NHS
Merton
Clinical Commissioning Group

MERTON CLINICAL COMMISSIONING GROUP
GOVERNING BODY

Date of Meeting: 30th November 2017

Agenda No: 10.1 **Attachment:** 12

Title of Document: Update on Merton CCGs Primary Care Strategy for Governing Body	**Purpose of Report:** For Note
Report Author(s): Dr Karen Worthington, Rebecca Blackburn, Lucy Lewis.	**Lead Director:** Andrew McMylor

Executive Summary:

A consensus about direction of travel was reached in 2016 with the development of the Primary Care Strategy for Merton following a period of engagement with a variety of stakeholders, including our member practices, adult and children's social care colleagues, community services and our Patient Engagement Group (PEG).

This paper provides the governing body with an update on the key health and wellbeing priorities that have been achieved to date, and are continuing to be delivered since the strategy was refreshed earlier this year. In addition, the paper gives a high level update on the key priorities in the strategy for primary care, patients and practices for the remainder of the year.

Key sections for particular note (paragraph/page), areas of concern etc:
The executive summary and conclusion.

Recommendation(s):
The Governing Body is asked to note the Update on Merton CCG's Primary Care Strategy.

Committees which have previously discussed/agreed the report: None

Financial Implications: n/a

Implications for CCG Governing Body: n/a

How has the Patient voice been considered in development of this paper:
PEG through previous engagement

Other Implications: None.

Equality Assessment: NA

Information Privacy Issues: None

Communication Plan: All documents appearing on Part 1 of the Governing Body meeting will be accessible via the CCG's website.

Update on Merton CCGs Primary Care Strategy
Governing Body November 2017

Executive Summary

This report largely covers delivery by the Merton Primary Care Team in respect to the second iteration of the primary care strategy in January 2017.

Key achievements in Merton

- Investment in primary care; more and better quality **access**. Merton has produced around 50,000 extra GP appointments available this year, c. 4000 extra each month between 8am and 8pm 7 days a week.
- Two brand **new hub** sites one each side of the borough. Better access across both sides of the borough compared to one side this time last year. Over 90% of **patients** feel they have easy or **very easy access** to the new service and 95% **would recommend** the service to their friends and family.
- PMS Review - Merton were the **1st CCG in London** to issue a complete offer that could be signed up to immediately following a successful review process with positive engagement with the LMC.
- Further investment in primary care; Six **QIPPs** live and planned for 17/18 to deliver strategic priorities; reduction in A&E attendances, winter resilience, unwanted variation in referrals, reduction in avoidable acute spend.
- A new approach to **GP engagement** and relationship building with a focus on change management, delivered by **partnership managers** and **strong clinical leadership**, has proven an effective enabler to deliver key achievements.
- New quarterly protected learning events to support **workforce** and **system resilience**.
- An expanded multi-disciplinary team model of **proactive care** for complex patients is underway through development of **integrated locality teams**. A spotlight is on the end goal for an **effective Multi-Speciality Community Provider model**.
- Six **strategic estates** developments are **on track.** Key objectives are to enhance general practice provision across the borough and **reduce health inequalities** as part of the East Merton Model of Health and Well-being.
- The LDU senior leadership has committed to **support early adopters** of **new models of care** such as the emerging Primary Care Home model.
- Delivery and development of our local GP federation; a robust and **dedicated focus** has resulted in new successful contracts.
- As part of **delegated commissioning** the primary care operations groups and committee have managed the **early intervention** and **quality assurance** of contractual arrangements.
- Positive patient outcomes through social prescribing pilot – noticeable reduction in use of inappropriate GP appointments and **all patients** who used the tool reported an **improvement** between May and September.
- On-going focus on GP **IT interoperability** to help facilitate new schemes and the changes in how services are accessed by patients.

Introduction

A consensus about direction of travel was reached in 2016 with the development of the primary care strategy for Merton following a period of engagement with a variety of stakeholders. These included our member practices, adult and children's social care colleagues, community services and our Patient Engagement Group (PEG). The strategy aimed to address some key health and wellbeing priorities in Merton and to deliver improvements both now, and in the future for our patients and practices.

The strategy included a ten-point plan that described the principles and approach to the transformation of primary care in Merton:

1. *To provide high quality, holistic care leading to good health and wellbeing*
2. *To achieve a reduction in observed health inequalities and practice variation*
3. *To provide evidence based care*
4. *Care to be delivered by a highly skilled, sustainable workforce*
5. *To be innovative in its approach using new models and IT*
6. *To be proactive and reactive as needed*
7. *To be informed by Public Health data and focus on prevention of illness*
8. *To achieve integration across all providers of care in its widest sense moving towards an Multispecialty Community Provider (MCP) model of care*
9. *To harness resources from within local communities and promote self-care and support*
10. *To produce efficiencies to release savings that will drive transformation*

Over the last year since the strategy was launched, interim presentations have been given to the Merton Health and Wellbeing Board (HWBB), our PEG and member practices. The purpose of this update to the Governing Body is to revisit some of the priorities identified in the primary care strategy and to check progress against them. In addition, the last year has seen the development of the Local Delivery Unit with Wandsworth CCG, and the emerging SWL Alliance, both of which have broadened the scope of primary care in Merton.

Key Themes of the Strategy

It is pleasing to report that significant new investment has been put into primary care services for patients by deploying GPFV[1] funding, Estates and Technology Transformation Funding (ETTF)[2], National Resilience Funding[3] and also new investment by Merton CCG into the PMS contract review to ensure practices' finances were not destabilised, and invest to save schemes[4]. The money has been used to fund the following improvements in care and drive transformation.

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[1] https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

[2] https://www.england.nhs.uk/gp/gpfv/infrastructure/estates-technology/

[3] National resilience funding supported practices registering patients from the dispersed Wilson list, assisted a practice in CQC special measures and funding has been awarded in 17/18 to several practices meeting the scheme's criteria.

[4] invest to save schemes-frequent A+E attenders, COPD winter resilience scheme and care home scheme

- **Improving Same Day Access to Primary Care**

In line with point 2 and 5. '*Reduce inequalities and variation…and to be innovate...using new models*', the primary care team have delivered a significant increase in access to primary care by three routes:

1. **Improving Access to Primary Care Local Incentive Scheme (LIS*)***. All 23 Merton practices are participating in the scheme (one in progress under new contract) which delivers more appointments in both core and extended hours, provides dedicated slots for children needing same day access and also allows for the appropriate redirection of patients back to primary care from any urgent care provider.

2. **2 x GP Access Hubs East and West Localities**. Hubs are open Monday to Friday 5pm-8pm, 8-8 pm Saturday and Sunday in the east, and 8-8 pm Saturday in the west. Both are open 8-8pm on Bank holidays. Hubs have multiple access pathways; by appointment via 111, GP practices and local emergency department. Identified wound care need is delivered by nurses. The model of care is evolving and from 1/10/17 the contract is held by Merton Health our GP federation, providing local ownership of the quality of the service.

   In line with point 5 again, for utilising *'innovative IT'*, clinicians in the hub have full access to the medical records with patient consent, and appointments from practices can be booked electronically. This facility improves patient safety and experience and ensures that the hub consultations are offered in an integrated way rather than as a stop gap or duplication. A further enhancement from 1/12/17 will be the provision of routine GP appointments providing more convenience for working people, some routine nursing services such as spirometry and cervical screening and we will also be piloting routine telephone appointments with a GP.

   The clinical model has been co-designed with input from clinicians in the CCG'S clinical reference group and Merton Health clinicians, and the primary care team have also worked with our local emergency departments and NHS 111 to ensure a robust model.

Overall Merton has around 50,000 extra GP appointments available this year, below is the most recent data showing increased appointment numbers, utilisation of the hubs and patient feedback on the hub service:

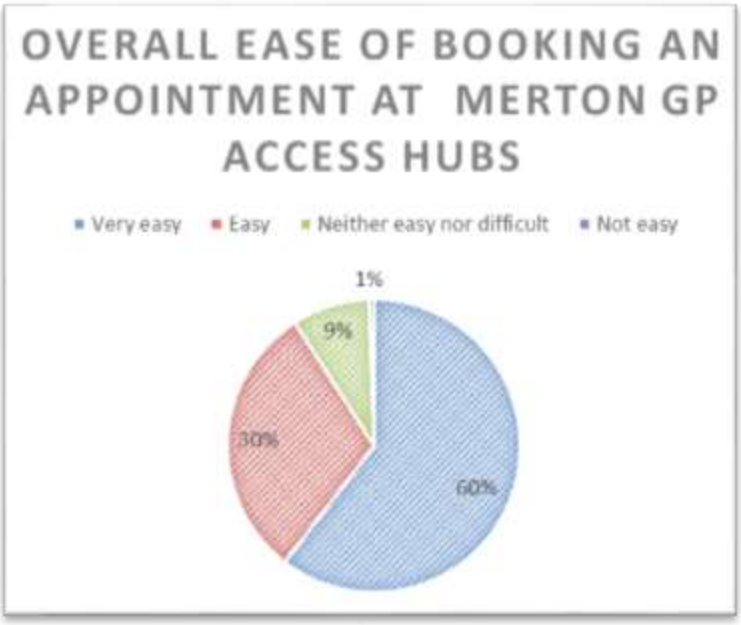
- 3,700 extra appointments at Merton's 23 GP practices every month many of which will be earlier in the morning or later in the evening than in the past; and
- 1460 appointment slots each month at two GP hubs.

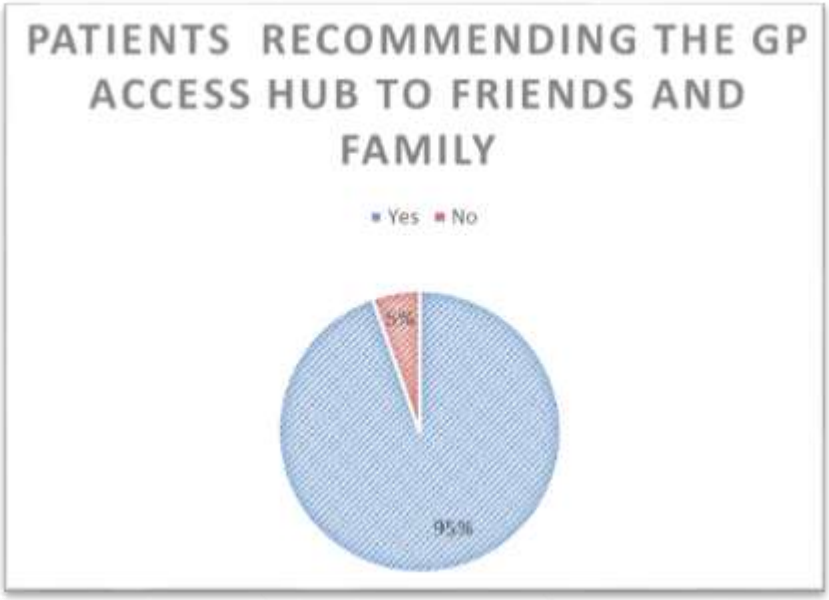
That is a total of 5,100 appointments available each month and c.4,000 additional appointments each month when compared to last year.

The utilisation of the hubs continue to climb each month with usage in July presenting the highest demand so far of the new service. We anticipate utilisation to rise further as direct booking is available from October at both sites.

Month (2017)	Utilisation (across both hubs)
April	47%
May	47%
June	59%
July	74%
August	69%
September	73%

Patient feedback has been collected since April to gather patients' views of our new service. The feedback has been extremely positive. As the service develops we will be looking to our patients to assess how well the service is working.





3. A **Quality Access Scheme** was offered to all practices in September. The scheme focuses on patient experience and aims to help vulnerable groups. Its content was designed using feedback from patients (both locally and using the national patient survey) and with some suggestions from Merton Healthwatch. This funded piece of work consists of four modules aimed at upskilling frontline staff (improved telephony in practices led by the Merton practice managers' forum, a focus on access for children including practice based awareness campaigns, improved experience for carers and ensuring ease of registration for vulnerable groups including migrants and the homeless).

- **Proactive Care**

There is a focus on proactive care in several of our work streams, in line with our ten point plan, in order to improve outcomes for patients, manage variation and to realise financial savings. This has been done by identifying vulnerable cohorts and high users of services for earlier interventions.

Examples include:

1. Introduction of a new PMS Premium Service to ensure that all categories of frailty are identified on primary care registers so that patients can be offered appropriate interventions for self-care.

2. A funded Frequent A&E Attenders Scheme for both adults and children to offer these patients a longer appointment in primary care to see if their needs can be met more appropriately elsewhere.

3. A Chronic Obstructive Pulmonary Disease (COPD) winter scheme as part of Practice Variation Phase 3, identifying patients at higher risk and working with them to prevent hospital admission.

4. A care home scheme open to practices caring for significant care home populations. This provides resources to support advanced care planning and improved end of life care for the most severely frail to prevent unnecessary hospital attendances and admissions.

5. Continuation of the Pathology Improvement Scheme as part of Practice Variation Phase 3, to include education and learning, sharing good practice to manage variation in testing behaviour and ensure more appropriate testing for patients.

- **Integration of Services and Prevention of Admission**

Our plan calls for '*integration in its widest sense*', through practice visits and locality meetings we have raised awareness and utilisation of CLCH community services such as HARI and MERIT which provide care closer to home. A recent Practice Leads Forum focussed on improved working across the primary care/social care interface. We have been contributing to the work to develop Integrated Locality Teams based around GP practices. The final model

will deliver an integrated Multidisciplinary Team approach between primary, community and social care to enhance care for patients, and will also have a proactive arm linked to the primary care frailty registers and case management.

- **Training and Education - Workforce Development**

Training and education is central to the strategy to deliver a highly skilled workforce and evidence based care and we are committed to championing a, '*high quality, sustainable workforce*'. Protected Learning Time (PLT) for teams has been prioritised and funded allowing three of four quarterly learning events to take place to date. These have been hosted jointly between the primary care team and Merton CEPN and have provided opportunities for all primary care staff, clinical and non-clinical.
The clinical programmes have aligned with some of the planned care work streams in diabetes and cardiology and the most recent one focussed on mental health. Additional training such as sign posting training, dementia friends training and carers support training will be delivered soon as part of PMS Premium Specification mobilisation. The primary care team have also assisted practices to access medical assistant training, training on DXS and Kinesis and jointly with the CEPN, won a successful bid to Health Education England to develop 2 full days of holistic paediatric care training for our practices.

- **Supporting Skill Mix**

Widening the skill mix is important to the future sustainability of our practice teams to ensure that the increasing demands on primary care can be met during a time of recruitment difficulties for some categories of health care professional. Widening the skill mix provides a more cost-effective workforce solution for practices and also broadens choice for patients. Our plan is to, '*produce efficiencies to…drive transformation'*, and the LIS funding for improving access has allowed some practices to employ new team members, such as nurse practitioners and physician's assistants and to extend the role of existing staff, such as health care assistants. The primary care team have also supported a Merton wide bid, involving 12 practices for clinical pharmacists which is being considered by NHSE.

- **Focus on Prevention of Ill Health and Reduction in Health Inequalities**

Merton has longstanding health inequalities between the east and the west of the borough. Our Primary Care Strategy acknowledges these inequalities and ensures that prevention is built into all of our work streams. Some examples as follows: -

1. During the recent PMS review we identified areas that would incentivise prevention in primary care services including improving uptake of bowel screening, identification of frailty with a view to proactively preventing ill health, ensuring maximal uptake of immunisations both in children and adults and prevention of diabetes complications by focussing on those with the least well controlled diabetes.

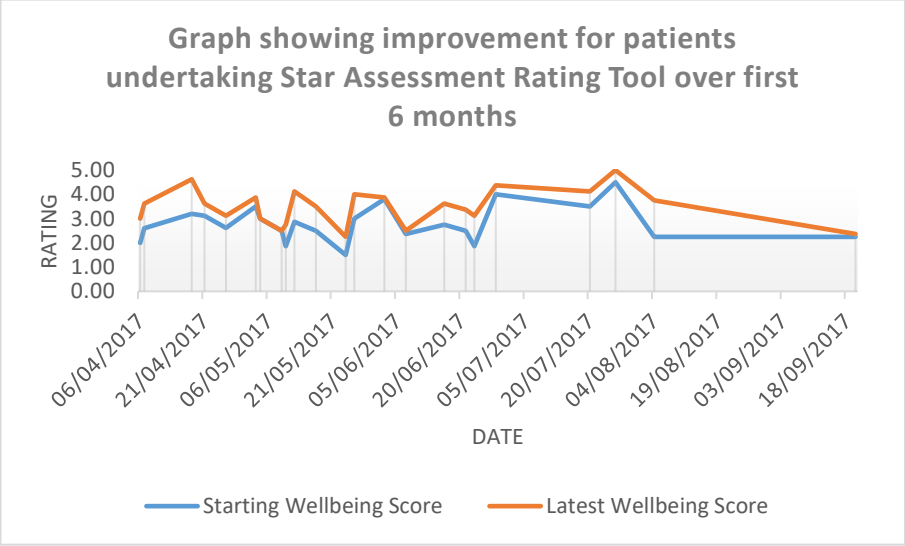
2. Schemes to focus on frequent users of urgent care and patients with COPD –both of these issues are more prominent in the east of the borough and linked to higher rates of long term conditions, smoking, deprivation and mental health problems.

3. The development of the East Merton Model of Health and Wellbeing to be delivered from new premises based at the old Wilson hospital site. It is hoped that the combination of a health and wellbeing campus with easy access to community based medical care will reduce health inequalities in the east of the borough by addressing the main determinants of ill-health in one model. There has been significant community input into the future design and work is ongoing with the east Merton practices to develop the primary care provision.

- **Social Prescribing**

Social Prescribing was identified in the strategy as part of the future offering within primary care to better tackle some of the non-medical determinants of health such as social isolation and employment issues. In accordance to our plan to, '*harness resources from within local communities and promote self-care and support*', a pilot has been underway since January 2017. Wide Way and Tamworth House practices and a separate but parallel care navigation service is available at the Nelson. Data so far shows benefits to patients' wellbeing and self-management, and also an overall reduction in utilisation of GP appointments.

The evaluation tool showed that all patients who used the tool reported an improvement between May and September. A breakdown of the sub-categories of the measure shows that on average participants improve in all categories between their first and latest Social Prescribing appointments.



There is now an appointed clinical lead for social prescribing and the pilot is being led by primary care managers as part of the LDU. A business case is being developed to support the wider roll-out of the model across other practices in East Merton throughout the coming year.

- **Practice Variation and Demand Management**

Whilst much of the variation in Merton can be explained by factors such as deprivation and disease burden, the primary care team has worked to explore and manage unnecessary variation. This work stream drives point two of our plan to, '*reduction in health inequalities and variation'*. The approach taken has been to share data and to use peer review and education to deliver a reduction in unwanted variation. This has been achieved through the new approach to GP engagement and change management through a Practice Variation (PV) work stream which is now in Phase 3. Some schemes align to QIPP.

1. Two rounds of PV (Phase 1 & Phase 2) have been completed to all 23 Merton practices by the clinical leads and partnership managers. Results of clinically-led discussions and practical management solutions in Phase 1 (such as encouraging in-house review of referrals and the introduction of a locum toolkit) significantly reduced GP initiated first outpatient appointments by 7% with savings of circa £400K 16/17. Peer review and locum toolkit have been incorporated formally in the new PMS Premium Service Specification for sustainability.

2. Phase 2 PV resulted in pathology testing savings of £60k for 15/16 and £171k in 17/18 to date. This was achieved by upskilling practices about community pathways, providing clinical guidelines for the use of certain tests,

3. Phase 3 visits with an expanded focus on pathology, and COPD are being booked for November/December 2017. Phase 4 will be launched in Q1 18/19.

4. Kinesis is now available in all practices to offer an alternative to traditional outpatient referral and is part of the PMS Premium Service Specification for Year 1.

5. DXS has been made available in our practices to ensure clinicians have access to the most up to date clinical guidelines and local pathways.

6. A lot of work has been done in collaboration with the planned care team as part of the ECI SWL review. This will ensure equity of access to evidence based treatments for our patients.

- **Estates Improvement**

Modern, fit for purpose primary care estates is vital for the provision of high quality care. The primary care team has supported practice applications both to the ETTF and the improvement grant (IG) fund to help practices to improve their premises. In addition there has been involvement by the primary care team at SWL level at the Strategic Estates Board as part of the LDU. These projects will underpin the migration to more integrated service delivery, in line with our MCP trajectory, from multiple, fit for purpose locations.

Key projects in 2017 include: -

1. IG schemes for Central Medical were awarded this year for a loft extension with ground floor extension and other improvements;

2. James O'Riordan won a bid to remove existing doors and replace with automated door closer equipment;

3. A successful bid for improvements to Wide Way Surgery is also underway to extend and provide six new consulting rooms;

4. The Wilson Health and Wellbeing Campus programme and project boards continue to work together on developing appropriate clinical and community services on the old Wilson site. A communications and engagement strategy is being developed for all stakeholders, with regular updates to HWBB and PEG;

5. Successful ETTF bids were won in 16/17 for Colliers Wood Surgery's co-location to new premises at Merton Vision on Clarendon Road, and for Princes Road Surgery's relocation to refurbished premises at Patrick Doody Clinic, Pelham Road. Both schemes are being monitored through the SWL Strategic Estates Board, and the Local Transformation Board.

6. A scheme for new purpose built primary care facilities at the Rowan Park site is also underway. We are working with London Borough of Merton over the plans for the S106 community centre at the site. A comms and engagement strategy is being developed for all estates schemes.

- **IT Projects**

Improvements in IT in primary care is a key enabler needed for transformation. Despite challenges in some practices with IT issues the following IT projects have been delivered:

1. **DXS** - a large piece of work has been done to get all clinical guidelines, pathways and referral forms onto DXS and for practices to be trained how to use it.

2. **Kinesis** to allow clinicians to obtain consultant advice. The use of this advice and guidance tool has led to a reduction of GP referrals into our local acute and better use of alternative community services.

3. **EMIS** access in the two GP access hubs and direct booking into the hubs

4. **OptimiseRX** software roll out to provide electronic prescribing support in practices.

- **Provider Development with Merton Health, GP Federation**

All 23 practices are members of Merton Health, our local GP federation. As commissioners, it is important that we have a robust primary care provider organisation to contract with to deliver the new models of care which are necessary for the future sustainability of our local health care system. To this end the primary care team has worked robustly with the federation management team; keeping services local and integrated:

1. **Access LIS monitoring contract** –ensures that all practices have been able to participate and encourage upscaling through networking and consideration of joint recruitment;

2. **Access Hub contract** - delivery from 1/10/17

3. **Referral Management Centre pilot** - The quality assurance of the pilot is being run by Merton Health.

Other contributors to the success of Merton's Primary Care Strategy

The work to deliver the aims and objectives of the Primary Care Strategy for Merton have been done in collaboration with other directorates in the CCG, and Public Health colleagues who all work together to improve outcomes for Merton residents.

Additionally, the **PMS Review** mandated by NHSE and devolved locally has allowed the CCG to offer a refreshed set of PMS Premium Specifications to practices that will deliver improvements in care for patients. This piece of work was clinically led and took a positive approach to successfully deliver a new set of KPIs in collaboration with Merton and London wide LMC. The mobilisation and sign up to these new specifications will take place from October 2017 through to April 2018. To date 9 practices have signed up and all practices have had the opportunity for one to one meetings to discuss their offer.

Merton PMS Premium Specifications October 2017:

1.1 Improving Access to Services for Carers
1.2 Opening Hours, Appointment Numbers and Facilitation of Access for Patients to Local GP Access Hubs (as per current requirements)
2.1 Engage with and demonstrate actions (as per Practice Action Plan) have been achieved from Working with the CCG's Medicines Optimisation Team
2.2 Support Practices to work towards Achievement of HSCIC Targets for Electronic Prescription Service (EPS)
3.1 Uptake and Utilisation of Advice & Guidance Tool (Kinesis) amongst Practice permanent referring staff to help reduce referrals to Secondary Care
3.2 Peer Review of Referrals to Secondary Care for 8 Highest Specialties across the CCG (or those deemed appropriate by the CCG as part of CCG's Demand Management work)
4.1 Supporting Proactive Care for People Living with Mild and Moderate Frailty - Healthy Ageing for Patients Aged 65 or Older
4.2 Improved Understanding of why Patients are Exception Reported in QOF for 2 Diabetes Markers: DM006 and DM009
5. Practice Development using one of the Ten High Impact Actions – Implementation of Active Signposting and Dementia Friends Training
6. Prevention:
    - MERTON PS 6 OPTION A: Improved Uptake of Bowel Screening in Non-responders in Patients Eligible for the National Screening Programme Aged 60-74

- MERTON PS 6 OPTION B: Improved Uptake of Childhood Immunisation - 5-in-1 Vaccine by 1 Year
- MERTON PS 6 OPTION C: Improved Uptake of Childhood Immunisation - Aged 2+ and 5+.
- MERTON PS 6 OPTION D: Improved Uptake of Immunisation - Flu Immunisation 65+
- MERTON PS 6 OPTION E: Improved Uptake of Immunisation - Flu Immunisation - Under 65 'At Risk'
- MERTON PS 6 OPTION F: Improved Uptake of Immunisation - Pneumococcal Immunisation 65+

7.1 Wound Care

7.2 Administering Non-Contraceptive Hormonal Implants or Injections

Looking to the future – our roadmap

- New models of care
- Integrated Locality Teams
- Improvements to GP IT (including use of new technology)
- Ensuring the patient voice is heard in all areas of work
- Continued positive engagement with GP membership

New models of care all require primary care to work on a larger footprint with a focus on population health as well as individual care for patients. Our 23 practices are currently individual contractor businesses and the future requires them to upscale to meet the challenges both now and going forwards. Merton predicts both an increase in population size and also an increase in older people who may require more services both from health and social care. Most of the pilot sites nationally for new care models are based on a population size of 30-50,000 and this is also the vision of our STP in South West London.

The journey towards Integrated Locality Team (ILT) working and the development of a Multidisciplinary Community Provider (MCP) for Merton is underway but requires more intense primary care focus to reach a fully developed model. The primary care team would like to see the opportunity of a functioning MCP by 2019. Work has begun with the membership to try to shift ways of thinking and determine how this will look for general practice. Our priority is to add value and efficiencies not duplication and careful exploration of change and impact will be required to secure an effective working model.

The LDU senior leadership has committed to support early adopters of new models of care. In east Merton there is a network of four practices, with two planning to join, who have recently been accepted as part of the national Primary Care Home (PCH) model community of practices. Examples of benefits already achieved in working in a networked way include collaborating for a clinical pharmacist bid; developing a locum staff bank; plans to employ a CQC compliance officer and, a new approach to care of diabetic patients. PCH have networked their IT systems to facilitate working at scale and plan to set up video consulting.

Practices are keen to embrace new technology but continuing IT issues in some of our surgeries affects both business as usual, as well as future plans. The current issues have

been escalated via our LDU senior leadership for resolution as they impact both daily working efficiency in practices and initiatives such as the use of DXS. Future opportunities to use IT to enhance clinical practice include the possibility of e-consultations and video consultations as well integration of IT across care providers.

The patient remains at the centre of all that we do in primary care. It is vital that new services and ways of working are informed by the patient voice and communicated efficiently, appropriately and reach all parts of the community. A variety of approaches are needed including working with our PEG, seeking individual feedback, community conversations and engagement events, use of social media and working with our local councillors who have an additional reach into their communities.

Conclusion

This paper identifies that much of the Primary Care Strategy has already been delivered especially in relation to improved access in primary care, and this is testament to the willingness of our member practices to offer more access both in practices and via the two new GP access hubs. However there is no room for complacency and even within the access work there are plans for ongoing service improvements and the possibility of widening the scope of the hubs. We have built up positive and strong engagement with our GP membership throughout 16/17, and will continue this in order to support primary care development, further key transformation pieces and promote good practice.

Some areas of the strategy remain a ‘work in progress’ but with clear plans and intention for delivery, such as the East Merton Model of Health and Wellbeing with links to Estates improvements, and the Integrated Locality Teams. The journey towards new models of care and primary care at scale is reflected in the paper and will now start to pick up pace into 2018/19 through the joint efforts of our membership the primary care team.