PAPER 04

SWL Collaborative - Transforming Primary Care Delivery Plan Review

Reviewed at workshop held on 7th January 2016

Summary of key themes

SWL delivery plans outline that

March 2017: **coordinated care** will be delivered to 90% of the population by Q4 2017

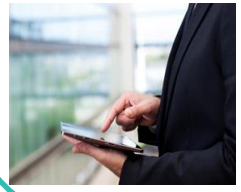
July 2017: **accessible** and **proactive care** will be delivered to 90% of the population by Q1 2018

Across SWL some of the key areas of focus include:

Accessible care

CCGs are in the process **of developing and piloting extended access options for patients**, through GP hubs, practice clustering or walk in centres. Developing a shared patient record is a key focus, and two CCGs have launched electronic records in 2015.

SWL have **invested in patient online facilitators** to support practices to improve their understanding and use of their systems which will enable online services to be accessible to patients. This includes a **multi channel communications campaign** across SWL



During the next 3-6 months **a facet survey is being undertaken across SWL** to understand the primary care estates requirements. Accessibility improvement plans will be developed following review of the findings, focussing on addressing access barriers.

Coordinated care

There are several **pilots or vanguards in SWL**, Sutton Home of Care, Richmond's rapid test site for the new Primary Care Home model as well as PMCF for GP hubs. The **learnings from these will be shared across the CCGs in SWL**.

Currently four CCGs are **exploring and developing Multi-speciality Community Provider (MCP) models** or **Outcome Based Commissioning (OBC) contracts** which aim to support care coordination across providers.

All CCGs have schemes / programmes in place or in development to coordinate care for patients with complex needs. During 2016 many CCGs will be exploring **new ways to improve care coordination**, for example Merton have a Darzi fellow reviewing best practice guidelines for identification and care planning and MDTs, and Croydon are developing a new clinical dashboard to support risk stratification.

Proactive care

By **Q4 2016 each CCG in SWL will have an asset map available** to help patients and the public to find organisations and services to support their health and wellbeing needs.

SWL CCGs have a **strong track record of co-designing services** and agreeing local priorities with stakeholders, through thinking partners / Locality Patient Groups / Critical friend groups / Clinical reference groups / GP visits to seldom heard groups and engagement with Public Health.

Delivering accessible care in SWL

Across SWL

- Patients will have the **choice of access options**, including rapid access or continuity of care, whether to book online, on the phone or in person
- **All patients will be provided with a named GP** contractually by Q4 2015. Local areas, in alignment with the Healthy London Partnership Workforce programme, will develop the workforce over the following years to ensure that it is sufficient to provide care coordination
- Practices will be open at routine opening hours, with 5/6 CCGs providing Saturday morning appointments at scale with shared medical records (Wandsworth pending financial model)
- All CCGs are incentivising extended access
- **Each CCG has a federation in place** and developing in maturity, two CCGs already hold contracts with the CCG
- SWL will be the **first SPG in London to re-procure NHS 111**, providing an integrated out of hours and 111 service
- Technology: **SWL have invested in patient online facilitators**, supported by an SPG wide comms campaign. All CCGs are also exploring or piloting e-consultation software. Some CCGs are scoping or piloting telephone triage systems
- Estates: A **facet survey is being undertaken to understand the premise**
- Workforce: Strategies and training programmes are in development

Richmond specific local approach

- PMCF for 4 GP hubs, providing 8-8 access 7 days a week for pre-bookable appointments (via the practice or NHS 111) with a shared medical record

Wandsworth specific local approach:

- Saturday appointments at practice level (pending financial model)
- Extended access through walk-in services at 4 hub sites.
- Working towards having pre-bookable appointments at the walk in centres, with shared medical records (subject to sustainable financial model)

Merton specific local approach:

- Two out of hours hubs to be developed – providing weekday evening appointments, and weekend appointments booked via NHS 111
- Scoping opportunities for practice clustering scheme to provide weekday evening and weekend pre-bookable or unscheduled appointments, with a shared medical record

Kingston specific local approach:

- Support available for non-English speakers via Kingston Refugee Council
- Walk in centres to provide 8-8 access 7 days a week, with shared medical records through the Kingston Health Passport
- CCG scoping potential options for enabling these to be pre-bookable

Sutton specific local approach:

- Help for Health education programme for non-English speakers launched in Q1 2016
- Phased roll out of GP hubs providing 8-8 access on Saturday, to be phased to include weekday evening access for some days during the week for pre-bookable appointments, and shared medical record via the Integrated Digital Care record

Croydon specific local approach:

- 3 /4 GP hubs will be mobilised for 1 April 2017, providing 8-8 access 7 days a week for pre-bookable appointments with a shared medical record
- All GPs will be using one clinical system to enable interoperability

Delivering proactive care in SWL

Across SWL

- **SWL CCGs have a strong track record of co-designing services** and agreeing local priorities with stakeholders, through thinking partners / Locality Patient Groups / Critical friend groups / Clinical reference groups / GP visits to seldom heard groups, local community networks, and engagement with Public Health and the LMC
- By **Q4 2016 each CCG in SWL will have an asset map** available to help patients and the public to find organisations and services to support their health and wellbeing needs. The sites used include Health Help Now, Care Place, Wandsworth Wellbeing Hub and MiDoS.
- Expert patient programmes are in place, as well as self management programmes to support patients to proactively manage their care
- Many **CCGs will be applying to the Primary Care Transformation Fund** to provide television screens and Wi-Fi to support proactive care messaging to be communicated to patients

Richmond specific local approach

- Community involvement coordinator supporting local health and wellbeing champions
- Pharmacist First programme to provide information and advice for self care
- Health care assistants in place
- High users of GP resource whose health may be at risk of deteriorating are identified
- Pre-diabetes register in place

Wandsworth specific local approach:

- Community navigators are available on the telephone and advertised on the online Wandsworth Wellbeing Hub
- Piloting hosting Citizen Advice in two localities during 2016.
- Scoping an MCP model to empower other service providers
- Training for health care professionals to have individual health conversations

Merton specific local approach:

- Co-design has taken place for the Holistic Assessment and Rapid Investigation (HARI) service, the development of the Health Help Now app, and scoping of the MCP model
- Healthy Living Pharmacies programme aimed at achieving consistent delivery of services
- Live Well champions, as part of Proactive GP practice pilot, engage with hard to reach groups to support screening and to provide advice
- Patient education schemes providing information and advice

Kingston specific local approach:

- Kingston Coordinated Care's active and supportive communities workstream has patients forming some of the design team. The workstream identify high users of GP resource whose health may be at risk of deteriorating
- Healthy Living Pharmacies programme aimed at achieving consistent delivery of services

Sutton specific local approach:

- Undertaking needs assessments to identify high users of GP resource who may benefit from support from dedicated social prescribing team, who provide coaching / sign posting to relevant services
- Wellbeing navigators in place to provide additional capacity
- Practices incentivised to proactively identify AF or diabetes
- Patient education schemes providing information and advice

Croydon specific local approach:

- Two year programme of engagement to co-design the Accountable Provider Alliance - an MCP model
- Developing MyPlan which provides information and advice for patients to support them to self care
- Health care assistants available to provide information and advice
- Personal independence coordinator role currently being scoped

Delivering coordinated care in SWL

Across SWL

- As part of the Better Care Fund, CCGs are working closely with local authorities and community services - these partnerships will support development of MDTs and MCP models
- All **CCGs have schemes in place to provide patients with LTCs or complex needs with coordinated care.** Risk stratification tools, as well as clinical judgement, are used to identify patients for coordinated care
- Patients identified as benefiting from having their care coordinated are added to a coordinated care register and provided with a named professional who oversees their care and ensures continuity
- The named professional may be a GP, or a care coordinator / navigator
- **Patients and carers are invited to develop a holistic care plan**
- Many CCGs have training programmes planned for health care professionals to work in their new models of care, and to have individual **health goal conversations**
- **MDT's including social care are in place, or being piloted** across SWL
- The **two vanguards – Sutton Home of Care and Richmond's rapid test site for new Primary Care Home model** - will share the learning across the CCGs in SWL.

Richmond specific local approach:

- GP led model of care scheme identifying patients at risk of being admitted to hospital, and proactively supporting them through integrated mode of care
- Dementia scheme in place to support screening and diagnosis of dementia

Wandsworth specific local approach:

- Planning All Care Together scheme for patients with LTC or complex needs, commissioned via the federation
- The PACT enhanced care pathway launching in 2016 will work with social services and other organisations, and will have a shared flagging system to link GP systems with the acute

Merton specific local approach:

- Holistic Assessment and Rapid Investigation (HARI) providing community-based holistic care for people with LTCs, comorbidities or frailty, it aims to keep patients well and improve self-management.
- Utilising risk stratification to identify patient cohorts and the care most appropriate to meet their needs.
- Developing coordinated care tool to enable care records to be centralised into one care record system
- Work to standardise care navigator processes through the MCP

Kingston specific local approach:

- Kingston Coordinated care programme in place, and is defining the population segmentation approach
- Four community hubs to be rolled out during 2016 bringing together health and social care, mental health and acute services
- Contracting model in development for project to care for people with complex needs – with voluntary and community sector

Sutton specific local approach:

- Long term conditions programme in place, identifying patients receiving care from multiple professionals as well as a wider cohort specifically patients with COPD or Diabetes
- Four clinical facilitators in place to support integrated health and social care work around MDTs

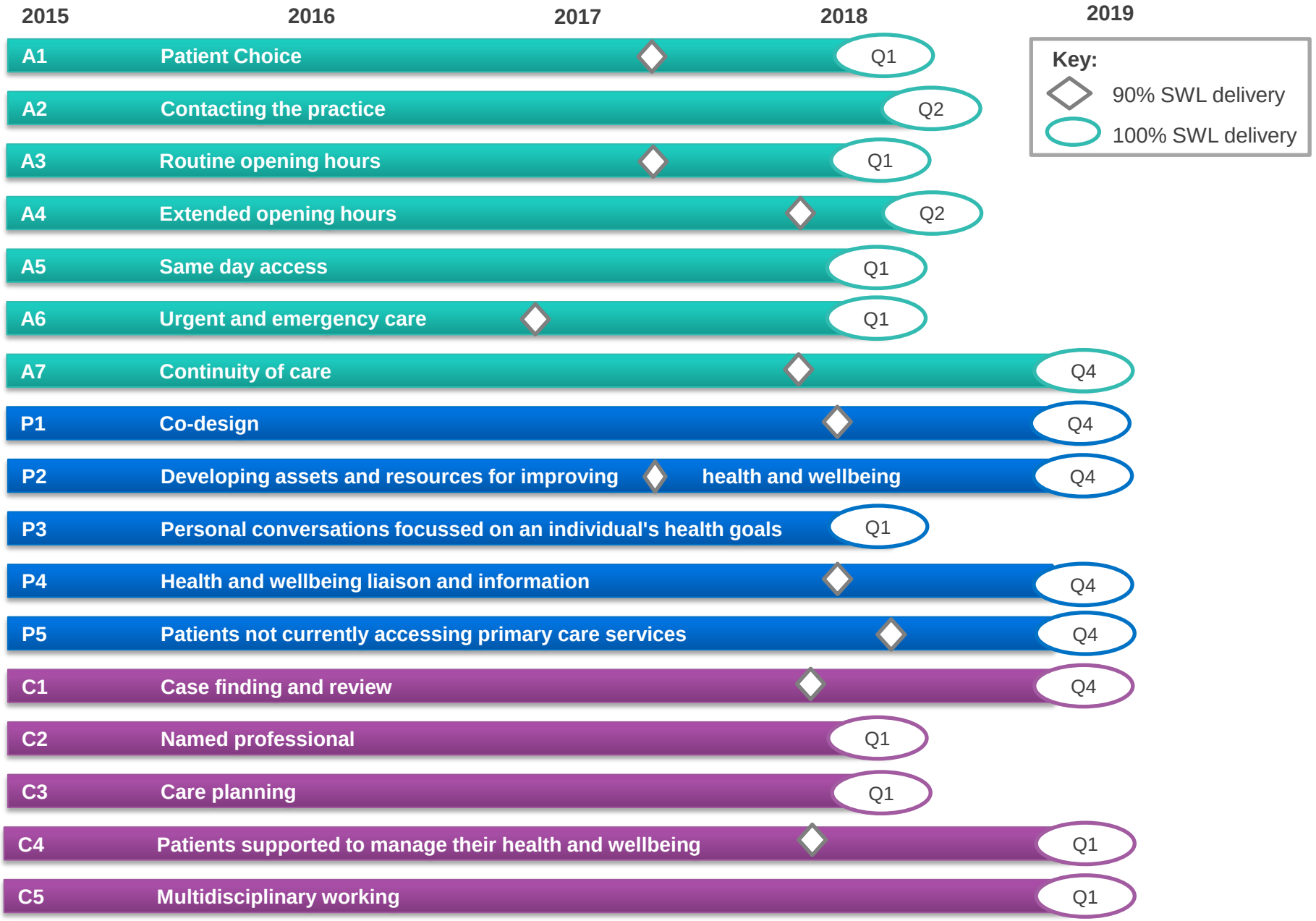
Croydon specific local approach:

- Coordinate My Care clinical service is used to share the patient's care plan between healthcare providers
- Risk stratification tool further developed to include a clinical dashboard providing data from acute services
- Piloting options for clinical psychologist involvement in coordinated care
- OBC contract with APA for care of over 65's from April 2016

Reflections from the development of the aggregate SWL delivery plan

Reflections discussed in the workshop	Workshop responses and recommendations:
Opportunity for CCGs to share best practice There are many areas where CCGs are investing in pilots, or new initiatives and the learnings could be shared, such as: • PMCF pilot 8-8 hubs in Richmond • E-consult pilots in Kingston and Sutton • Telephone triage systems – examples where this has been particularly effective • Live well champions as part of Proactive GP Practice Pilot in Merton • Clinical dashboard in Croydon • Training programmes, such as: Health care professional training course in Wandsworth and training of front line professional staff to identify emergencies	• *Deep dives on these topics would be beneficial, especially focusing on sharing learning from pilot initiatives* • *It was suggested that this list should also include sharing an approach to federation development, enablers, as well as development of MCP models* • *The forum for these deep dives needs to be agreed – one possibility is to use some time in the SWL Delivery Group*
Developing a baseline to understand where we are now, and monitor progress going forward Many CCGs found planning some aspects of the delivery difficult due to a lack of an existing baseline, or due to variation across practices. There may be an opportunity to use a similar approach as some CCGs to address the challenge, including: • Reviews which support understanding of variation in Croydon and Merton • Practice level surveys in Merton	• *It will be key to support the monitoring of progress to establish a baseline. This will also support CCGs to understand if there are gaps where further activity to support delivery needs to be planned* • *Merton conducted practice level surveys using Citizen Space – and it may be cost effective to use this for the whole of SWL* • *Options for this to be discussed at the SWL Delivery Group*
Observation that some CCGs % delivery stretches further than the planned activity – for example P2 asset mapping will not be at 100% until Q4 2018 Do these delivery dates need further re-calibration, or some clarification as to what the additional activity will be to drive the later delivery?	• *Primary care leads agreed to review the aggregate SWL delivery plans, and highlight any activities that could be re-calibrated* • *Review the measures dashboard development by the Healthy London Partnership – this may support understanding of when we have "achieved 100% delivery"*
Agreeing a SWL shared ambition for transformation There many be areas where CCG's have varying levels of ambition to deliver the specification (for example - A5 Same Day Access)	• *We need to obtain an agreed SWL view of "what good looks like" for elements of the specification where currently there is variation*
Vital role of the federations for delivery of the specification As federations will support much of the delivery of the specification, plans need to be in place to support them to develop in maturity during 16/17. There is an opportunity for CCGs and the more mature federations in SWL to support the development of the newer / less mature at scale providers.	• *Agreed that the federations are vital – however raised the risk for delivery of the plans if the federations are given contracts before they are sufficiently mature.* • *To be further monitored and discussed as part of the SWL Delivery Group*

SWL Transforming Primary Care delivery timescales



Next steps

- Reviewing the plans following the December TPC Implementation Board decision regarding variance in delivery plans from the specification
- Finalising the CCG plans & SWL aggregate view ahead of the meeting with Simon Weldon
- Agreeing SWL Collaborate approach to track progress going forwards