance of senior leadership within the PCT. It also notes that the spread of self care depends on cultural change within the NHS, more widely in relevant organisations, and in the general public – which will be achievable only over time and with some difficulty.

#### *Project 7: General Practice Nursing*

This is one of four WiPP projects concerned with developing the non-medical workforce in general practice. With its sister project on health care assistants (with which it shares a Steering Group) it promotes the shift of appropriate work from GPs to other clinical staff and so sits at the heart of the WiPP remit. (Projects 9 and 10, also workforce-related, are designed to enhance skills in the management of general practice.)

The number of general practice nurses (GPNs) has grown hugely in the last two decades, largely because of the 1990 GMS contract but also because of the quality expectations in the nGMS contract and the pattern of incentives associated with them. Nurses in general practice now do a great deal that would formerly have been done by GPs, freeing them to concentrate on more complex cases.

This project set out to reinforce this trend, safely substituting nursing for medical skills in a wide array of services and enhancing the quality of services provided by doctors. It aimed to create resources for improving standards in general practice nursing and addressing anomalies in roles, skills and remuneration.

The project team has developed a Toolkit, in association with Staffordshire University and with the support of practice and PCT pilot sites, to highlight good practice in relation to GPNs in five key areas:

- employment practice

- education and professional development
- competence
- integration with the wider community health workforce
- quality improvement and evaluating practice.

The Toolkit, which is extensive and well engineered, explores each of these areas from a variety of perspectives: GPN, employer, PCT, patient or education provider.

The project has also produced a *Guide for Commissioners* on general practice nursing and a tool for assessing GPN capacity requirements in a practice, taking account of its size and numbers of patients with long term conditions. It has established a national General Practice Nursing Education Forum, which has organised two 'summit' meetings to consolidate the profile of general practice nursing and review arrangements for professional support and development.

The project's Toolkit has been tried and tested but not formally evaluated.

#### *Project 8: Health Care Assistants*

The rationale for the Health Care Assistants project is comparable with that of its sister initiative on GPNs. General practice teams continue to grow and widen in their skill mix. An important ingredient has been the emergence of the Health Care Assistant (HCA) role, and rapid growth in the number employed. HCAs are helping general practice provide more services to its patients by freeing up the time of nurses and GPs. HCAs take on less complex, but still important, tasks that have traditionally been performed by nurses. They also work alongside GPs so they can spend more time focusing on their patients and less on administration and paperwork. A recent review of training programmes for HCAs identified around thirty separate tasks, many of them traditionally 'nursing' tasks, carried out by Health Care Assistants. HCAs are integral to the smooth running of many practices.

The project has closely resembled the GPN project with which it has run in parallel, sharing a Steering Group. It too has developed its resources in association with Staffordshire University (and practice and PCT pilot sites).

The core resource is a Toolkit with the same overall shape as the GPN Toolkit. It defines good practice in relation to HCAs in eight key areas. Its main units cover:

- employment
- competences
- personal development
- education and training
- career development
- integrating the HCA role
- quality

- evaluation.

Again, the toolkit can be approached from a range of user perspectives.

The project has developed a series of six interactive workshops with full supporting materials, run several (oversubscribed) conferences and supported the setting up of local HCA Forums. The website and resources include various booklets and other publications.

The project and its leadership have played an energetic and important championing role for HCAs at just the right moment, and their influence has extended beyond the formal toolkit products.

This project has also been assessed by the Academic Unit of Primary Care at Sheffield University, using a range of reviewers. They concluded: 'The toolkit gained an overwhelmingly positive response from all reviewers, who all felt that they had gained learning and insight from the toolkit's contents and found the linked sites and attachments helpful. The most enthusiastic reviewers were the toolkit's primary audience – the primary care employers, in the shape of GPs and practice managers..... The results of this evaluation clearly showed that the toolkit is a highly relevant and useful tool, which will support the development of Health Care Assistant roles in general practice.'

#### *Project 9: Vocational Training Scheme for General Practice Managers*

This development project, one of two WiPP projects directed at management in general practice, was run by the Institute of Healthcare Management (IHM) with funding and other support from WiPP.

Its aim was to improve the effectiveness of general practice management, in an increasingly complex environment, by developing a competency-based assessment framework for general practice managers and offering a training and mentoring scheme and a career pathway for new entrants. It was expected that this would improve recruitment and retention and reinforce the confidence of GPs, other practice staff and patients.

The essence of the scheme was to develop a cohort of experienced practice managers and train them as trainers, and then link them as mentors with new managers to support them as they worked through the scheme's curriculum and learning experiences (including reflective writing exercises and case-based discussions and tutorials) and its schedule of periodic assessments.

A pilot scheme, endorsed by the Royal College of General Practitioners, began in November 2005 and ran for a year. Over fifty applications were received from potential trainers and trainees and eighteen were selected.

The VTS pilot was evaluated positively by the Collingham Healthcare Education Centre.

### *Project 10: Primary Care Management Development Programme*

This programme (PCMDP) was developed and piloted by the NHS National Clinical Governance Support Team<sup>10</sup> and the National Primary Care Development Team<sup>11</sup> with financial and other support from WiPP.

The programme is an interactive online course with nine modules, starting with an assessment of prior learning and educational needs. It then covers a number of key management areas, each including elements of knowledge and skill and practical tools and techniques. It is delivered using a range of methods including web-based learning, action learning sets and facilitator support and is assessed by national examiners.

Initially, 302 participants enrolled from a range of settings, mainly general practice and PCTs. The course took students up to 13 months to complete.

The programme was evaluated by the Collingham Healthcare Education Centre who found that participants rated it well, on the whole, and judged their competencies to have increased through their participation.

### *Project 11: Alternatives to Sickness Certification*

This project, managed by Developing Patient Partnerships<sup>12</sup> with financial and other support from WiPP, set out to explore and evaluate alternatives to the current system of sickness certification and absence management, with a focus on occupational health services and the role of occupational health advisers, avoiding or reducing calls on GPs. The project was led by Dr Barbara Kneale at Peugeot-Citroen. Three models were developed with a view to testing them in a range of organisations and workplaces.

The pilot was reported and evaluated by the Centre for Primary Healthcare Studies at the University of Warwick. Only ten organisations completed the pilot. The extent to which alternatives to conventional certification can affect sickness absence rates and return to work remains unclear and the pilot was unable to demonstrate any impact on GP workload. The pilot encountered numerous organisational, professional and political challenges and a lack of coordinated commitment. It was concluded that without considerable, organisational, political and possibly legislative change, the effects of alternative approaches on GPs would be marginal.

### *Project 12: Mental Health Collaborative*

The Improvement Foundation launched the initial two-year phase of the National Primary Care Mental Health Collaborative in February 2006 to improve the primary care of adults of working age with common mental health disorders. It had financial support from WiPP and others. The Collaborative

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<sup>10</sup> The NCGST was disbanded in March 2008.

<sup>11</sup> NPDT became the Improvement Foundation.

<sup>12</sup> DPP will close at the end of June 2008.

placed emphasis on evidence-based practice, patient involvement, shared learning and the spread of good practice.

The first wave has now finished. Seventeen PCTs took part with 70 practices involved.

The programme claims positive results and is hoping to secure funding from PCTs for a second wave. Further detail is accessible on the Improvement Foundation website by searching on National Primary Care Mental Health Collaborative.

WiPP's involvement has been marginal.

#### *Project 13: Repeat Medication*

This project was managed by the National Prescribing Centre and piloted in Bath and North East Somerset PCT. WiPP provided financial and professional support. The aim was to produce a resource pack of tools that could be used to reduce GP/practice workload by improving the repeat medication process.

Four practices worked as test sites and specific tools were developed. 'Before and after intervention' data were collected. The project was not able to quantify the benefits in time terms resulting from the use of its tools. There was some evidence however that item synchronisation in repeat prescribing offered the biggest beneficial impact on workload. The resource pack is available. The full project report calls for further work on a number of issues.

WiPP's involvement was again marginal

## Annex D: nGMS paragraphs 6.46 - 6.48

6.46 The new GMS contract recognises that if the primary care sector is to be expanded and practices are to be allowed to manage their workload and earnings to suit their aspirations, a clear strategy to use clinicians' time effectively whilst improving availability of services for patients is essential. This strategy will identify those situations in which patients could be enabled to manage their own conditions, use services effectively, or where the services could be offered by other health professionals, especially where these services could be accessed more easily and more cost-effectively than through traditional general practice. There are many examples of progress being made, but in some instances this work is on a small scale and implementation of proven initiatives patchy.

6.47 Under the new GMS contract there will be national arrangements to coordinate and facilitate the development of schemes to maximise the effective use of health services and provide evidence based alternatives to general practice. In Scotland, Wales and Northern Ireland existing arrangements will take forward this agenda. In England, there will be an integrated multi-disciplinary group under the aegis of the Modernisation Agency working with relevant external bodies. It will also have significant public and patient involvement as a part of its membership and hold a programme budget of £10m over three years to sponsor, evaluate and encourage spread of good practice. It will also champion these issues in discussions across Government.

6.48 Its work programme will cover a number of important areas for development, including:

(i) development of minor illness management and self-care education programmes by professionals such as nurses, therapists, pharmacists and paramedics

(ii) development and support for *Expert Patient* initiatives to make better use of primary care and general practice, building on the evaluation and roll out of the current national scheme, but extending its principles to more local practice-driven schemes

(iii) supporting non-GP based chronic disease management schemes aimed at helping to manage ongoing, and develop, new secondary prevention initiatives

(iv) promoting effective use of health services, better patient communication, and better self care through initiatives such as those developed by, for example, the Doctor Patient Partnership and other national health charities

(v) furthering attempts to reduce certification work within general practice. National initiatives such as those established through the Cabinet Office will be implemented. Major local pilots in large companies and the NHS will be

sought to evaluate the effectiveness of in-house occupational health services as an alternative to using general practice for certification. Should the pilots be successful the aim would be to allow the system to be refined so certification responsibility can be moved to occupational physicians and occupational health nurses, making significant progress towards national coverage by April 2006

(vi) promoting the education of young people via the National Curriculum about management of health, maintaining their health status and how to use health services responsibly through initiatives such as the proposed *Making Sense of Health*<sup>13</sup>

(vii) evaluating how patients use services and understanding how best to communicate with them about effective use of, and changes in, services. This work will build on that started by the Department of Health, the Doctor Patient Partnership and the University of Southampton and will be used to inform all the demand management programmes.

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<sup>13</sup> *Making Sense of Health* is an initiative from the Doctor Patient Partnership. Its aims include encouraging a culture shift in public involvement in their own health care management, improving people's ability to use the NHS appropriately and increasing the number of those in future generations who choose careers in the NHS. The initiative will provide imaginative and impartial health education and training to teachers, parents and pupils via the National Curriculum.

## Annex E: Membership of the Working in Partnership Programme Advisory Group (WiPPAG) and Project Steering Groups

Note – membership and organisation is as at creation of group and represents past and present membership

### WiPP Advisory Group (WiPPAG)

Name	Organisation
Prof Sir George Alberti	Department of Health (Emergency Access)
Richard Armstrong	Department of Health (Primary Medical Care)
Gary Belfield	Department of Health (Primary Care)
Karl Blackshaw	Department of Health (Self Care)
Dr John Chisholm CBE	General Practitioners Committee, British Medical Association
Dr David Colin-Thomé OBE	Department of Health (Primary Care)
Sarah Dahlgren	Department of Health (Primary Care and Pharmacy)
Ayesha Dost	Department of Health
Mark Duman	Patient Information Forum
Briony Enser	Department of Health (Health Improvement and Prevention)
Mike Farrar CBE	South and North Yorkshire SHAs
Rosey Foster	Institute of Healthcare Management
Dr Simon Fradd	GP and Consultant to Developing Patient Partnerships
Bob Gann	NHS Direct Online

Cathy Hamlyn	Department of Health (Sexual Health and Substance Misuse)
Jeannette Howe	Department of Health (Pharmacist)
Robert Johnstone	Arthritis and Rheumatism International
Anne Joshua	NHS Direct
Ruth Kennedy	National Primary Care Development Team
Louise Jarvis	WiPP
Clayre La Trobe	WiPP
Dr Philip Leech OBE	Department of Health
Michael Levitan	Middlesex Group of Local Pharmaceutical Committees
Claire Lodge	Department of Health (Communications)
Dr Hamish Meldrum	General Practitioners Committee, British Medical Association
Karen Middleton	Department of Health (Allied Health Professionals)
Gopa Mitra MBE	Proprietary Association of Great Britain
Helen Northall	Primary Care Contracting
Jeff Peers	Department of Health (Primary Care Access and Extended Services)
Mala Rao	Department of Health (Public Health Development)
Gul Root	Department of Health (Pharmacy)
Dr Mike Sadler	NHS Direct
Barbara Stuttle CBE	Castle Point and Rochford PCT

Dr Nigel Sparrow	Royal College of General Practitioners
Sarah Squire	Clinical Governance Support Team
John Stanley	Essex Local Pharmaceutical Committee
John Taylor	Department of Health (Primary Care Demand Management)
Chris Town (Chair)	Greater Peterborough Primary Care Partnership
Dr Ian Trimble OBE	Nottingham City PCT, Advisor to Department of Health
Simon Williams	The Patients Association
Lynn Young	Royal College of Nursing

### **Workload Analysis Tool Steering Group**

Richard Armstrong	Department of Health (Primary Medical Care)
Anita Baylis (Project Manager)	Healthcare Communications
Janet Bell (Pilot Project Manager)	WiPP
Dr John Chisholm CBE (Chair)	General Practitioners Committee, British Medical Association
Jon Ford	BMA
Sandy Gower	Institute of Healthcare Management
Kate Howie	Royal College of Nursing
Louse Jarvis	WiPP
Dr Philip Leech OBE	Department of Health/Independent Advisor
Katharine Robbins	NHS Information Centre

Dave Roberts	Information Centre
Dr Nigel Sparrow	Royal College of General Practitioners
Jayne Tabor	Institute of Healthcare Management
John Taylor	Department of Health (Primary Care Demand Management)
Chris Town (Chair)	Greater Peterborough Primary Care Partnership
Dr Ian Trimble OBE	Nottingham City PCT, Advisor to Department of Health

### **GPN/HCA Steering Group**

Dr John Chisholm CBE	GP/WiPP Advisor
Sue Cross	WiPP GPN Project Manager)
Sheila Dilks	Department of Health (Access Directorate)
Marilyn Eveleigh	Brighton & Hove City Teaching PCT
Louise Jarvis	WiPP
Jackie Jones	Eastern Deanery
Dr Mustafa Kapasi MBE	General Practitioners Committee, British Medical Association
Sue Nutbrown	Practice Nursing Association, Royal College of Nursing
Dorf Ruscoe	South West Peninsula Deanery NHS
Dr Nigel Sparrow (Joint Chair)	Royal College of General Practitioners
Paul Vaughan	WiPP HCA Project Manager
Lynn Young (Joint Chair)	Royal College of Nursing

### Self Care for Primary Care/Self Care for You Steering Group

Alison Baker	Royal College of General Practitioners
Karl Blackshaw	Department of Health (Self Care)
Professor Alison Blenkinsopp	Department of Medicines Management, Keele University
Dr John Chisholm CBE	GP/WiPP Advisor
Ayesha Dost	Department of Health
Louise Jarvis	WiPP
Helena Jordan (Stone)	WiPP Self Care for Primary Care Project Manager
Anna Lynall	WiPP Self Care for People Project Manager
Gopa Mitra MBE	Proprietary Association of Great Britain
Dr Peter Smith OBE (Chair)	GP/ National Association of Primary Care
Adrian Reyes-Hughes	NHS Direct Online
Sue Thomas	Royal College of Nursing
Eleanor Thomas	WiPP
Caroline Turnbull	Royal College of General Practitioners

### Making Sense of Health Steering Group

Norman Burrows	Software Production Enterprises Ltd (SPE Ltd)
Dr John Chisholm CBE	Developing Patient Partnerships (DPP)
Dr Simon Fradd	GP
Kristin McCarthy	Developing Patient Partnerships (DPP)

Pam Prentice	Developing Patient Partnerships (DPP)
Jeff Vicarioli	Software Production Enterprises Ltd (SPE Ltd)
Peter Waller	Software Production Enterprises Ltd (SPE Ltd)

### **Joining Up Self Care in the NHS Steering Group**

Prof Alison Blenkinsopp	University of Keele
Pam Bradbury	Department of Health
Dr John Chisholm CBE	WiPP
Paula Clark	Erewash PCT
Amelia Curwen	Asthma UK
Ayesha Dost	Department of Health
Dr Sam Everington OBE	GP
Dr Simon Fradd	Developing Patient Partnerships (DPP)
Helen Galloway	Erewash PCT
Prof David Haslam CBE	Royal College of General Practitioners
Jeremy Holmes	PMSI Healthcare
Louise Jarvis	WiPP
Dr Jim Kennedy	GP
Clayre La Trobe	WiPP
Jo Lenaghan	Birmingham and The Black Country SHA
Anna Lynall	WiPP
Kristin McCarthy	Developing Patient Partnerships (DPP)

Gopa Mitra	Proprietary Association of Great Britain
David Mowat	Department of Health
David Pink	Long-term Medical Conditions Alliance
Prof Mike Pringle CBE (Chair)	University of Nottingham
Gul Root	Department of Health
Dr Peter Smith OBE	GP/National Association of Primary Care
Dr Ian Spencer	NHS North East SHA
Helena Stone (Jordan)	WiPP
Ash Pandya	NHS Direct
Sara Richards	Royal College of Nursing
Rob Webster	Department of Health
Libby Whittaker	Proprietary Association of Great Britain
Gerald Zeidman	Pharmacist
PAGB's Primary Care Working Group	

### **Improving the Management of Repeat Medication in Primary Care Steering Group**

Clive Jackson	National Prescribing Centre
Dave Roberts	National Prescribing Centre
Trudy Granby	National Prescribing Centre
Maureen Devlin	Project Manager
Bath and NE Somerset PCT	

### **Primary Care Management Development Programme Steering Group**

Caroline Pike	National Clinical Governance Support Team
Jill Allen	National Clinical Governance Support Team
Dr John Chisholm CBE	WiPP

Jacqui Comber	National Primary Care Development Team
Tracey Cooper	National Clinical Governance Support Team
Wendy Evans	NHS Alliance
Dr Clare Gerada MBE	National Clinical Governance Support Team
Clayre La Trobe	WiPP
Trish O’Gorman	National Primary Care Development Team
Sharon Ombler-Spain	National Clinical Governance Support Team
Debbie Wall	National Clinical Governance Support Team
Lucy Warner	National Primary Care Development Team

### **Vocational Training Scheme for General Practice Managers Steering Group**

Ann Burtonwood	FBA working group
Dr John Chisholm CBE	WiPP
Fiona Dalziel	FBA working group
Sarah Farge	Professional Development Lead
Rosey Foster	Institute of Healthcare Management
Sandy Gower	Institute of Healthcare Management – FBA Chair
Phil Milligan	Institute of Healthcare Management
Dr Nigel Sparrow	Royal College of General Practitioners
Jayne Tabor	Primary Care Sector

### **Database of Good Practice Project Steering Group**

Professor Alison Blenkinsopp	Dept of Medicines Management, Keele University
Dr John Chisholm CBE	WiPP
Ayesha Dost	Department of Health
Jill Gamlin	Hinchingbrooke Hospital

Mark Gatfield	WiPP Project Manager
Sandy Gower	Institute of Healthcare Management
Clayre La Trobe/Louise Jarvis	WiPP
Michael Levitan	Middlesex Group of Local Pharmaceutical Committees
Barbara Stuttle	Castle Point and Rochford PCT
Dr Ian Trimble OBE (Chair)	Nottingham City PCT, Advisor to Department of Health

### **National Primary Care Mental Health Collaborative Steering Group**

Lesley Callow	National Primary Care Development Team
Alan Cohen	Sainsbury Centre for Mental Health
Ruth Kennedy	National Primary Care Development Team

### **Sickness Absence Management Steering Group**

Dr David Beaumont	Occupational Health Physician
Dr John Chisholm CBE	WiPP/Developing Patient Partnerships
Gail Cotton	Association of Occupational Health Nurse Practitioners
Cathy Harrison	Department of Health
Clayre La Trobe	WiPP
Professor Sayeed Khan	EEF
Dr Barbara Kneale	MPSA
Karen Middleton	Department of Health
Professor Jeremy Dale	Warwick University
Thomas Oppenkowski	Warwick University
Jolanda Luime	Warwick University

## **Annex F: WiPPAG terms of reference**

The Working in Partnership Advisory Group (WiPPAG) is expected to meet quarterly up to the end of the programme, which, at April 2004, is funded to March 2006.

It is chaired by Chris Town (Chief Executive, Greater Peterborough PC Partnership).

1. The Advisory Group, working under the aegis of the Modernisation Agency, will include relevant external bodies and have significant public and patient involvement as part of its membership.
2. The Advisory Group will take forward the Working in Partnership agenda, forming priorities within the framework set out within the new GMS Contract, and oversee arrangements in England to co-ordinate and facilitate the development of schemes in line with those priorities, so as to maximise the effective use of care services, provide evidence based alternatives to general practice and address clinicians' workload issues in general practice.
3. There is a programme budget of £10m over three years (originally profiled £0/£5m/£5m from 2003/04). The Advisory Group will develop or commission proposals (as set out in paragraph 6.48 of the new GMS contract) and make prioritised recommendations for the deployment of the £10m budget for the purpose of sponsoring, evaluating and encouraging the spread of good practice.
4. The funding, provided by the Department of Health as part of the overall allocation to fund the new GMS Contract, will be deployed on the basis of the recommendations of the Advisory Group unless there is a specific and overriding reason of financial propriety, probity or VFM for not doing so.
5. The Advisory Group will also champion this agenda with the wider group of stakeholders and in discussion across Government.
6. The Advisory Group will provide annual reports to the Department of Health on the use of the funding and the activities it has sponsored. These reports will be submitted in June and cover the work of the group on the previous financial year (April to March).

## Annex G: Organisational structure

