WESTERN LOCALITY SYSTEM IMPROVEMENT BOARD

NHS

PROGRAMME REPORT

Programme Name	**Primary Care**
Programme Lead	**SROs: Dr Shelagh McCormick and Mark Procter; Programme Lead: Nicola Jones**
Reporting Period	**To 24th January 2018**

Programme Overview: Aims and Objectives

Aim: To develop and redesign primary care as part of the system of health and wellbeing

Objectives:

- To achieve sustainability in primary care with respect to workforce, funding, IM&T and premises to ensure patients' access to high quality primary care provision and self-care – and at the interface of community and acute care
- To support, influence and enable design and implementation of new models of primary care built around a community with integration between primary care, secondary care, the voluntary sector and the community and provided efficiently and effectively 'at scale' where appropriate while maintaining access and continuity where important.
- To maximise and influence investment and resource opportunities, prioritising according to the needs of the population and the needs of the health and wellbeing system, whilst supporting innovation

Key Issues, Risks and Actions for Escalation

Risks (as reported through Western Locality Risk Register)**:**

- Current and forecast significant challenges to sustainability of general practices including workforce, demand and capacity
- Variable and limited capacity in general practice and practice groups to transform to improve sustainability and enable system wide developments without support
- As with general practice there are now challenges to the sustainability of the community pharmacy network that need to be reflected
- Lack of evidenced change to new models
- Insufficient change capacity at all required levels
- Lack of proven ability to plan and mitigate for high risk failure in primary care

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Workstream	Activity (Projects)	Progress Updates and Key Milestones
Leadership and governance for transformation	(a) Improving practices' capacity to transform at scale with investment of £120k funding for a year and aligning commissioner and provider staff to each group for collaborative working to deliver change more rapidly (b) Aligning and strengthening delivery of primary care transformation by forming a Partnership, bringing together the Primary Care Programme Group and Western GP Collaborative Board) to hold and drive the primary care programme, reporting to the System Improvement Board	For (a) and (b): Progress updates: • Proposal developed (Sep 17) • Proposal shared with each practice group and LMC for feedback – positive reception (Sep/Oct 17) • Supported and iterated at Primary Care Programme Group (3/10/17) • Circulated to GP Collaborative Board members for views (10/10/17) • Finalised with Primary Care Programme Group • Launched at GP Forum (17/10/17) • Letter to practices and other invitees for Partnership meeting (21/11/17) • Western Primary Care Partnership commenced (12/12/17) • Launch meeting with partners Key milestones: • Agree use of £30k funding with each group and fully implement. • Second practice group GP Forum to review actions from first GP Forums and refresh action plans (by Mar 18)
Model of Care: • **At Scale Model (eg Primary Care Home)** • **Pathways of Care (eg Care Homes)**	(a) Implement a model for provision of primary care to people living in care homes. Implementing this will maximise the easing of workload and workforce pressures and reduction in impact to urgent care system (by Dec 17). (b) Develop a model for provision of home visits. Implementing this will maximise the easing of workload and workforce pressures and reduction in impact to urgent care system (by Dec 17). (c) Develop a system of integrated telephone triage for practices. Implementing this will maximise the easing of workload and workforce pressures (by Dec 17) and reduction in impact to urgent care system (by Dec 17). (d) Review benefits of Primary Care Home initiatives at Beacon Medical Group and determine whether Primary Care Home is a good model for wider Western (scale to be determined) (e) Review financial risk management barriers and opportunities for GP practices to enable system integration through development of an ACO. (f) Review the boundaries for GP practice federations to ensure they	(a), (b) and (c): Progress updates: • Scoping and action planning (CCG and NHSE) (Sep 17) with order of priority agreed as care homes, then home visiting and integrated telephone triage • Installation from Aug 17 of telephone triage capacity (Devon Doctors) at Ocean Health Group (use for learning) • Scoping with Devon Doctors for potential options complete. Planned for 5 days over Christmas / New Year for Devon Doctors to provide. Not implemented due to governance concerns. Other remote support offered instead. Key milestones: • Following feedback received at a meeting with GP practices, medical cover for patients in intermediate Care Home beds provided by Devon Doctors from 22/1/18 with support for practices requiring capacity for services for care home patients • For telephone triage, review to either close or explore in other ways. (d) Key milestones: • Evaluation of Beacon Medical Group Primary Care Home (e) Progress updates: • Beacon ACO working group meets monthly

	enable integrated primary care and development of health and wellbeing hubs. (g) Develop a single team / single point of contact approach for mental health. (h) Finalise and implement Livewell's offer of resource (i) Maximise opportunities for Community Pharmacy to reduce demand on General Practice (j) Develop triage to community pharmacy by 111 using DDocs (k) Implement online consultation (l) Take opportunities to use IT effectively to enhance patient care	Key milestones: • To be determined through Beacon ACO group (ongoing) (f) Key milestones: • For discussion and agreement of milestones at Primary Care Partnership (Dec 17) (NB interdependencies with Health and Wellbeing Hubs, development of integrated primary care) (g) Key milestones: • Being progressed by the Mental Health Commissioning Team (h) Key milestones: • Discussed at Primary Care Programme Group (Oct 17) Progress updates: • Implementation in line with relevant priorities (as plan) (i) Key milestones: • Scope with Primary Care Partnership (by Mar 18) (j) Progress updates: • Submitted application to Integrated Pharmacy Fund (k) Progress updates: • Project Plan in place Key milestones: • Review interest from Practices • Support Practices with roll-out (l) Key milestones: • Liaise with colleagues in IM&T to align delivery of relevant strategies
Access and Workload	(a) Reduce patient demand on general practice where a better alternative is available (b) Ensure appropriate services are available in relation to demand (c) Inform patients and redirect demand where appropriate from Urgent Care. Increase capacity within the system (d) Ensure plans and funding for extended access (w.e.f. Apr 19) align with national specification and funding criteria/dates and the aims and objectives of this programme (e) Review DRSS to address practice concerns that DRSS creates a barrier between primary and secondary care rather than an aid to efficient referral management and relationships (f) Eradicate duplication in patient experience for QOF (across GP,	(a) Progress updates: • Social Prescribing will be available in all Plymouth and some South Hams and West Devon Practices from early 2018 • Training of Care Navigators Key milestones: • Develop scope, priorities and trajectory for reduction in workload over the next 2 years (March 18) • Deliver project (timescales TBC but should have some measurable positive impact by spring 18) (b) Key milestones: • Scope for each tranche of service change (c) Progress updates: • CCG, NHSE, PHNT and Livewell regular liaison with actions

	pharmacy, PHNT, Livewell, Devon Doctors etc) (g) Expand the Single Trusted Assessment used by PHNT and Livewell to general practice to avoid delays in discharge from hospital (h) Facilitate practices sub-contracting with each other for the full range of enhanced services (all commissioners)	Key milestones: • Further analysis at practice level to ensure mitigations are effective (monthly monitoring) (d) Progress updates: • Initial scoping of extended access take-up (current DES), mapping with potential hubs and development of primary care at scale Key milestones: • STP-wide preparation of opportunities to meet national requirements (Jan 18) • Plans developed through Primary Care Partnership (by Jan 18) in liaison with other programmes, particularly urgent care and mental health (e) Key milestones: • Determine project lead (Jan 18) • In liaison with planned care, prepare project plan (Jan 18) • Deliver project (timescale TBC in project plan) (f) Key milestones: • Scope opportunity and prepare project plan (Jan 18) • Deliver project (timescale TBC in project plan) (g) Key milestones: • Determine project lead (Jan 18) • In liaison with urgent care, prepare project plan (Jan 18) • Deliver project (timescale TBC in project plan) (h) Key milestones: • Summary proposal to Primary Care Partnership meeting (Dec 17) • Identify opportunities (websites) for practices to inform others of asks and offers (Dec 17) • Identify administrator and protocols (Jan 18) • Implement (Apr 18)
Workforce (this section to be aligned with STP Workforce Plan)	(a) Develop a system Workforce Plan (b) Determine 'Workforce Gap' (ie difference between current workforce and future workforce needs) (c) Arrange clinical interface opportunities (e.g. evening sessions) for GPs, practice nurses, consultants, specialist nurses and others (d) Enable portfolio careers by finding how the system can allow trainees to work across organisations, eradicating barriers and duplication (e) Simplify career navigation such that the clinical workforce are enabled to make career changes which meet a workforce need in our local system (f) Enable GP career changes for joint	Progress updates: • Workforce workstream leadership in place • Primary Care Conference supported (Nov 17) • Positive discussions with PHNT and Medical School to create best environment • Variety of pharmacy roles in practice with various funding mechanisms (Practice, CCG, NHSE) • CCG/Livewell/PHNT agreement for system working in Pharmacy to improve recruitment and retention of pharmacists. Inaugural meeting of System MO and Pharmacy Board to oversee (19/10/17) • Good liaison with proactive LPC • HEE funding received Key milestones: • Set delivery plan within STP-wide primary care workforce

	primary/secondary care roles required by the system (g) Describe the role of Physician Assistant and determine whether this is useful locally (h) Arrange action learning sets for training grades / all clinicians (i) Implement a health passport across the local system so the workforce can share and not duplicate mandatory training across organisations (j) Enable and increase placements of student nurses in practices (k) Find a way to join up recruitment across organisations (l) Ensure maximum advantage is taken of the GP international recruitment national programme in partnership with PHNT and the Medical School (m) Better understand, optimise and secure the role of clinical pharmacists and pharmacy technicians	strategy • Continue to deliver HEE funded-plan for Plymouth
Data, Quality and Safety	(a) Data exchange between commissioners and providers (CCG, NHSE, PHNT, Devon Doctors, Livewell, pharmacies practices, AHSN) and decisions taken as a result (b) Improve outcomes for patients with chronic pain (c) Promote benefits of intra operability	(a) Progress updates: • Data being exchanged between organisations ad hoc, with appropriate information governance, through various projects including practice dataset (May 17), Beacon ACO (ongoing) Key milestones: • Finalise information sharing protocols • Implement within projects across organisations (b) Progress updates: • CCG medicines optimisation and NHSE liaising • Action plan developed (11/10/17) • Positive Practice Engagement meeting (14/11/17) • Pilot commenced (23/11/17) Key milestones: • Pilot evaluation (c) Key milestones: • Liaise with colleagues in IM&T to align delivery of relevant strategies
Change Support	(a) Ensure practices' delivery of At Scale and Resilience plans is embedded in relevant activities in each workstream and that practices are using At Scale and Resilience funding to best effect (b) Recruit Change Manager to support practices and practice groups to make required change more rapidly	(a) Progress updates: • Supportive review taking place with practices (ongoing) Key milestones: • Ensure next tranche of funding implemented to support delivery of this programmes aims and objectives (in progress) • Practice specific priorities agreed for 17/18 (b)

		Progress updates: • CCG/NHSE urgently exploring potential for joint post to better integrate opportunities and levers for change Key milestones: • Recruitment (timescale TBC)
Resource Enablers	(a) Ensure live ETTF projects will deliver (b) Create a plan for infrastructure (estate and IT) change required with consideration of whole system (urgent care, elective care, mental health etc)	(a) Progress updates: • PCC OPE working with Beacon Medical Group (b) Progress updates: • Primary care estate sub-group of health and wellbeing hubs programme group developed • Crafting initial plan for IT and telephony liaising with other programmes etc Digital Roadmap Key milestones: • Develop project plans ensuring estate and IT are planned together (Feb 18)
Communication and Engagement	(a) Ensure change is supported by communication and engagement – scope is all stakeholders (public, patients, providers, voluntary sector, national) supporting all workstreams	Progress updates: • Initial scoping of immediate opportunities with CCG complete (Sep 17) • Primary care commissioning input to winter plan communication (Sep/Oct 17) • Winter comms plan shared with practices (13/10/17) • MP briefings (Sep/Oct 17) • Western GP Forum (17/10/17) • Health navigation information now included on Practice phone messages • Teleconference CCG and NHSE with practices re messaging and channels to support practices (19/10/17) • Z Flyer distributed to 70,000 Plymouth homes (Dec 17) Key milestones: • Continue implementation of communications plan and engagement with practices to inform (ongoing)

Note – this plan is under review by the Western Primary Care Partnership.