



Community and Wellbeing Scrutiny Committee

19 July 2017

Report from Brent Clinical Commissioning Group

Wards affected: ALL

Primary Care Transformation

1.0 Summary

1.1 This report provides the Community and Wellbeing Scrutiny Committee with an update on our programme of Primary Care transformation. This work is led by NHS Brent CCG alongside Primary Care providers and stakeholders who include Brent Local Authority, the other seven CCGs in North West London (NWL), NHS England and other providers and patient representatives.

2.0 Recommendation(s)

2.1 We are asking the Committee to discuss and note the content of this report.

3.0 Detail

3.1 The Committee will be familiar with the challenges facing local health and care services. We have a growing number of people aged 85 and over (expected to increase by 20% in NWL by 2020/21), many people aged 65 and over living alone (increasing the risk of social isolation), demand on services is outstripping our ability to deliver care, there is variation in care quality and in outcomes, financial pressures are putting providers at risk, we have an aging infrastructure (IT, Estates) and collectively this is exacerbating recruitment and retention issues. These pressures are felt acutely in primary care and reflected in patient feedback.

3.2 Brent has 62 GP practices serving a registered population of 371,405 people. The registered population has grown 7.4% in the last 4 years and

with demographic growth and local regeneration and housing projects, the population needing primary care services, will continue to grow.

- 3.3 This places a significant pressure on individual practices – some of whom have seen a 12% growth in their list in the last 12 months. The primary care system must respond to this. This requires a balance between short term solutions to relieve immediate pressures, and work that must take place now to deliver a major transformation of Primary Care and the wider health and care system.
- 3.4 Brent CCG has always supported Primary Care as we recognise without it we cannot have a strong and sustainable health and care system. In the last five years we have made notable progress – practices have introduced new roles (e.g. Healthcare Assistants, Care Navigators), new ways of working (sharing care records and care plans, multidisciplinary team meetings) and begun working together at scale in new provider models.
- 3.5 The CCG does not currently receive money for Primary Care services; but we do invest. In 2016/17 we invested in local enhanced services (e.g. Cardiology diagnostics, Diabetes care, Management of Rheumatology) and new models of care (GP access hubs, Whole Systems Integrated Care, Enhanced support to Care Homes & High Risk Housebound patients).
- 3.6 Progress has been made but there is significant work still to do. The **Five Year Forward View** (FYFV) set the national direction of travel presenting short term priorities around GP access, Cancer and Mental Health and medium to longer term objectives for a transformation of care to focus on keeping people healthier for longer and avoiding unnecessary hospital admissions.
- 3.7 Following the publication of the FYFV, the **General Practice Forward View** (GPFV) was published April 2016. It made a commitment to invest in Primary Care to 2020/21 to deliver key objectives around access, quality, patient experience and at scale provision. The GPFV focus is sustaining and developing the resilience of general practice, whilst laying the foundations for Primary Care to play a pivotal role in delivery of new care models – working together at scale, and with partners.
- 3.8 Delivery plans have been produced locally to reflect national objectives. Most notably the Sustainability & Transformation Plan (STP) – which in Brent we have refined locally into the *Brent Health and Care Plan*. Primary Care has a key role to play in implementation of this and the achievement of outcomes – improved health and wellbeing, improved quality, financial sustainability.
- 3.9 NHSE also requested a specific plan from each CCG articulating delivery of the GPFV locally. This was submitted and assured end of 2016 following a period of rapid engagement with key stakeholders. In this plan the CCG was asked to outline our proposed approach to delivery of key

GPFV priorities and use of any investment. The plan covered extended access, provider development and resilience, development of online consultations and development of the primary care workforce. It also sought outline plans for delegated commissioning and progression of the PMS contract review.

- 3.10 It did not specifically ask about Primary Care's role in person centred and coordinated care, however the preceding *Strategic Commissioning Framework* stated these objectives, and we have a major programme of work underway with Primary Care and partners under the STP and Brent Health and Care Plan.
- 3.11 In reading this report, we hope the Committee can see reflected the recommendations of the Brent Scrutiny Task Group (2015). The task group was concerned with primary care's ability to meet demand and provide fair and equitable access. It recommended investment, development of innovative ways to meet and manage demand, promotion of health and wellbeing and encouraging residents to support themselves wherever possible.
- 3.12 The objectives above and work to deliver against these comprise a major programme of Primary Care transformation; below we give an overview of work in progress and next steps for our major priorities.

Extended access

- 3.13 Extended and improved access to GP services became a national priority three years ago when the Prime Ministers Challenge Fund was put in place to improve access to general practice and stimulate new ways of working. The model implemented and replicated nationally was the GP Access Hub model – 'top up' or standalone hubs that provide extended pre-bookable access to GP and Nurse appointments.
- 3.14 In April 2015 Brent commissioned hubs from the three GP Networks. We currently have nine hubs providing an additional 60,000 evening and weekend appointments annually. Hub appointments are offered to patients when a practice is unable to accommodate a request for a same day appointment and when a patient wishes to see a GP at the weekend.
- 3.15 Even with the hub service, access to GP services remains a concern for residents. Hubs are under-utilised particularly at weekends (a trend seen nationally) and patient feedback is yet to improve in a significant way.
- 3.16 Access remains a national priority for the NHS and the GPFV outlines a number of requirements local areas must implement. Brent has also considered its own priorities – holding a series of task & finish groups with providers and Healthwatch. Since January 2017 we have implemented a range of changes that should support better access to primary care:

- Access to GP appointments from 8 am to 8 pm, seven days a week for Brent- registered patients – delivered from the Willesden Hub
- Standardised online booking for practices - appointment availability is now shown online to every practice; as a result practices can offer and book straight away when a patient contacts their practice
- Online access for Hub GPs to the patient's clinical record – ensuring the hubs can offer a full service and better continuity of care
- Use of the clinical system to directly share discharge and follow up information with the patient's own practice
- Text messaging – patients get a text from the Hub with their appointment and are able to cancel if they can no longer attend
- Communication – Brent has commissioned a short video raising awareness of the hub service. This will be shown during our next patient engagement roadshow and on websites and in GP practices. We are also producing posters and leaflets to go into practices.

3.17 During 2017/18 we will be working on:

- Direct booking into hubs by NHS 111 – the directory of services used by 111 already includes the hubs, but they cannot directly book appointments and the patient has to contact the hub directly. Streamlining this so an appointment can be made during the 111 call should have a positive impact on weekend utilisation rates
- Redirection of patients attending Urgent Care Centres where they might be better served by the GP access hubs (building on a pilot underway in the Harness Network)
- Implementing a common script for receptionists across the 62 practices - to ensure they consistently explain and offer hub appointments at the point a patient calls their own practice
- Patient direct booking – looking at the merits of patients being able to book online directly, as opposed to booking via their practice or hub telephone numbers
- Technology enabled access – considering how technology might be used as part of the hub model including electronic consultation and links via apps
- Contract review - hub contracts expire March 2018 so we have commenced a review of the model of care (skill mix and ability of hubs to manage a full range of needs), hub locations, operating model, utilisation,

communication and outcomes. Providers and Healthwatch have engaged and we will undertake wider patient engagement starting with a road show this month.

- 3.18 Improving access to core practice services is also a priority. We need to address supply (practice systems, staffing and management) and demand (patient expectations, communications and use). Kings Fund note direct (face-to-face and telephone) contact with patients by practice teams increased by 15.4% between 2010/11 and 2014/15, so practices must rethink the way they work and the offer to patients.
- 3.19 Through our work on provider development and resilience (described below) we are working with individual practices to look at use of appointments, scheduling, patient flow, the role of reception (booking, active signposting, patient communication), managing patient expectations, use of online booking, reducing DNAs, productivity (workflow, use of workforce), use of data and embedding of self care and social prescribing.
- 3.20 Brent CCG also successfully bid to join the National Time for Care Programme; we have practices doing in-depth work to develop approaches to improve access for example managing frequent attenders and team planning and practice capacity (GP and nurse availability during peaks and troughs in activity).
- 3.21 The benefits of improving access to primary care include: improved access to routine booked appointments outside core hours; patients with urgent needs being assessed and directed to the right place, first time; patients are able to make use of technology to access primary care advice; and, patients avoiding unnecessary unscheduled care attendances. We will measure our progress and levels of patient satisfaction using hub surveys, wider engagement, and the national GP Patient Survey.

Provider Development & Resilience

- 3.22 Provider development & resilience is one of our biggest priorities and the role CCGs play is growing as we take on more responsibility for Primary Care. There is considerable emphasis in the GPFV on provider development - at individual practice level and at scale. Key challenges to address include investment, workforce, workload, infrastructure and care redesign.
- 3.23 Individual practices are facing significant challenges. This includes external pressures (increasing patient numbers, increasing demand, gaps in workforce) and internal pressures (partnership arrangements, costs and financial viability, performance in key outcomes); but there is much enthusiasm for the opportunity to proactively develop and deliver existing and new offers to patients.

3.24 Part of the solution for individual practices will be 'at scale' working. There are many potential benefits to 'at scale' working:

- Delivery of services unrealistic for individual practices – seven-day access, integrated care pathways, dedicated support to care homes;
- An equitable offer to patients across Brent - services individual practices may not have the skills or capacity to provide, can be offered from other sites or in patients own home by dedicated teams
- Recruitment and sharing of staff and new roles – Practice Managers, Care Navigators, Clinical Pharmacists, Analysts, Operational Managers
- Shaping and delivery of programmes of support, training and development across practices - staff training, qualifications, mentoring
- Opportunities to organise and modernise Primary Care 'back office' services and achieve economies of scale in purchasing the supplies and services needed to run a practice
- Primary Care has a platform on which to engage other providers in the development and delivery of new models of care – Trusts, Local Authority, voluntary sector.

3.25 Brent is further forward than many other areas - the three Brent GP Networks are CQC registered legal entities, who now also work as a Federation (Brent Care Ltd). Every practice is a member of one of the Networks, and in turn the Federation. Significant contracts are already held. But we need to go further and faster to support sustainable general practice and new models of accountable care delivered by partnerships of providers.

3.26 Most of the resource for our provider development work comes from a nationally mandated £3 per head to be found from the CCG baseline. This represents over one million pounds of investment for Brent during 17/18 and 18/19. With this we are supporting each tier of the primary care system – individual practices, groups of practices or Networks and the Brent wide Federation. Below we briefly outline work to date:

- Individual practice support commenced March 2017. We have budgeted to work with every Brent practice over the next 18 months. Support areas were agreed with stakeholders and include improving access, workforce planning, leadership and management development, team development, coaching and mentoring, business planning and use of IT. Initial practice diagnostics are followed by tailored action plans identifying key outcomes and support. The focus is short term resilience and medium to longer term development

- We are currently focusing our work with groups of practices on discussions with Practice Managers - defining common priorities (access, quality improvement) and opportunities – including how we embed new roles (Care Navigators, Clinical Pharmacists) and approaches (personalisation, use of data to improve key outcomes)
- Federation development is a priority for NWL. In Brent joint commissioner / provider facilitated workshops commenced in March 2017. The output of the workshops will be a development plan that ensures investment and effort are focused on Brent's requirements for support to frontline practices and delivery of new models of care. Workshops will generate a shared understanding of progress to date, challenges to overcome and a level of consensus around collective tasks ahead. This will provide a 'roadmap' to be refined with stakeholders so they are able to see clearly what 'at scale' primary care could do and potential impact on key outcomes

3.27 To summarise, during 2017/18 we will be working on:

- The second and third cohorts of our practice based support
- Increasing the pace of development with 'at scale' providers
- Brent wide workshops focused on common challenges where collaboration would be beneficial ('access and demand', 'maintaining standards & quality')
- Engaging stakeholders to agree the key features of each tier of primary care and what makes sense to deliver 'at scale' across Brent

3.28 We will know if we have succeeded if we see providers taking tangible steps forward and developing some of the key capacities and capabilities required, if practices, the Networks and Federation have established development plans that align and can be communicated to patients and stakeholders and if commissioners are confident we can deliver our strategic objectives with fully engaged primary care providers driving reduction in unwarranted variation, improvement in key outcome measures, services being delivered closer to home and active participation in accountable care.

Online consultations and use of technology

3.29 This work is a major enabler of improved access and speaks directly to recommendations from the Scrutiny report. The way our population wants to interact with healthcare is changing and evolving; nationally internet usage is growing across all age groups and smartphones are increasingly becoming a tool we use to manage our lives.

- 3.30 Patients expect to be able to engage with public services online and increasingly directly with health professionals via health apps and technology. The digitisation of the workforce and its systems and processes is also key; this includes sharing information to support direct care, care plans that are also accessible to patients and systems that support easier access and more efficient management of demand.
- 3.31 We have been rolling out Patient Online which offers patients online appointment booking, repeat prescription ordering and access to care records. This has been enabled at all Brent GP practices and patients are being encouraged to register for this service. The aim was to have 10% of registered patients with a live or active account by March 2017. We dedicated capacity to increasing use and by March over 20% of Brent patients were registered. We are working closely with NHS Digital and Healthy London Partnership to raise awareness and advertise to patients.
- 3.32 We are also improving the Brent health app and aligning to a NWL wide solution. This will support access to GP services and include symptom checkers, health advice and a directory of local services. We hope to have this in place in Autumn 2017. By providing advice on common conditions the app should enable people to care for themselves where appropriate. It will also mean people are better able to accurately identify the service that can help them. The project group will meet over summer to localise content - it includes GP representatives, IT and a patient representative.
- 3.33 Finally, a number of NWL practices are testing online consultation software. We are awaiting further guidance under the GPFV but are starting to test solutions before considering the best approach for NWL. Practices in NWL are testing the two that are best developed. There are a number of practices about to commence testing of the Babylon app – this provides 24/7 access to GP advice and follow up. Four Brent practices have also been testing E-Consult – also known as WebGP – since last year. This provides access to the patient's own practice via the practice website with the ability to submit online consultations 24/7 for a response within one working day.
- 3.34 These solutions allow patients to access primary care from anywhere to check symptoms, confirm their GP is the right service, access self-help and/or submit or take part in an online consultation. These solutions adhere to clinical governance guidelines by identifying red-flags and redirecting to urgent or emergency care where necessary, and information governance guidelines.
- 3.35 The pilot in Brent has seen 1450 visits (1250 unique users) and 480 e-consults submitted in the last 6 months. Data from one practice suggests most patients using the service are aged 25-44, although 22% were over 55 and 12% over 65. Women accounted for the majority of the consultations (69%).

- 3.36 The next step is a wider strategic conversation across NWL to agree how we progress the online consultation agenda including whether we roll a common solution to leverage economies of scale as the software is expensive, but could support major improvements to access, demand management, appropriate use of services, patient experience and satisfaction and practice workload.

Workforce

- 3.37 Workforce challenges are acute and both a driver for and barrier to Primary Care transformation. The GPFV focused a lot of attention on workforce, workload, productivity and new roles. It also acknowledged the fact we have an aging workforce in primary care and a significant lack of GP trainees going on to full time employment in general practice.
- 3.38 Challenges faced include: recruitment and retention - in line with the national picture, this is very challenging in Brent; retirement from general practice – we have an above average number of GPs over 60 (~21%, second highest in NWL); training and development - given the pressures on primary care it is increasingly difficult to release staff for development and training; skill mix - there is a recognised need to develop and utilise a broader range of skills in primary care and to identify which clinicians are best placed to support care, but this requires a significant shift in working practices, scheduling, training and patient expectations.
- 3.39 Our delivery plans include a range of priorities for training and development. Some of this will be delivered through our work on provider development and resilience, the rest through the delivery of our annual Health Education NWL (HENWL) plan. We have an annual programme of training that includes clinical and non-clinical skills development, professional development and accreditation.
- 3.40 We are linking this more closely to our primary care transformation priorities and delivery of the GPFV and in 2017/18 work will include:
- Training and embedding new roles – including Medical assistants, Clinical Pharmacists, Practice based Care Navigators, Nurse Assistants and Primary Care Mental Health Workers. As an example Clinical Pharmacists can work as part of the practice team on day-to day medicine issues
 - They can work with patients directly providing extra help to manage long-term conditions, advice for those affected by polypharmacy and better access to health checks. They can also provide leadership on medicines optimisation and quality improvement and support delivery of enhanced services. This should improve access, patient outcomes and help manage the general practice workload

- Making Brent an area of choice for GPs and other clinicians by offering opportunities for training in a special interest and opportunities to work across settings of care (primary, community, secondary, education)
- Offering to support and host peer groups for different professions – we already host a Young GP Forum, attend and work with a Brent Practice Managers Forum and the CCG primary care (medicines optimisation) team have supported the Federation to bid for 12 Pharmacists to work across the 62 practices to support patient care
- Exploring structured career pathways and the potential to develop employment opportunities in Brent by working with providers and communities to look at career pathways within and between services. We have already sought Healthcare Assistants keen to take up Nurse Assistant training, and supported three practice managers onto a Postgraduate Certificate in Management. We are also looking at training programmes for Secondary Care Nurses to transition to Primary Care through funding BSc (Hons) Primary Care (Practice Nursing) degree in conjunction with City University
- Training and organisational development for providers in the skills and techniques required to deliver new models of care within practices and at scale. This includes training in approaches like Coaching for Health and motivational interviewing which enable professionals to play a role in supporting people to self-care and self-manage
- Supporting practices to identify GPs for the national Retainer and Returner scheme which seeks to retain retiring or returning GPs in general practice
- Working with individuals and practices to improve their confidence in use of new technology

3.41 There are also a number of key pieces of work the CCG has been asked to take forward by NHSE as part of the wider primary care transformation agenda. These pieces of work are relevant to the commissioning of primary care services. Specifically the GPFV seeks progress in the PMS contract review and the move to fully delegated commissioning. These two areas of work are outlined below.

PMS Contract Review

3.42 NHS England (NHSE) are currently the lead commissioner for Primary Medical Services (GP services). They use one of three contract types to commission core GP services:

- GMS (General Medical Services) - nationally agreed and nationally negotiated contract which delivers medical care to a registered population

- PMS (Personal Medical Services) - locally agreed contract which builds on the GMS and was introduced to pilot new ways of working
 - APMS (Alternate Provider of Medical Services) – based on the GMS but does not require a GP to be the contract holder
- 3.43 Brent has 46 GMS practices, 11 PMS practices and 5 APMS practices.
- 3.44 An NHSE review in 2015 suggested the majority of services provided by PMS practices could now be deemed as 'core', are incentivised through QOF or are commissioned as enhanced services. They also pointed to the differential funding levels between GMS and PMS practices, and across PMS practices.
- 3.45 NHSE launched the PMS Contract Review to try and equalise funding between practices. There is a transition period of up to 4 years (depending on change in income) to allow practices to adjust to new funding levels however transition should be completed by 2021. The review will see an amount within the PMS contract value known as the 'premium' released and redistributed across all practices. NHSE were unable to move beyond negotiations with GP representatives from London wide LMCs and have now asked CCGs to negotiate a solution locally.
- 3.46 We have commenced detailed planning with NWL CCGs to ensure equity of approach. We have submitted detailed implementation plans for assurance by NHSE and LMCs. We have also begun to review financial information, agreed a transitional funding model, developed commissioning intentions (services or schemes we will commission to reinvest monies released across all practices for example stretch flu immunisation targets and enhanced support for carers) and commenced informal engagement with practices.
- 3.47 Next step is formal negotiations; this will give us a clearer idea of the potential changes required at practice level and the timescales for this and enable completion of equality and quality impact assessments. PMS practices will all be offered support under the practice development and resilience workstream to help them formulate their response to these changes. New contracts should be agreed within 2017/18.

Delegated commissioning

- 3.48 NHS Brent CCG has in place arrangements for the 'joint commissioning' of GP core services alongside NHSE. This is known as 'Level 2' commissioning and is overseen by the Brent CoCommissioning Committee.
- 3.49 In line with national policy, in 2016/17 NWL CCGs consulted practices on the option of a move to 'Level 3 - fully delegated' commissioning from 1 April 2017. CCGs that move to full delegation assume a range of responsibilities currently held by NHSE:

- Contracting for GP core services
 - Managing the general practice budget (primary medical allocation)
 - Managing the contracts for primary care services
 - Designing local enhanced service and incentive schemes
 - Supporting day to day running of general practices so they are sustainable
- 3.50 Functions retained by NHSE include management of the national performers list, management of GP revalidation and appraisal, capital expenditure and section 7A functions (e.g. screening and immunisation).
- 3.51 Delegation means a more direct relationship between the CCG and practices and greater local ownership over the design of enhanced services currently commissioned by NHSE. It therefore also requires robust due diligence, a fit for purpose commissioning and governance structure and sufficient capacity to meet practice and NHSE expectations.
- 3.52 CCG member practice support was required by NHSE, so a ballot was held. Brent practices chose not to move to Level 3 at that stage (as did Hounslow); however NWL CCGs are committed to working as an STP footprint so Level 2 CCGs are working in much the same way as neighbouring CCGs. Furthermore, many of the responsibilities devolved by NHSE as part of GPFV delivery and the wider primary care transformation agenda reflect roles and responsibilities under delegation.
- 3.53 We are preparing our commissioning structures and seeking to ensure our governance (CCG Constitution, Committee terms of reference) is refreshed and fit for purpose. We are likely to offer the option again with engagement and a vote in 2017, ready for a potential move from 1 April 2018.

4.0 Financial Implications

- 4.1 Investment has been made available from NHSE to support delivery of the GPFV. This includes money for extended access, online consultations and a small amount for provider development and resilience. We are also expecting monies from HENWL to support the annual workforce development plan. Remaining resource will come from CCG baselines - invested directly through programme delivery and contracts which align to these transformation objectives, and through pan-NWL programmes.
- 4.2 The PMS review has financial implications for the practices and the CCG. Premium monies released from practice contract values will be re-invested and the process of transition will need to balance release of premium with reinvestment to avoid significant cost pressures to the CCG.
- 4.3 The due diligence completed by RSM as part of preparation for a move to Level 3 – delegated commissioning suggests Brent CCG would have 'headroom' within the primary medical allocation (budget for core GP

services) if we took this on. This is subject to change as cost pressures from GP rent reviews and changes to the baseline contract value (based on price per patient plus adjustments) are made; however, if practices choose to move to Level 3, it is likely some investment will be possible.

5.0 Legal Implications

- 5.1 The PMS contract review requires a change in contract for the PMS practices.
- 5.2 Any move to Level 3 delegated commissioning would require the approval of member practices in line with the terms of the CCG Constitution.

6.0 Equality Implications

- 6.1 Delivery of the GPFV and wider primary care transformation programme should support delivery of our equality duty and positively contribute to a reduction in health inequalities and variation across Brent and its communities. Our duties will be reflected in the design of schemes, services and programmes of work related to primary care transformation.
- 6.2 The PMS Review will include explicit consideration of the potential impact on different groups and how any subsequent change in service offer made by practices might impact different groups of patients in different ways. We will produce equality and quality impact assessments and work with providers to ensure patient views and needs are taken into account in any forward planning.

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