Committee: Health & Wellbeing Board

Date: 28th March 2017

Wards: N/A

Subject: Update on Merton CCG's Primary Care Strategy

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Recommendations:

A. The Board is asked to note the achievements so far and work in progress.

B.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

The draft Primary Care Strategy was approved by Merton CCG's Governing Body in July 2016 and a period of consultation with local stakeholders took place during August and September of 2016 which informed the final direction of the strategy.

The purpose of this report is to update the Health & Wellbeing Board on achievements to date, and to share work in progress.

2 DETAILS

2.1. The Board is particularly asked to note how the investment from the GPFV will be utilised to deliver the transformation of primary care and reduce health inequalities in the borough.

3 ALTERNATIVE OPTIONS

3.1. N/A

4 CONSULTATION UNDERTAKEN OR PROPOSED

4.1. N/A

5 TIMETABLE

5.1. N/A

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1. N/A

7 LEGAL AND STATUTORY IMPLICATIONS

7.1. N/A

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1. N/A

9 CRIME AND DISORDER IMPLICATIONS

9.1. N/A

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1. N/A

11 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

- Appendix A: Presentation to the HWBB

12 BACKGROUND PAPERS

12.1. N/A

right care
right place
right time
right outcome

NHS
Merton
Clinical Commissioning Group

Update on Merton CCG's Primary Care Strategy

Achievements and Work in Progress

1. Introduction

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. The draft Strategy was approved by the Governing Body of the CCG in July 2016 and a period of consultation with local stakeholders took place during August and September 2016 which informed the final direction.

Primary Care also sits centrally in the National Strategy for the NHS described in the 5 Year Forward View 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. The more recently published GP Forward View (GPFV) describes how this will be achieved through investment, development of and work force and infrastructure, control of workload and care redesign.

Merton's Primary Care Strategy details how the investment from the GPFV will be utilised to deliver the transformation of primary care and reduce health inequalities in the borough. It proposes a ten point plan describing what it should look like and deliver:

1. **High quality, holistic care leading to good health and wellbeing;**
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 moving towards an MCP model of care;**
9. **Harness resources from within local communities and promote self-care and support;**
10. **Produce efficiencies to release savings that will drive transformation.**

2. About Merton

- The primary care footprint in Merton consists of 24 GP Practices currently split into 2 localities with 10 in the east and 14 in the west;
- It serves a population of 203,515 residents (2014 ONS data), with projected population growth to 223,900 by 2020[1];
- In Merton, overall life expectancy at birth is longer than the England average, but there is a difference between the most and least deprived areas within the borough of about 7.9 years for men and about 5.2 years for women[2];
- Premature mortality (deaths under 75 years) is very strongly associated with deprivation, with all wards in East Merton being more deprived and having higher rates of premature mortality than their West Merton counterparts;
- In general, East Merton is younger, poorer, and ethnically more diverse, with relatively lower levels of education outcomes and training qualifications than West Merton.

3. Progress against Key Components of Merton's Primary Care Strategy

3.1 Locality Working

Currently our practices work in two well established localities (east and west) and these will shortly be complemented by 2 Primary care access hubs which will provide 7 day access to primary care across Merton. The term locality is used to describe the form and function of a geographically based system. We are aiming for our Practice teams to be closely aligned to our community provider and social care, and to increasingly utilise the resources of the local community.

The Primary care access hubs are the Nelson site in the west, and as an interim measure pending the redevelopment of the Wilson site, the east Merton access hub will be provided at Cricket Green Medical practice which hosts our current Out of Hour's service provider. It is hoped that the access hubs will provide the future focus for development of a multi-specialty community provider (MCP) model of care and provide more services closer to home for patients.

[1] http://www.merton.gov.uk/community-living/statistics/population.htm

[2] http://www.merton.gov.uk/jsna_summary_document_2015_final.pdf

3.2 Primary Care Access Improvements

Merton GP practices already offer more than 1 million consultations per year. Despite this the need to further improve access to primary care has been requested by patients and also identified as a priority by our member practices.

In 2014, Merton Healthwatch published '*Strategies for improving GP services in Merton A Healthwatch Merton Research Report'* which identified some short and long term recommendations around five key themes:-

- Access to GP services including telephone, appointment availability, consistency and home visits;
- Information provided at GP services;
- Out of hours GP services;
- Use of technology;
- Urgent care support (primary care not A&E).

This report will be used to inform both the design of our care pathways into our new primary care access hubs and also the quality initiatives that we are working on in 2017 to improve patient experience of access.

Our access initiatives will be resourced via GP Forward View funding, bringing £1 million of extra funding into Merton for the provision of this service over the next 2 years. The CCG has a plan to deliver improved access which is made up of 3 components and reflects many of the recommendations made in the Healthwatch research report:-

i. **An Extended Access Local Incentive Scheme** - to be delivered from 1st April 2017 by all Merton practices. This will boost capacity both during core surgery hours from 8am to 6.30pm Monday to Friday and also during extended hours which is before 8am Monday to Friday, 6.30pm to 8pm Monday to Friday, and on Saturday mornings in some practices. In response to requests from patients we will be providing more dedicated children's slots and also including some educational component during these consultations about appropriate use of services for urgent care, and self-care for parents on behalf of their children.

ii. **Hub Provision** - this will be delivered from 1st April 2017 through two primary care access hubs, one in the east of the borough and one in the west. The hubs will offer extended access Monday to Friday until 8pm and on Saturdays 8am-8pm, with the one in the east also open

Sundays 8am -8pm. Initially the hubs will offer same day access only with plans to move towards a 'full practice service' of same day and routine care from October 2017.The hubs will also provide access to nursing at the weekends from April 1st, for those who need wound care.

iii. **A Quality Improvement Scheme** - to be developed in 2017/18 with our practices to focus on the quality aspects of access. This work follows on from the outputs of practice visits made by the primary care team to all Merton practices. The scheme will be launched in the summer and topics identified for focus so far include the needs of carers, telephony improvements, training receptionists to better meet the needs of the homeless, including identifying the hidden homeless, and the primary care needs of frequent attendees to our local emergency departments.

The access improvements will provide additional face to face appointments with primary care clinicians across Merton in 2017 both in practices, and via the hubs with plans to increase this further by use of new types of consultations such as e-consults later in the year as part of plans across south west London.

3.3 East Merton Model of Health and Wellbeing

Longstanding health inequalities exist within Merton between the east and west and also other demographic differences meaning that a model of care needs to be tailored to the needs of the local population to bring about change.

The Marmot Review 2010 into health inequalities in England, titled *'Fair Society, Healthy Lives'* identified that health inequalities arise from a complex interaction of many factors. These include housing, income, education, social isolation and disability - all of which are strongly affected by one's economic and social status.

There are clear health inequalities between the east and the west of the borough and a reduction in the observed differences is a key aim of the Primary Care Strategy for Merton CCG. The Primary Care Strategy is an enabler for the development of the East Merton Model of Health and Wellbeing and will support the primary care functions that will be on the site as part of the clinical model which is currently being designed.

3.4 Social Prescribing

A Social Prescribing pilot is underway for 1 year in 2 practices in east Merton and will be formally evaluated. Depending on outcomes there are plans to extend this to other east Merton practices too. Early feedback from the pilot as of

23/2/17 revealed 60 referrals from the Social Prescribing Navigator to local services and 30 patients seen for appointments lasting between 30 and 60 minutes as needed.

A data base of local community resources is also being built as part of the project. There is also a care navigator as part of the Holistic and Rapid Investigation (HARI) service for patients with complex needs on the Nelson site, directing patients and carers to relevant local voluntary sector organisations. The Social Prescribing scheme is expected to feature strongly within the East Merton Model of Health and Wellbeing which will harness the local community resources on the community campus part of the site.

3.5 Development of the MDT and Workforce Development

Development of the workforce is vital to both the transformation plans and also sustainability of practices going forwards. The following plans are in place in 16/17 and 17/18:-

i. Education and Training

- Successful 16/17 HEE Strategic Investment Programme bids:
  - Funding to improve skills of primary care staff in providing more holistic care to children awarded £22,500 (Merton successful bid);
  - Workflow optimisation awarded £79,500 (joint SWL bid with Kingston and Wandsworth);
  - Simulation Mental Health Training awarded £30,000 (joint SWL bid with Kingston, Richmond and Wandsworth);
  - Care Navigation and Receptionist Training £19,000 (provider yet to be identified).
- Protected Learning Time (PLT) for whole practice teams taking place quarterly and jointly run with the Community Education Provider Network (CEPN). The CCG has provided financial support to this initiative. One session on Diabetes took place in January and was attended by 280 staff from all Merton practices. A second event will follow in April with a focus on Cardiology;
- Expansion of the CCG's clinical workforce, with the appointment of some additional clinical leads, from January 2017 (including leads for GP IT, planned and primary care and a children's lead to also act as the named GP for children's safeguarding in Merton). This strengthens the CCG's commitment to being a clinically led organisation;
- Future Leaders Programme - the CCG will be investing in this programme for all new and existing clinical leaders in the CCG;
- The Primary Care team signposts all staff towards training opportunities in newsletters and update bulletins;
- Trainers and Tutors - The CCG has a senior nurse as part of the primary care team who leads on the educational development of practice nurses

and Health Care Assistants in Primary Care. Many of our practices also host medical students from St Georges Hospital, train GP registrars and some are also trying to widen skill mix by supporting the training of physicians' associates and primary care pharmacists as part of the team.

3.6 Integration

One of the key aims of the strategy is to improve integration between providers of care to enhance both efficiency and patient experience. To this end we have worked with our community services provider, Central London Community Health (CLCH), to clearly align the community teams to individual practices ensuring that all practices have named nursing teams and access to a named Health Visitor. To further develop this relationship we have had presentations from the CLCH team that provides a rapid response for prevention of admission to our locality meetings and encouraged the provider to send staff out to meet with practice teams. All GP practice leads have also visited the Holistic and Rapid Investigation service (HARI) on the Nelson site to improve understanding and utilisation of this multidisciplinary team approach to any patient with complex or rehabilitation needs.

Closer integration between NHS111 and care navigators in our local Emergency Departments is being included in our care pathways for same day access to primary care described in our hub specification.

Other initiatives have taken place via our locality meetings to improve integration with our local dementia hub, local community pharmacists, public health colleagues and Merton IAPT. By promoting better understanding of team roles and service provision we aim to improve information flows and ensure pathways are seamless for patients.

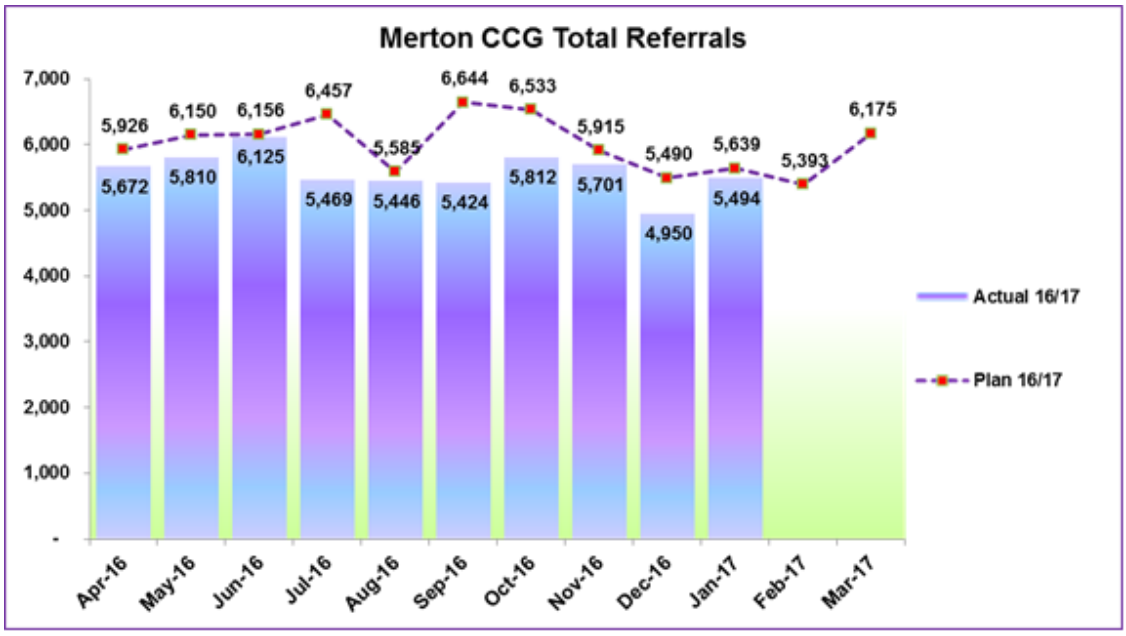
3.7 Reducing Practice Variation

One of the aims of the Primary Care Strategy is to reduce unwanted variation in primary care provision and outcomes for patients. Since 2016 we have embarked on a successful work stream which involves visiting each practice and sharing data with them to encourage peer discussion and to identify educational needs and potential commissioning gaps.

Practice Variation Phase 1 focused on the variation between practices in referring patients to outpatient services. This identified the need for the development of some community diagnostic pathways which are being worked on by the CCG's Planned Care team, including services such 24hr Ambulatory Blood Pressure monitoring and provision of anticoagulation initiation and monitoring in primary care. It also led to the peer review of cases within

practices; better knowledge and utilisation of community pathways that were already commissioned, and the setting up of a locum information pack in every practice to improve patient care. A PLT educational event took place in January on Diabetes as this was identified as an area where there needed to be improved knowledge about how to take up Tier 3 Community Diabetes services.

As a result of this we have succeeded in achieving a significant reduction in utilisation of secondary care services indicative of sustained clinical behaviour change as seen in the chart below, showing referral activity reduced immediately after the Phase 1 visits concluded and remains below planned.



Phase 2 completed in February 2017 with a key focus on variation in utilisation of some key pathology tests between practices. This has allowed the CCG to share appropriate clinical guidelines and to remind practices to avoid duplication in test requests and improve information flows in relation to pathology testing between primary and secondary care.

Additionally during the visit the primary care team have gathered information from all practice teams about the varied approach to handling same day demand for consultations. The outputs from this will feed into the work to be done in the summer on developing individual practice access plans and sharing best practice.

Phase 3 will occur in the summer of 2017 and will focus on variation in diabetic care. Diabetes is a major cost to the health of our local population especially in the east and also a financial cost to the CCG impacting hospital, community and prescribing budgets.

In summary the benefits of this approach to practice variation to date has been:-

- Improved working relationships and communication between the CCG primary care teams and our practices.
- The opportunity to identify and share good practice;
- To use peer review and education as levers for improvements for patients;
- To use the data obtained to inform commissioning decisions (for example, Improving Access to Primary Care Local Incentive Scheme and the outcomes of our recent review of our locally commissioned services.)
- To save money for the CCG by ensuring referrals to secondary care are appropriate and the best clinical outcome for the patient;
- To work towards the reduction of unwarranted variation in service quality for patients.

3.8 Prevention

Primary care has worked with Public Health colleagues in giving feedback about the re-procurement of healthy lifestyles services through locality discussions. In addition, a member of our primary care team sat on the moderation panel for the new service.

Senior CCG clinicians have worked with our Director of Public Health to ensure that changes proposed to commissioning intentions in relation to surgical readiness support prevention of adverse surgical outcomes and improve long term health in relation to smoking cessation and management of obesity;

The needs of specific groups have been highlighted to our community service provider to ensure that services are culturally appropriate to improve outcomes e.g. a Tamil speakers' Diabetic Education Group has been started. By improving self-management of Diabetes, complications should be prevented in the future. All practices were encouraged to sign up for the National Diabetes Audit at our Diabetes education event - currently uptake in Merton is low with only 8 practices participating.

3.9 Update on enablers identified in the Primary Care Strategy (IT & Estates)

Implementation of DXS, Kinesis, Referral Facilitation

All of these IT initiatives are being rolled out across practices during 2017 and will support clinicians in making evidence based decisions relating to care pathways, and allow a system to get advice from secondary care colleagues without the need for a referral if clinically appropriate. Referral facilitation will ensure that appropriately worked up referrals are made to preferred providers ideally in the community.

Optimise RX
The CCG is investing in this piece of software to support prescribing decisions for all practices from a safety and cost effectiveness perspective. This has been demonstrated at locality meetings and feedback provided from local GPs.

Health Help Now App
The CCG is working to improve uptake amongst people who work in Merton and patients of Merton as this provides a valuable source of information about health issues and local services and is part of the Primary Care Strategy's aim to promote self-care. The marketing of this resource is being boosted in local practices and emergency departments in quarter 4 of 2016/17.

Investment in Estates
Merton CCG has secured significant national capital funding for upgrading primary care estates in Merton which will be critical to transformation especially in relation to the shift of some services from secondary to primary care as described in the SWL STP. Improvement Grant (IG) schemes for Central Medical were awarded this year for a loft extension with ground floor extension and other improvements; James O'Riordan won a bid to remove existing doors and replace with automated door closer equipment. A successful bid for improvements to Wide Way Surgery is also underway.

In addition the CCG supported Estates and Technology Transformation Fund (ETTF) bid applications for a wide range of schemes. We are still working through the revenue consequences of these schemes.

Contractual Review
There is a nationally mandated review of GP PMS contracts which has been devolved locally due to take place in 2017. The CCG has set up a working group jointly with NHSE to take this forward. There will be engagement with GP providers and the Local Medical Committee (LMC) to review the contract Key Performance Indicators to ensure that they are fit for purpose, and will assist with the delivery of the CCG's objectives for improving patient care whilst maintaining stability in general practice.

4. Work to Improve Resilience across Primary Care

We are aware that primary care in Merton is under significant strain especially in relation to rising demand from an increasingly aging population with more complex health needs and workforce shortages. The CCG has attempted to overcome this by building on our model of locality working and support. Some practices are in the early stages of identifying a need to work at greater scale in

the future and our GP federation Merton Health will be crucial to this going forward.

The Primary Care Team will be promoting the '10 high impact actions' identified in NHS England's Releasing Time to Care study[3] as a structure for dealing with the increasing complexity and volume of work in General Practice and have had a workshop to begin discussing these ideas at our Practice Leads' forum in January 2017.

The CCG has invested in Primary Care in 16/17 and continues to work collaboratively with Merton Health to develop resilience in primary care. Our Primary Care team work closely with our NHS England colleagues in the local area team to provide rapid support if a situation is identified - an example of this is the provision of a dispersal package from national resilience funds to support local practices in re-registering patients from the dispersal of the Wilson Practice's list.

5. Work in Progress and Challenges

- Further development of practice and community Multi-disciplinary Teams (MDT) is needed, especially closer integration with social care. This will be important in reducing emergency admissions and length of stay in hospital. Progression towards a Multi-disciplinary Community Provider (MCP) model of care through transformation is identified locally as a priority.
- IT systems in Primary Care remain relatively undeveloped and we need to develop rapid interoperability with appropriate data sharing agreements and a robust information governance framework. This will allow safe up-scaling of services especially in the provision of extended access.
- Funding will be made available later in the year to help introduce new modes of consultation such as Skype and e-consulting.
- From 1st April 2017 we will become a Local Delivery Unit (LDU) with Wandsworth CCG which will provide scale and resilience to the commissioning of services for patients in both boroughs and help with our drive for transformation. Merton CCG is going through a period of change and is currently developing a joint management structure, as well as retaining its own governance structure as a Clinical Commissioning Group.
- Merton CCG needs to play its part in delivering the South West London Strategic Transformation Plan (STP) including the transformation of hospital outpatient services within St Georges Hospital. The interface between Primary and Secondary Care needs to shift with more care being provided in the community with a rapid pace of change.

[3] https://www.england.nhs.uk/expo/2016/11/14/releasing-time-for-care-10-high-impact-actions-for-general-practice-dr-robert-varnam/

- Closer links are needed between Merton Voluntary Services and we need to ensure that the patient voice has greater prominence in commissioning decisions some of which are potentially contentious in a time of financial austerity.
- Close ongoing partnership working is needed with the Local Authority to deliver the redevelopment of the Wilson site. There is a plan to invite some of the local councillors to the locality meetings in April to improve understanding of respective roles.
- Prevention needs to be embedded in all pathways and an ethos of making every contact count to promote health and wellbeing.

6. Summary

This paper highlights the significant work done by Merton CCG's Primary Care team in collaboration with our GP membership and practices to deliver improvements in access to GP services which will commence in April 2017; the enthusiasm of the workforce to take up educational opportunities and develop practice teams; and a commitment to quality and use of peer review to reduce unwanted practice variation.

The CCG has bid for, and been awarded, national funding to help further drive the transformational agenda - including proposed improvements to Primary Care Estates and IT infrastructure. Ensuring the resilience and sustainability of Primary care and improving patient outcomes and experience remains at the heart of everything we do.