right care
right place
right time
right outcome

NHS
Merton
Clinical Commissioning Group

MERTON CLINIVAL COMMISSIONING GROUP
GOVERNING BODY

Date of Meeting: 21st July 2016

Agenda No: 6.1 **Attachment**: 06

Title of Document: Primary Care Strategy	**Purpose of Report**: For Approval
Report Author: Karen Worthington (East Locality GP Lead)	**Lead Director**: Cynthia Cardozo (Director of Transformation)

Executive Summary:

The aim of this document is to outline how Merton CCG is to deliver on its aspiration to provide the right care, in the right place at the right time and with the right outcome. The direction of travel is one of integration between services, delivered locally as outlined in the Five Year Forward View.

The proposed solution is for networks of Practices to work together to provide care to larger populations of 30,000 to 50,000 people along with other primary care professionals, social care and the third sector. By up-scaling, improving integration and utilising all of the local community resources we could achieve both the local and national aspirations. The model of care described as Multispecialty Care Providers (MCPs) in the Five Year Forward View is considered in the GP Forward View as 'a fundamental element' of future health and social care system planning.

Based on a population size of 205,100, and in keeping with the preferred model it is proposed that 4 networks of health care providers each servicing approximately 50,000 people could be set up. These networks which would include the Practices would form localities – 2 in the east and 2 in the west. The term locality is used to describe the form and function of a geographically based system, with Practice aligned teams from the community provider and social care, and utilising the resources of the local community. It is suggested that these localities would then be in a position to fully develop into a MCP type provider of services over a defined time period, and through collaboration achieve service integration and co-location.

The strategy recommends three components to the contracting model for primary care: (i) Accessible Care, (ii) Proactive Care, and (iii) Co-ordinated Care, (as set out in London's Strategy Framework for Primary Care). All of the functions of the model would be monitored via locality meetings when the 2 networks for East and the 2 in the West would come together as a multidisciplinary group to review performance and share learning through peer support.

Cont/d Overleaf

There are a number of enablers required to deliver this strategy:

1. A comprehensive IT strategy
2. An estates service development plan
3. A training and education plan.
4. Appropriate use of electronic tools and registers such as CMC.
5. Referral support for clinicians via DXS, kinesis and alternative community pathways.
6. A willingness to engage fully with the 3rd sector and explore the potential value of social prescribing.
7. The Better Care Fund.
8. A commitment to work in innovative ways with our community provider and across the primary and secondary care interface.
9. An appraisal of the evidence and best practice to understand how it could be applied to Merton.
10. A new clinical leadership structure
11. Programme of engagement with all key stakeholders

Key sections for particular note (**paragraph**/**page**), **areas of concern etc**:

- Locality description.
- Components to primary care model.
- Enablers.

Recommendation(**s**):
To develop a detailed implementation plan to deliver the primary care strategy covering the following;

- The criteria for site selection for rapid access to primary care.
- Building on previous work, to finalise an options paper which reviews the future of urgent care services.
- Complete cost analysis for the rapid access to primary care service model, and possibly increased GP input into CPAT and early hospital discharge above core service needs to be modelled.
- To develop a timeline and agreed measures of performance.

Committees which have previously discussed/agreed the report:
Primary Care Commissioning Committee, 21st June 2016.

Financial Implications:
None at this stage.

Implications for CCG Governing Body:
The proposal aligns with SWL STP, and ensures there is a system-wide approach, which will enable the delivery of new models of care to meet Merton's population needs.

How has the Patient voice been considered in development of this paper:
To date, the patient voice has not been obtained in developing these proposals. This paper seeks approval to commence consultation.

Other Implications: (**including patient and public involvement/Legal/Governance/Risk/Diversity/Staffing**)
Further engagement and consultation with a range of patient and public groups will be required following approval.

Equality Assessment:
An Inequalities Impact Assessment is yet to be completed and specialist public health analysis of the specific needs of each network will be commissioned to help develop the model of care and reduce inequalities.

Information Privacy Issues:
No patient identifiable information has been used in developing the proposals.

Communication Plan: (**including any implications under the Freedom of Information Act or NHS Constitution**)
The following high level Communication Plan is outlined below:

- The preferred Locality structure is discussed at Locality GP forums in mid-September using a format of facilitated workshops. Where necessary, follow-up discussions will take place with individual GP Practices.
- Discussions with our key partners, (e.g. Local Authority teams, (including public health), Community Services, Mental Health Trust), residents and registered patients, (including Merton's Patient Engagement Group), will take place from August.
- Implementation and notice of a change is communicated by the end of November, following presentations at key meetings.
- Mobilisation is planned for 1st April 2017.

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A Primary Care Strategy for Merton

1.0 Introduction

1.1 A robust primary care strategy is essential to the delivery of the local health and social agenda in Merton both now and in the future if Merton CCG is to deliver on its aspiration to provide the right care, in the right place, at the right time and with the right outcome[1]. Primary care also sits centrally in the national strategy for the NHS described in the 5 year Forward View[2] which describes the challenges for the NHS in caring for a population that is living longer, often with more complex health needs and multiple co-morbidities. This document outlines how 'the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health and between health and social care'. The direction of travel is one of integration between services in new models of care which will ensure that far more care will be delivered locally.

1.2 Merton proposes a ten point plan describing its Primary Care Strategy and what it should look like and deliver.

1. High quality, holistic care leading to good health and well being.
2. A reduction in observed health inequalities and practice variation.
3. Provision of evidence based care
4. Be delivered by a highly skilled, sustainable workforce
5. Be innovative in its approach using new models and IT
6. Be proactive and reactive as needed
7. Be informed by Public Health data and focus on prevention of illness
8. Achieve integration across all providers of care in its widest sense
9. Harness resources from within local communities and promote self care and support
10. Produce efficiencies to release savings that will drive transformation

2.0 Drivers for Change

2.1 It is widely accepted that the isolated GP model seems to be no longer fit for purpose in the current climate of financial constraint and an increasing burden of patients with complex needs requiring care in the community.

[1] "Right care, right place, right time, right outcome – year 2" Merton CCG 2015/2016 Operating Plan Refresh 19 March 2015

[2] https://www.england.nhs.uk/ourwork/futurenhs/nhs-five-year-forward-view-web-version/5yfv-exec-sum/

2.2 At the same time General Practice is under unprecedented strain with workforce shortages and low morale. The current fragmentation of the system is exacerbating these issues and reducing the quality of the patient experience. Interestingly, the Five Year Forward View asserts that 'the foundation of NHS care will remain list-based primary care' recognising the cost effective role of General Practitioners in case managing the whole person, advocating on behalf of the patient and navigating them through the healthcare system in the most appropriate way.[3] One possible solution therefore is for networks of Practices to work together to provide care to larger populations of 30,000 to 50,000 people along with other primary care professionals, social care and the third sector. By up-scaling, improving integration and utilising all of the local community resources we could achieve both the local and national aspirations previously described.

2.3 All over the country, in vanguard sites, there are already examples of Practices working within such models described as Multispecialty Care Providers (MCPs) in the Five Year Forward View. In the General Practice Forward View (April 2016)[4] MCPs are referred to as 'a fundamental element of the plan' with plans to contractualise the model on a voluntary basis from April 2017. Additionally, in some sites the Primary Care Home Model[5] is being piloted which involves a devolved, capitated, unified budget to ensure accountability and balances personalised care with population health needs.[6]

3.0 How could this work for Merton?

3.1 Merton Facts:

- Population 205,100 (2014)[7].
- x24 GP Practices operating out of 26 premises.
- An overarching GP federation.
- Served by x3 acute trusts , x1 community provider, x1 local authority and x1 mental health trust.
- Well recognised health inequalities between the east and the west of the borough.

3.2 Based on a population size of 205,100, and in keeping with the preferred model it is proposed that 4 networks of health care providers each servicing approximately 50,000 people could be set up[8]. These networks which would include the Practices would form localities – two in the east and two in the west. The term locality is used to describe the form and function of a geographically based system, with Practice aligned teams from the community provider and

[3] http://www.theguardian.com/society/2014/jun/17/nhs-health
[4] https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf
[5] http://www.napc.co.uk/control/uploads/files/1445347156~Primary_Care_Home_Paper_without_Ack_v1.pdf

[6] Home run for integrated primary care? BMJ 2016;353:i2922

[7] http://www.merton.gov.uk/jsna_summary_document_2015_final.pdf
[8] Primary care hubs paper 1/6/16 author Ben Homer

social care, and utilising the resources of the local community. A sense of place is crucial to the ethos of this approach and this was clearly observed by those of us who recently attended the visit to Bromley by Bow. It is suggested that these localities would then be in a position to fully develop into a MCP type provider of services over a defined time period, and through collaboration achieve service integration and co-location.

3.3 Historically and recently, we have good evidence of well established local working relationships between Practices, and anecdotally clinicians prefer to work alongside locally based colleagues. It should be noted that although Practices will sit within one of the four networks that their registered populations may span more than one locality. It is important therefore that for core primary care services such as community nursing that the community provider teams retain a Practice- focussed approach to allow more cohesive team working with GPs which is critical to the care of patients with complex needs.

3.4 The geographical arrangement also acknowledges the health inequalities that exist within Merton between the east and west and also other demographic differences which means that the model of care can be tailored to the needs of the local population- this approach is already being taken in the development of the East Merton Model of Health and Wellbeing and has support from the Health and Wellbeing Board (HWBB) and patients. It provides the opportunity to develop social prescribing as an intervention in Primary Care by clearly identifying sites of local community support such as community centres and children's centres and ensures that all Practices will have the chance to work in this way. A social prescribing pilot is already planned as part of the HWBB's commitment to the East Merton Model of Health and Wellbeing with some funding already identified. Close collaboration with CLCH will also be needed to ensure the locality arrangements fit their operational delivery model and mutually agree sites from which to provide clinic based services. It is proposed that there will be 4 sites, one in each network that will have services co-located with the community provider.

3.5 It should be noted however that some areas of service provision will need to be shared across the whole of Merton such as the urgent care centres, dementia hub, hospice services and the Nelson offering specialist care. The proposed new development at the Wilson will in the future offer both services targeted at the local community with a focus on reduction of health inequalities, plus some borough wide services.

3.6 Merton CCG is committed to ensuring that all member Practices have the chance to work in a networked way, ultimately leading to the development of full MCP sites, so that all patients in Merton will realise the benefits that this model will bring, regardless of where in the borough they live. Having said this there would still be an opportunity for Practices to work collaboratively outside of their network as well if they choose to for specific reasons of innovation. The CCG envisages that the Federation in Merton will play an important role in delivering the new models of care with all commissioning decisions being underpinned by robust procurement advice.

3.7 See Appendix 1 for map of Merton with suggested networks, localities and community sites.

4.0 Locality description

4.1 It is anticipated that each locality would contain:-

- GP practices
- Community nursing including specialist nursing
- Social care
- Mental health including IAPT services
- Allied health professionals including community pharmacy
- 3rd sector organisations
- A clear route to diagnostics and community pathways
- A CCG partnership manager
- Public health advice
- Health visiting and links to school nursing in local schools

4.2 Having established form, function would flow from the key demands of modern primary care and the culture it is based upon. The latter is well described by the WHO definition of quality in healthcare[9]

- ✓ Effective
- ✓ Efficient
- ✓ Accessible
- ✓ Person-centred
- ✓ Equitable
- ✓ Safe

4.3 The care provision would need to cover all aspects of care with an understanding that patients may need different types of care at different times in their lives. These should be delivered seamlessly and where secondary care is required, the interface should function appropriately.

4.4 The role of GPs as 'specialist generalists' needs to be utilised to its full potential and this will only be possible with improved skill mix in primary care to free up GP time to deal with more complex cases. The experience of senior clinicians in Merton also needs to be deployed in mentoring and education as a way of supporting skill mix in practice and assisting with workforce succession.

4.5 Currently the contracting model for primary care diverts attention away from this task and sets overlapping targets against which GPs are performance managed and paid (PMS KPIs, QUoF, AUA DES). These also potentially overlap with the commissioned outcomes measures for the new community provider. Clearly if all providers in the locality could work collectively for the same population with agreement on its target caseload this would lead to a leaner approach and allow a real and meaningful MDT model of management to be achieved.

[9] http://www.who.int/management/quality/assurance/QualityCare_B.Def.pdf

5.0 The components of the model

5.1 These reflect the three aspects of care that matter the most to patients identified by the strategic commissioning framework "Transforming Primary Care in London" which was developed by NHSE in 2015.[10]

5.2 Co-ordinated care

The chosen approach of the CCG is detailed in the Practice variation work stream. This has several strands running concurrently including Practice based audit, peer review of referrals, the use of technology to assist referrers (DXS and Kinesis) and a pilot RMC to be delivered by the Federation. Additionally since 1/4/16 the CCG has commissioned Connect Health to provide a new comprehensive musculoskeletal service. It is hoped that all of these approaches will reduce unnecessary referrals to secondary care and release financial savings for reinvestment and protect the financial viability of the CCG. The feedback from the Practice visit programme and audit running from June to September 2016 will identify areas to target improvement of planned care pathways and make more services available in the localities.

5.3 Proactive care

This would involve identifying high risk populations such as those with long term conditions including mental health problems, vulnerable and frail housebound people, nursing home residents and high users of emergency departments. Agreed risk stratification tools could be utilised to identify the target population such as those with moderate or severe frailty, and develop an integrated *locality owned* approach to these patients with a focus on advanced care planning and shared, agreed ceilings of care. This approach should deliver a higher number of patients being cared for in their 'preferred place of care' and also reduce inappropriate ED attendances and admissions. By using clinical administrators shared across sites it would be possible to develop a planned programme of care for patients on specific registers and improve uptake of screening and prevention. Importantly, integration of IT systems and wider use of electronic registers such as CMC would reduce duplication of effort in information recording and allow any clinician to work safely with any patient. In addition to interoperability of systems, data sharing agreements and approved protocols for data entry quality would be needed across all health care providers.

5.4 Accessible care

This incorporates improving same day access to Primary care which was highlighted as a need in Merton by Healthwatch in their response to the latest NHSE patient survey,[11] and also prevention of admission. A careful evaluation will be needed to match supply and demand, and pre-booked and same day access to primary care and set this within the context of all of the other asks required of general practice at the present time. It is envisaged that care

[10] NHS E London, Strategic Commissioning Framework for Transforming Primary Care in London. 2015 (http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2015/03/lndn-prim-care-doc.pdf

[11] http://www.healthwatchmerton.co.uk/news/our-response-nhs-england%E2%80%99s-gp-patient-survey

navigators would work in the localities to signpost patients through the system and may involve some practices operating as a ‘same day access site’.

5.5 These Practices would need the resources, including sufficient staff, to provide an extended access service 8am-8pm seven days a week. Resources could be identified by reviewing Merton’s current urgent care provision and diverting savings to the new service. 5.6 For instance, a recent study published in the journal Emergency Medicine [12] found that improving the availability of appointments and opportunities to speak to a GP or nurse at short notice may help to reduce attendance at emergency departments. Practices would require funding in addition to their core funding including existing hours delivered under the extended hours DES and the service contracts would be awarded following a procurement process.

5.7 The financial model for this improved accessibility to primary care would need to be developed as it will influence the number of sites that would be able to provide the enhanced same day access and on which days of the week and times of the day. Early high level assessments would suggest that 2 access sites could initially be provided one in the east and one in the west. Sites would be selected based on an analysis of patient flows identified by work on urgent and emergency care and an assessment of availability and suitability of existing primary care premises within the CCG’s premises strategy.

5.8 By providing a comprehensive same day primary care service a more efficient redirection from the ED could occur, a process which has so far failed under the current arrangements and it could also be utilised by the 111 service to reduce the number of referrals from their service to the ED. Resources freed up by a reduction in unnecessary ED attendances would be able to reinvested into patient services.

5.9 Merton CCG is unusual in facing three acute trusts all of which have urgent care centres that are co-located with emergency departments. These already meet national specifications and provide an opportunity to stream patients with less serious illnesses and injuries to a service that is resourced to meet their needs e.g. access to x-rays, and it is not proposed to change this provision at the moment.

5.10 The other component of reactive care is the prevention of admissions. To enable this to function properly a single point of access to clinicians is needed to make a rapid assessment and plan for a patient in need. These staff should be backed up by experienced care navigators who know how to make things happen at speed. Within our practices we have many very experienced senior receptionists whose roles could be developed to provide this service. We also have a CPAT team which could be enhanced by GP input such as giving medical support to the treatment plan, providing reassurance to patients and carers and onward referral to other community specialists such as HARI. This prevention of admission role of General Practice would need to be financially resourced and could also apply to provision of an enhanced early discharge

[12] BMJ 2016;353:i3422

plan whereby GPs would formally accept referrals from hospital consultants onto this community care pathway within agreed parameters. Once discharged these patients could be followed up via the existing AUA DES.

5.11 All of the functions of the model would be monitored via locality meetings when the 2 localities for East and the 2 in the West would come together as a multidisciplinary group to review performance and share learning through peer support.

5.12 The benefits for the patient of a more integrated approach to care that is delivered close to home is easy to see but what of the benefits to Practices who as holders of the registered lists would be central to this model? These can be identified as follow:-

1. Improved communication and relationships making a difficult job a bit easier
2. Improved job satisfaction
3. Opportunities for shared learning and education
4. A commitment to share many back room functions and achieve economies of scale
5. Improved sustainability
6. A locum bank could be agreed for each locality
7. CCG support via the partnership manager roles
8. Transfer of financial resources to support the model
9. The structure would be large but not impersonal

6.0 Enablers

6.1 The enablers that would be required include:-

1. A comprehensive IT strategy recently approved by the Primary Care Committee and EMT[13]
2. An estates service development plan[14] currently designed to deliver the transformational agenda.
3. A training and education plan. The CEPN training plan[15] describes a multidisciplinary plan that could drive some of the new ways of working through staff development. The CCG is also developing a proposal for Practice Learning time which could help with the co-ordination of mandatory training across the networked Practices
4. Appropriate use of electronic tools and registers such as CMC
5. Referral support for clinicians via DXS, kinesis and alternative community pathways
6. A willingness to engage fully with the 3rd sector and explore the potential value of social prescribing
7. The Better Care Fund[16]
8. A commitment to work in innovative ways with our community provider and across the primary and secondary care interface

[13] Merton GP IT strategy 2015/16 authors Ben Homer, James Corrigan
[14] Merton Estates service development plan 1/6/16 author Ben Homer
[15] CEPN training plan 2015/16
[16] BCF plan 2015/16

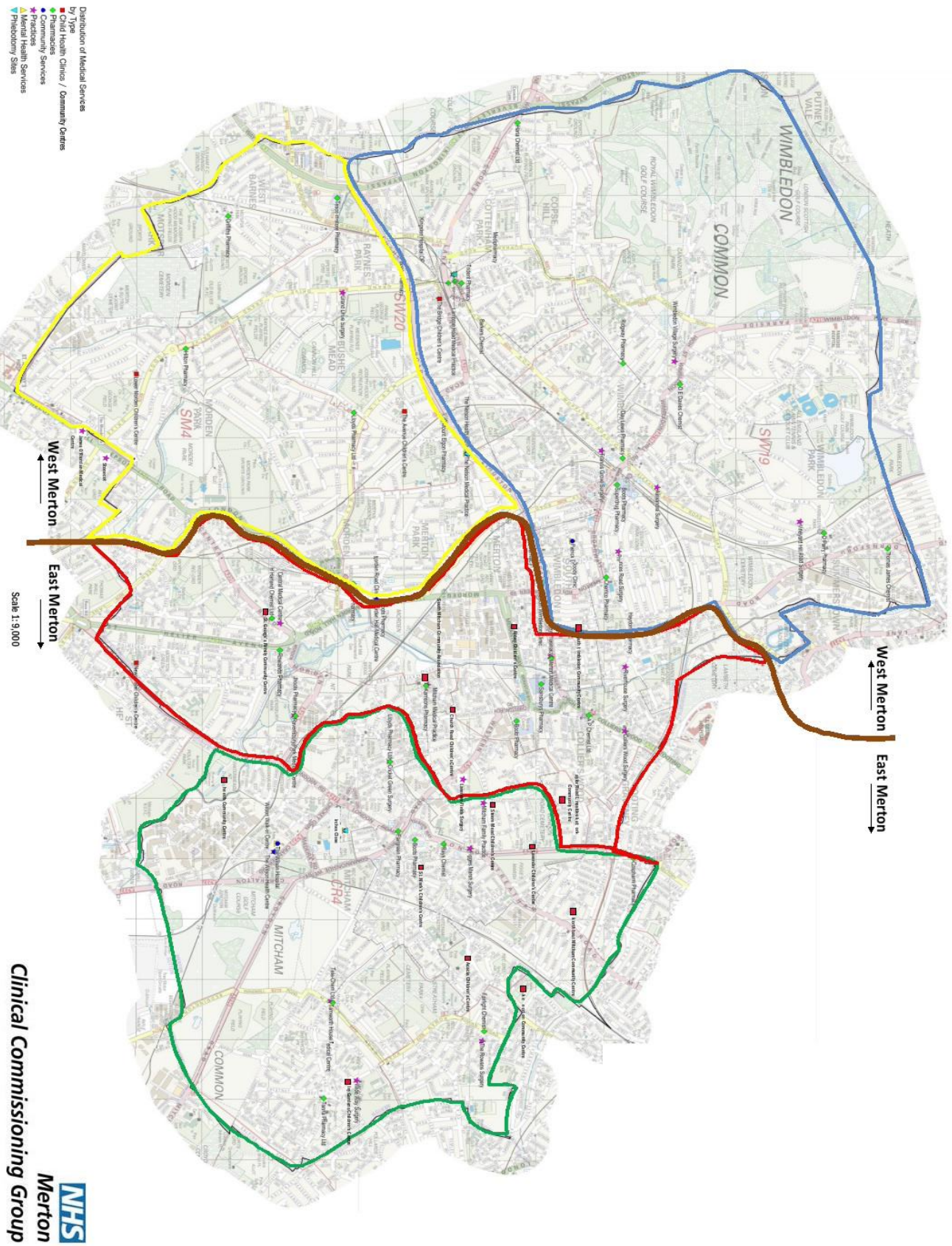
9. An appraisal of the evidence and best practice to understand how it could be applied to Merton
10. A new clinical leadership structure[17] currently under discussion to drive the strategy forward and ensure local buy-in.
11. A programme of engagement with all stakeholders to shape and agree the final strategy

7.0 Conclusion

7.1 The proposed Primary Care Strategy requires a significant shift in thinking at a time of turbulence in General Practice. Although there is no conclusive evidence yet about whether MCPs per se will lead to significant savings there is evidence both in the UK[18] and from abroad[19] to support integration as being of benefit. The Tower Hamlets Integrated Care Programme[20] made an ethical case for such an approach based on the needs of its population and the same case can be made to close the health inequality gap that has existed for so long in Merton. Practices need to expand their horizons and grasp the opportunity that some of the ideas in this strategy can offer to do things differently and thereby make a difference to their local population.

[17] Merton CCG proposed change to clinical leadership 2016 draft, Dr Andrew Murray, Adam doyle.
[18] https://www.kingsfund.org.uk/sites/files/kf/integrating-health-social-care-torbay-case-study-kings-fund-march-2011.pdf
[19] http://www.kingsfund.org.uk/publications/population-health-systems/nuka-system-care-alaska
[20] http://www.towerhamletsccg.nhs.uk/gp/Integrated%20Care/integrated%20care%20AUA%20DES%202015/Guide%20on%20integrated%20care%20in%20Tower%20Hamlets%20final%20Sept%202015.pdf

Appendix 1


Distribution of Medical Services by Type
Child Health Clinics / Community Centres
Pharmacies
Community Services
Practices
Mental Health Services
Phlebotomy Sites
West Merton
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Scale 1:9,000
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