Health Scrutiny Committee Meeting - GP Forward View Across Nottinghamshire

Primary Care Co-Commissioning in Bassetlaw

Bassetlaw has high performing primary care with our practices attracting higher than average rating across a range of patient reported measures. Two of our 10 practices have been assessed as Outstanding through the CQC assurance process with the remainder assessed as Good.

The Bassetlaw patient survey results from July 2017 show a continuation of this high quality of service provision. Key highlights from the survey include:

Out of 207 CCGs, Bassetlaw CCG is joint:

- 3rd in country for appointments being convenient.
- 3rd for overall good experience of GP surgery.
- 4th for would you recommend your GP surgery to someone who has just moved to the area.
- 24th in country for overall experience of making an appointment being very good.
- 37th in country being satisfied with opening hours.
- 60th in the county for receptionists being very helpful.

However, we are ambitious to do better.

Introduction of the Primary Care Home (PCH) model across Bassetlaw

Strategically the introduction of the Primary Care Home Model across Bassetlaw will continue to be of central importance underpinning other developments. Many of the individual initiatives described including those to deliver the high impact actions, are assisted by the structure and delivery of the Primary Care Home model.

In 2016/17 Larwood and Bawtry practices collaborated to jointly develop a new model of care for their registered patients. The Primary Care Home was initially a national pilot supported by NHS England the NAPC and the NHS Confederation and is a form of Multispecialty Community Provider (MCP) model. In 2017/18 two other Primary Care Homes have now been established within Bassetlaw encompassing the Newgate Medical Group practice and the Retford plus surrounding village surgeries respectively. This will result in all of Bassetlaw patients covered by the new model of integrated working.

The key features of this more integrated model of working are:

- Provision of care to a defined population of 30-50000 population
- An integrated workforce across partner organisations working collaboratively to deliver the health and care needs of their defined population
- A focus on strong partnerships spanning primary, secondary, social care and the third sector to design and deliver new ways of improving health and wellbeing outcomes, addressing the specific priorities of their patients
- A focus on personalisation of care with improvements in population health outcome through prevention and supporting self-care and self-management, empowering patients to look after themselves and exploiting community assets
- A key aim of the PCH is to remove the barriers to integrated out of hospital care and develop services which reduce avoidable admissions and secondary care referrals.
- Provide seamless care to the patient from an integrated primary care team (right person - right time).
- To ensure higher quality service with fewer hospital admissions - fulfilling patient wishes.
- Intelligent sharing of workload, and better use of skill mix in the team, retention and recruitment

The three Primary Care Homes will continue to build on the well-established integrated neighbourhood teams (INTs including community, MH, voluntary sector, social care) in place since 2014/15 with the expectation that wider partnership relationships with other public sector bodies such as police, fire and education will also mature Practices also now have the ability to inter-refer patients, supporting access to different skills and capabilities across practice teams with an information sharing protocol in place to support this. Initial development of this initiative has led to inter practice referrals for contraceptive coil fitting & implants, with further services potentially following.

PCH teams will combine these skills and professional talents to continue to focus on targeted cohorts of older frail patients in order to maximise opportunities to achieving the triple aim of improving the health and wellbeing of local communities, providing a better experience of care for patients and delivering financially sustainable services. 2018/9 will also see the accelerated development of further enabling strategies and techniques such as population risk stratification , frailty assessment, case management , care navigation and coordination personalised care planning, care home reviews, home re-ablement and support, social prescribing, practice pharmacy support, care home medication reviews, care coordination etc.

OD Programme

Key workstreams of the ACP will focus on supporting this ongoing maturity. For example, the Local Strategic Estates Group and a newly established Digital and IT work steam will support both estates and IT infrastructure development to encourage co-location of teams and interoperability between different organisational systems leading to increased record sharing and better access to rich data to support effective management of patients across teams, professionals and sectors.

We will continue to invest in our primary care teams, using funding available to accelerate at pace and scale the transformation towards our primary care home model. This programme of investment has included £3 per head of registered patient population in 2017/18 and 2018/19 to support practice capacity and improve access during the day thus providing capacity and reducing demand. NHSE investment for GPFV and primary care at scale will also be used to support the implementation of primary care extended hours services across Bassetlaw commencing September 2018, which will be delivered on a collaborative Primary Care Home basis.

Other specific initiatives across primary care include:

- Care homes support from teams – regular GP led review of care home patients to prevent admission/ deterioration and reduce GP visits.
- Development of Specialist Nurse Practitioner roles within the Out of Hours service to support both out of hours as well as in-hours assessment of patients and deliver timely urgent care to patients at home and within A&E
- Improved health through proactive case management through multi-disciplinary team support
- Extension to the availability of voluntary and community sector support to improve wellbeing of people through social prescribing
- Implementation of a minor ailment scheme Pilot to support local community pharmacy advice and support to patients
- Development of Care Navigation across practices to support active signposting of patients into local services appropriate to their needs
- The trial of an Advanced Nurse Practitioner working in A&E to support primary care streaming

GP Access Systems

The introduction of the 'AskMyGP' access system through Estates and Technology Transformation Funding (ETTF) has involved a review of practice capacity and demand to allow practices to understand patient access need and enable patients a more varied access pathway (http://gpaccess.uk/). Two practices, Larwood Health Partnerships (Including Westwood Practice) and Tuxford Surgery have both embraced this new model of access. .

The GP Access system includes the implementation of the 'askmygp' online system, care navigation and an overall shift to on the day access to GP services if appropriate. Among the previously demonstrated benefits are improved signposting and utilisation of staff, better satisfaction and greatly reduced DNA rates.

A new Innovation Fund has also been created with CCG GPFV monies to support new innovative thinking within PCHs and embed the integrated approach to working within teams.

Further funding to support primary care delivery and reducing health inequalities, including a Bassetlaw Baseline Payment and Prevention enhanced service focussing on early cancer detection and diabetes is described in the 'Reducing Health Inequalities' Section

New consultation types

The CCG is developing the following alternative consultation types with local GPs:

- 'Ask my GP online' will initially be introduced as part of the GP access system as described above. This, or similar web based consultations will be considered as part of the continuation of that package or as a stand-alone tool.
- An ETTF bid has been successful in supporting mobile technology and introduction of skype consultations and mobile working, particularly for work with care homes.
- The CCG is rapidly developing GP online services
- GP connect will allow inter-operability between EMIS and SystmOne practices, underpinning the development of the neighbourhood teams and the PCH.
- The introduction of a Medical Inter-operability Gateway (MIG) is a limited viewing platform that allows real time sharing of information between services across the health and care system.
- Enhanced Summary Care Records in Bassetlaw (ESCR) is a solution to medical records sharing. The Enhanced Data Sharing Mechanism (EDSM) will continue to be developed to allow effective sharing between SystmOne units which serve most of our GP and Community Services.
- The CCG is also working with the local authority to agree the introduction of the SystmOne module into Care Homes / Intermediate Care and Residential Care Homes in Bassetlaw.

Extended Hours / Access

- Bassetlaw is currently procuring its extended hours provision to commence from September 2018 and is commissioning this separately for the 3 Primary Care Home populations ensuring a spread of geographical access.

- This will be in addition to the existing extended hours provision

- The remaining funds within the GP access allocations will be utilised to improve overall access with initiatives most suitable to meet the needs of the individual primary care home patient populations, for example a proposed urgent visiting service

Sustainable Workforce in General Practice

The CCG is modelling the necessary general practice workforce requirements in line with the SYB ICS assumptions and the GP Forward View. It is currently estimated this requires the following for 2017-2021 across SYB:

- 100 new General Practitioners (GP) per year in SY&B.
- 40 new nurses per year working in general practice in SY&B.
- 40 new pharmacists working in general practice per year.
- 40 new advanced 'AHP' practitioners per year (paramedics/ emergency care practitioners, physios and OT).
- 30 physician associates per year.
- Major development of the support worker based in general practice comprising.
- 50 new clinical support workers (health care assistants) per year.
- Conversion of 50 practice clerical support workers per year into clinical support (patient facing) roles such as a 'care navigator'.
- Expansion of mental health therapists

Work will continue to fully and sensitively map the specific workforce requirements for Bassetlaw. This work will underpin existing workforce initiatives such as the successful introduction of clinical pharmacists.

Primary Care Workforce

The CCG has recognised the vital importance of our local workforce to ensuring long term as well as immediate primary care resilience. This incorporates both clinical and non-clinical staff. During 2017/18 the CCG has therefore overseen:

- The implementation of Heath Education England reporting tool with full participation of all practices providing a unique opportunity to assess the current workforce position
- A highly successful Workforce Workshop event 13th July 2017, supporting conversations with external speakers and local PCH/practices to stimulate new approaches to local workforce challenges
- The development of a Bassetlaw CCG Workforce Strategy and associated Implementation Plan which seeks to address key workforce issues. A key priority is the development of a Training Hub in Bassetlaw supporting new skills development and working across our community partners to promote new opportunities for training and development of staff. Work will continue into 2018/9 to develop this approach with the support of LWAB funding.
- Securing additional external investment to promote local organisational development initiatives that will support the evolution of new ways of working and PCH maturity
- Accessing the Nottinghamshire Primary Care Development Centre to co-create and deliver training programmes for clinical and non-clinical primary care staff. This has included bespoke local education and access to centrally organised developments. It is anticipated this will continue in 2018/19.

Continued delivery of Protected Learning Time to the wider practice team including practice nurses

a. Clinical Pharmacists in Practice

The CCG introduced clinical pharmacists in general practice during 2016/17 which as expanded in 2017/18 and will be maintained in 18/19 to increase the clinical capacity in practices to provide direct patient face to face medication reviews; see and treat patient consultations for minor illness and care home poly-pharmacy reviews within a consultant geriatrician and GP multi-disciplinary team approach for frail and elderly patients.

Developing our Primary Care Estates

Bassetlaw CCG has a clear vision towards a fully integrated Accountable Care Partnership that promotes the concepts of shared values and purpose achieved through partnership and united strategic leadership. Our Bassetlaw Place Based Plan provides a roadmap for delivery of this shared vision. Our Plan clearly articulates transformation towards enhanced 'connected communities', focussed on the concept of Primary Care Homes coordinating health and wellbeing services through integrated health and care teams. These teams promote not just a medial model of health, but are far more integral to supporting patients and citizens in the management of their own health and wellbeing and impacting on the wider determinants of health such as housing, education and employment.

A key element of this transformation requires consideration of the use of our combined estate and the need to maximise opportunities for increased efficiencies as well as new ways of working that better enable the achievement of our connected communities. We fully recognise that property and the built environment is an important component to delivering high quality, accessible and efficient public sector services. Therefore, alongside our partner organisations (including our local healthcare providers, the Local Authority and other community partners and patient groups) we are working together through a newly formed strategic estates group (SEG). The remit of the SEG is to use property to deliver a more integrated, accessible, innovative and efficient range of health and care services as well as developing our shared assets as an enabler to develop a wider range of shared services and to support community regeneration more widely. Key principles of the Estates Strategy currently under development are:

- Divest of poor quality, poorly performing and surplus assets
- Public and patient facing services prioritised for use of high quality assets
- Develop assets for the delivery of new models of care and service delivery
- Prioritise and enable use of high quality assets, such as LIFT
- Co-locate services in assets where possible, with shared and/or sessional use
- Increase utilisation of health and local authority assets, to create surpluses

Our local estates strategy will incorporate the need to develop out-of-hospital care as well as the development of our local Bassetlaw acute services based in Worksop. We will therefore continue to work with Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust and wider community stakeholders specifically to develop a shared vision for the development of our local hospital site at Worksop; ensuring that this site develops the local services needed to secure our shared vision and remains compatible with the wider review of Acute Services as part of STP planning.

The CCG will continue to work with premises providers (including NHS Property Services Ltd and Community Health Partnerships) to promote more effective use of current primary care estate, including ways to improve utilisation of current properties through the use of available commissioning levers.

Bassetlaw currently benefits from a generally high standard of primary care premises, with the majority of practices operating from LIFT or newly built buildings. A full review of the premises used to deliver primary care services by General Practices was commissioned by the CCG in 2016. The service specification required the undertaking of a six facet survey as well as assessing Care Quality Commission Outcome 10 in Bassetlaw GP surgery premises. This review has informed estates investment priorities as well as assurances that premises met statutory requirements. The information gleaned supported the development of the initial draft of our local place based Estates Plan as well as capital investment bids for the Estates and Technology Transformation Fund (ETTF) (total value £244k in 2016/7). Consequently, a successful capital bid was submitted for the

development of primary care estate at Tuxford to support additional consultation space. Other schemes submitted for ETTF funding related investment in new technology and practice equipment for patient care (e.g. lap tops, 24hr BP monitoring, telederm scopes, ICE printers, touch screens, askmyGP, defibrillators and paediatric probes) as well as improved information sharing via the Medical Interoperability Gateway (MIG). We plan to roll the MIG out so that medical records can be viewed across primary, secondary and community services as well as by other health and care providers in due course dependent upon future funding being available.

To support the delivery of our Primary Care Strategy, having fit for purpose estate is seen as critical to success, but the effective and efficient use of available estate also needs to be explored. A review of utilisation of the LIFT building at Harworth has therefore also previously been undertaken. The results of this show opportunities for improved space utilisation supported by the use of commissioning levers where possible. . Development of the site of Newgate Medical Group (Worksop) would also create a more modern, fit for purpose, primary medical centre for over 30,000 patients. We will support this through our local partnerships as much as possible

Other estates related priorities delivered within 2017/8 have included:

- A review of public sector estates (Worksop)
- The proposed merger of Riverside & Misterton practices
- Westwood boundary change
- An extension to Tuxford Surgery supporting increased integrated working

We recognise that there will be limited resources available for future capital development in terms of technology or estates. In collaboration with local partners, the CCG will therefore maximise use of existing buildings, with new builds being approved only when existing resources have been exhausted and/or opportunities for flexible or adaptive use of space has been explored. Consequently, future ETTF bidding rounds will provide opportunities for further development of estate/technology where this is regarded as critical to the successful implementation of our Bassetlaw Place Based Plan.

Our goal is to support fully integrated team working across our community, inclusive of health and care professionals, patients, carers, voluntary and community based groups. Therefore the utilisation of our shared estate will be a paramount consideration of our Place based Plan as will the technology and digital support systems that will facilitate this. We will work with partners to identify shared resources and funding that may also be helpful in this endeavour.

Reducing Health Inequalities - A Focus on Prevention

Public Health data suggests our population may be accessing health care later than would be ideal for cancer diagnosis. This is a high priority for the CCG. Through the new Primary Care Quality Framework we have focussed on significant event analysis of new cancer diagnosis in order to learn from (anonymous) patient cases to understand what opportunities may be for available to improve earlier diagnosis including access to diagnostics, improved local communication messages and knowledge of health professionals on risk factors and the targeting of these risk factors in primary and community care. We have also funded practices to participate in the Cancer Research UK facilitated audit and action planning and will do so again in 2018/19 in conjunction with the cancer alliance as follows.

Working Collaboratively with the Cancer Alliance

Successful implementation of the Cancer Taskforce strategy will support transformation in the local approach to prevention and early diagnosis, high value pathways, and living with and beyond cancer.

The majority of investment required will come from funding already allocated to CCGs and providers in baselines, and Cancer Alliances will be crucial in ensuring that investment is directed in effective and efficient place-based approaches to improve cancer patient outcomes. National bid programmes will be supportive of change and these will be led on a regional basis by the Cancer Alliance.

The strategy includes a number of recommendations. Most significantly for local delivery this includes driving earlier diagnosis, implementing the Recovery Package and stratified follow-up pathways.

We are fully engaged in the relevant workstreams of Cancer Alliance and are linking with hubs of best practice in our Cluster group, including the early diagnosis workstream as referenced above. Two Protected Learning Time Events are being dedicated to this, to fully involve Primary Care

A cancer improvement plan is being developed using Rightcare and Public health information, highlights that whilst we benchmark well for screening and diagnosis at this stage, there are many who do not present for screening. Therefore the plan will focus on early detection and prevention including and end of life care, building on the great services we have including aurora and the hospice. We want to focus our efforts on hard to reach groups and those who traditionally do not present, in liaison with Primary Care Homes. We have identified resources for next year for a cancer awareness campaign and Cancer research UK are being funded to help primary care review their data as part of participation in the early diagnosis workstream. This is a continuation of work completed in 17/18

Diabetes

The CCG has launched the National Diabetes Prevention Programme and incentivised successful referrals to it. This builds on previous work developing in house education sessions within GP practices. To then end of February 2018 269 successful referrals had been made against a target of 152 to that point. We shall continue this initiative in 2018/19 and have aligned our education programme for diagnosed diabetics to match its messages.

Overall

The breadth of activities to reduce inequalities is captured in the Bassetlaw Place Plan. Our plans to support primary care to reduce health inequalities include various elements

We will continue to implement the 'Bassetlaw Baseline', and locally Enhanced Services including a local Incentive Scheme. This Scheme supports local focus on key priorities including management of care home patients, addressing frequent attenders and users of emergency and urgent care,

prevention and health promotion, long term condition management including cancer, COPD and diabetes. The Scheme has proved successful in terms of achieving intended benefits. For example, the 'Interlocking Aim' element incentivises practices to deliver a composite reduction in respect to emergency admissions, certain A&E attendances, prescribing, and outpatient referrals.

A new Innovation Fund has also been created with CCG GPFV monies to support new innovative thinking within PCHs and embed the integrated approach to working within teams.

Further initiatives to support self-care include

- Provide Care Navigation training to front line primary and community care professionals to navigate patients to the most appropriate services that best meets the patient's needs such online resources for self-care, Community Pharmacies, self-referral to psychological therapies (IAPT), voluntary sector or other health and social care services.

- A primary-care based wellbeing hub will be established with advisors in practices to support people in developing resilience and seek earlier intervention for low level mental health support and long term conditions advice.

The voluntary sector social prescribing and mental health support will be expanded to provide more support in primary care, enabling people to navigate services that are available locally and access the right support quickly