General Practice: Development Toolkit

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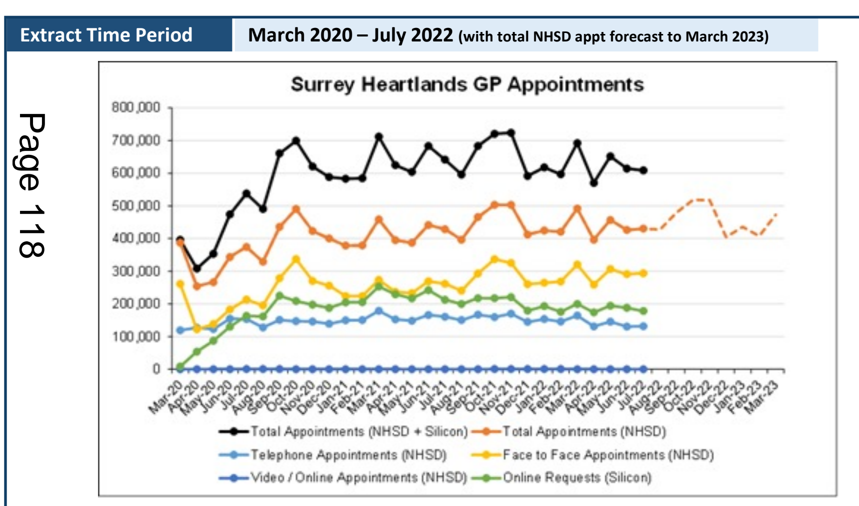
in collaboration with

Strategic Context – Highlighting key focus areas for Surrey Heartlands to successfully deliver the Fuller Stocktake

Closing the gap between supply and demand

The challenges faced by the health and care sector are greater today than they have ever been, with a gap between the demand for health and care, and what is currently able to be delivered. In line with the Fuller Stocktake, there is a need to radically modernise the design and delivery of health and care now and in the future. Building upon previous work undertaken across Surrey Heartlands, there is now a need to focus heavily on two key areas that matter most to local communities; making it easier to access care patients need, when they need it and creating the space and time for clinicians to provide the continuity of care that is so important to patients.



Key Headlines

Snapshot of demand for GP appointments booked in Surrey Heartlands through NHSD and SiLiCON

- Demand for all appointments booked either through NHSD and SiLicon has steadily risen from March 2020, peaking at c.725,000 appointments booked in November 2021

Fuller Stocktake
Key Focus Areas

Making it easier to access care patients need, when they need it

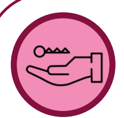
Creating the space and time for clinicians to provide the continuity of care that is so important to patients

Aims for the Developmental Toolkit

- Supporting GPs in providing efficiencies in the delivery of patient care
- Setting out priorities for initial focus and tangible solutions, ensuring Surrey Heartlands excel against the 3 measures as set out in the Fuller Stocktake
- Enabling Surrey Heartlands to focus on the ‘Critical Five’ objectives
- Comprehensive non-recurrent funding package to support the development journey

Key Components

The Fuller Stocktake report sets out a vision for integrating primary care, through improving access, experience and outcomes for communities. To achieve this, we need to identify priority area for initial focus in order to measure provisional baselines and future impact. Below provides seven areas that have been used throughout to measure success:



Access

An integrated approach to improve patient access

- Improving patient access by creating a model that allows an agnostic front door, uses the skill mix of the full team to effectively triage patients to the right person or service
- Using local knowledge and data to spot areas that may require more support

One System, One Plan

Delivery of the Fuller Stocktake

- One System, One Plan
- Shaping our approach with our communities
- How the new model works
- Creating the right space for our teams of teams
- Building expertise, developing talent and transforming recruitment
- Transforming digital infrastructure and data to accelerate change
- Sustainability and future success

Staff Safety & Staff Experience

Improving understanding and experience

- Moving from anecdotal to evidence of abuse to our staff in General Practice
- Gaining an understanding of staff experience to inform support packages

Modernising Access

Improving patient access to the most appropriate care channel

- Data into action
- Patient-initiated contact (GP access)
- Practice-initiated contact (Reaching in to populations)
- Cloud Based Telephony (Seamless transfer between services)
- NHS App – driving efficiency
- E-Hub (back-office)

Quality Improvement

Promoting relationship-based care models to enhance quality

- Relationship-Based Care / Continuity Toolkit
- Integrating teams (PCN & INT)
- Patient Experience

Winter Access Fund

Helping patients with urgent care needs to ensure they are seen, when they need to be

- National Winter Access Fund (now called PCN Support Fund)
- ICS scheme – Practice level additional capacity
- ICS scheme – federation bank holiday cover

Metrics

Ensuring practices achieve KPIs to receive financial compensation

- List of 'outputs' / 'jobs'
- Finance Schedule
- Reporting Metrics

These metrics will be developed by the ICS for sign-off through PCTB. We will never externally report lower than PCN level

Improving Patient Access

Improving Patient Access

Access in Surrey

Good primary care is the foundation of an effective health system for patients. When working well, it supports the early identification of serious illnesses and the management of chronic conditions, while also helping people to live healthier lives. Surrey Heartlands scores above the national average for the overall satisfaction of GP Practices (75% compared to 72%) but our patient co-design work has highlighted the need for more consistency and standardisation. We want to ensure patients can access the care they need, when they need it and any 'transfers' of care, internally or externally, will be seamless.

Personalised care for those who need it

Proactive, personalised support.
Delivery of the Fuller stocktake will ensure patients are able to access more proactive, personalised support from a named clinician working as part of a multi-professional team.

Holistic care from dedicated neighbourhood teams.
The development of neighbourhood teams providing joined-up holistic care to people who would most benefit from continuity of care in General Practice (such as those with long-term conditions) should be supported and delivered in partnership with system partners and primary care.

A Vision Based on Four Key Areas

Our vision for primary care focuses on four key areas: integrating PCNs into neighbourhood teams (aligned to local communities); streamlined and flexible access for people who require same-day urgent access; proactive, personalised care with support from a multi-disciplinary team in neighbourhoods for people with more complex needs, and more ambitious and joined-up approach to prevention at all levels.

Streamlined access

Streamlined access to urgent, same-day care and advice.
To improve access, primary care should be supported to provide streamlined services from an expanded multi-disciplinary team and given the flexibility to adapt their service to local need.

Optimisation of data and digital technology.
Optimisation of data and digital technology by systems to connect existing fragmented and siloed urgent same-day services is essential to streamlining access. Optimisation will empower primary care to build an access model for their community that provides patients with different needs access to the service that is right for them.

Increased resilience.
Streamlining access will increase GP practices' resilience, by connecting patients to the practitioner who meets their need, rather than increasing GP referrals to additional services This will increase practices' capacity to deliver continuity of care.

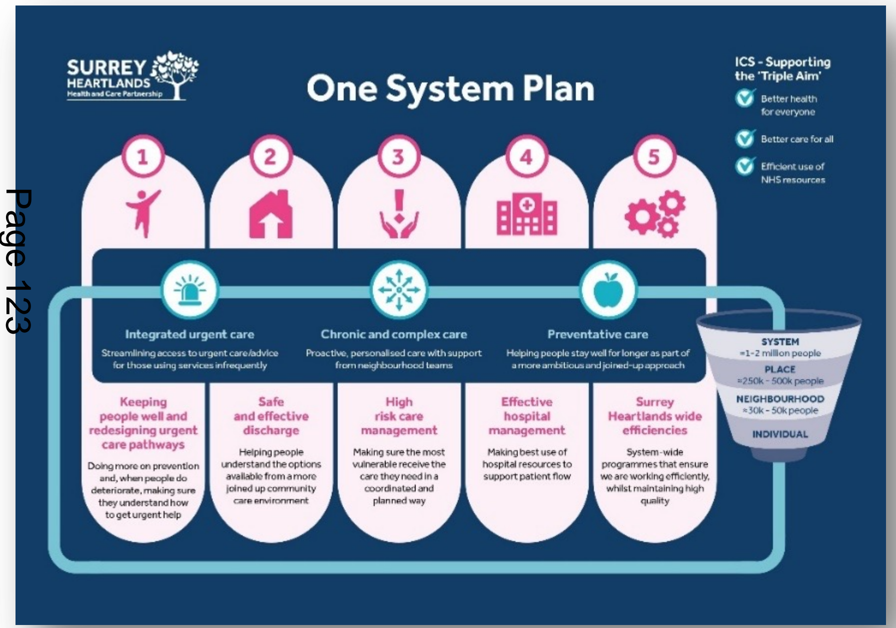
One System, One Plan

Delivery of the Fuller Stocktake

One System, One Plan

Purpose

The purpose of this document is to support health and care leaders and teams right across Surrey Heartlands to understand and embrace the opportunities our new way of working presents. It sets out how we are creating the conditions to break down many of the organisational barriers that have previously got in the way of health and care organisations delivering their services optimally to best meet the needs of our patients. At the heart of the document is how we are aligning everything we do in health and care to achieve two keys aims: **(1) Making it easier for patients to access the care that they need when they need it (2) Creating the space and time for our clinicians to provide the continuity of care that is so important to our patients.**



Health and care organisations – **supported by the voluntary sector and driven by local Place Committees** – will deliver against these objectives by providing more services through Integrated Neighbourhood and Place Teams

Integrated Neighbourhood 'Teams of Teams', will evolve from existing Primary Care Networks which will work collaboratively to improve the health and wellbeing of the local population.

Wrapping integrated neighbourhood teams around our practices will enable them to deliver the majority of care to the population, providing long term continuity and cradle-to-grave care wherever possible.

Creating the system conditions to **enable our four Place-based partnerships or Alliances** to transform the way family doctors and other health and care professionals offer care locally as *Primary Care Networks* transition into locally-designed Integrated Neighbourhood Teams.

Shaping our Approach with our Communities

Our Approach

The NHS response to the pandemic demonstrated what we can achieve when we come together as one. Our new model places neighbourhood teams at the centre of our approach, with **a clear reactive and proactive model enhanced by data and digital technology**. Local communities will be engaged to build approaches and plan, enabled by local exemplars.

Building together

Engaged to build our approach & plan

- **In depth qualitative research into access to General Practice**
- **Citizen panel surveys and qualitative research**
- **Talked to people in their communities**
- **Engaging with health and primary care teams, e.g. Guildford**
- **Covid-19 Community Impact Assessment**

Innovating locally

Enabled local exemplars

- ***Growing Health Together*** in East Surrey
- ***Guildford & Waverley Alliance*** appreciative enquiry approach
- **Equity Development Officers** in East Surrey
- Working with **Citizens Advice** to better understand financial challenges in our communities
- **Social prescribing** in some of our communities

Hard-wiring this approach by supporting Places to:

1. Develop and launch full partnership engagement programmes in next 12 months
2. Deliver more community projects supporting local well-being and prevention
3. Share learning and best practices for people involved in community development and health creation

HOW THE NEW MODEL WORKS: NEIGHBOURHOOD TEAMS

Creating a clear 'Reactive' and 'Proactive' model

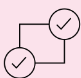
- **Reactive (patient initiated) –** Team of Teams streamlining urgent care same-day access delivered by a multi-disciplinary team
- **Proactive (practice initiated)** - The additional capacity releases time for GP practices to streamline things like medication reviews for patients with long term conditions and help patients avoid unnecessary appointments

Rolling out cloud-based technology across our system

Enabling the seamless flow and re-direction of patients by offering 'call-back' functions to enhance patient experience, the ability to audit clinical encounters, and enable patient data to be easily accessible to aid clinical decision making.

Improving demand and capacity responsiveness in primary care

A daily feed, directly from clinical systems, allows us to see in near real-time any rising pressure, which can trigger an automated alert to the local teams to respond by providing additional support to individual practices.



Improving planned care

Integrated Neighbourhood Teams will be supported by a Complex Care Function (CCF) operating across Surrey Heartlands, bringing together hospital specialists, specialist therapies, diagnostic infrastructure and virtual ward provision to deliver an improved CCF which will release capacity elsewhere in the system.

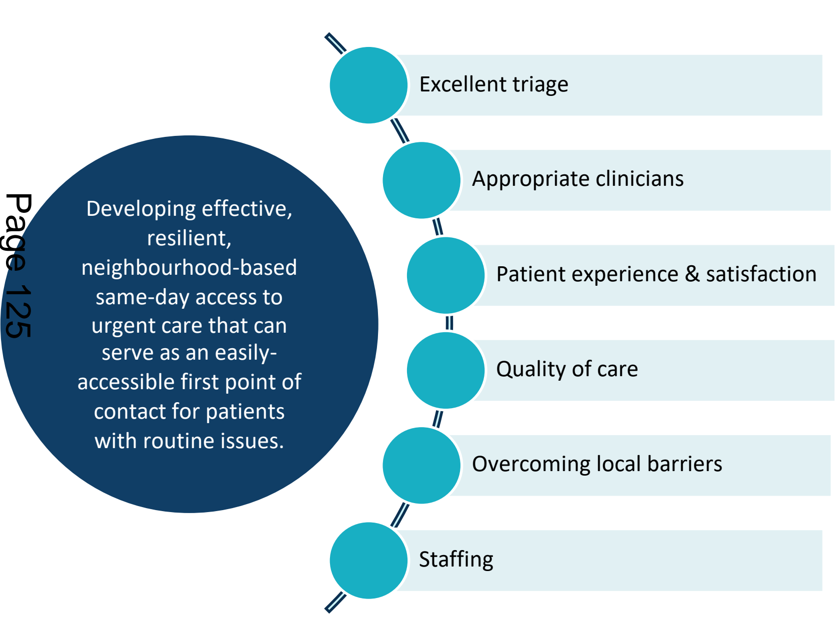
Creating the physical space for our team of teams

Reimagining how we use Primary Care buildings to create a positive working environment for staff, catalyse integration and focus on patient needs when thinking about how we use our buildings in the future.

How the New Model Works – Integrated Same-Day Urgent Care

A New Model Our new model seeks to improve access to same-day urgent care developing **a holistic approach that is effective, resilient and neighbourhood based.**

Our approach



Leading to…

Enhanced Access Hubs

Same day urgent appointments that can be accessed digitally and include multidisciplinary teams that work until 8pm weekly and across the weekends

Urgent Community Response

For more complex and frail patients, provision of an MDT rapid response approach to help patients avoid the need to be transported away from their home and into an acute hospital

Community Diagnostic Hubs

Working across Place, models of diagnostics have been developed that are placed within local communities. This includes outreach models such as working with the homeless communities who are now able to access mobile Hep C screening and liver testing as well as Covid Vaccinations from an outreach Community Team

Care Homes

An MDT approach to the management of care for these residents has been implemented, particularly those who are more complex requiring extra support to avoid hospital admission

Frailty Models of Care

Key ambitions for frailty services that work with our local communities and carers to deliver urgent care in frailty that allow people to stay at home for longer safely have been developed

Anticipatory Care Models

Utilising the new digital risk stratification, we can better target those most at risk of admission and attendance into the Urgent Care system

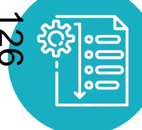
Creating the Right Space for our Teams of Teams

Overcoming key estate challenges

Finding the physical spaces for teams to co-locate and work together to improve care is one of the largest challenges. There is a dedicated team working across Surrey to identify joint opportunities around **using buildings that could support the future integration of services.**

Joint Opportunities

Baselining the whole estate
to understand the value, costs and condition of every building currently used for health, including the primary care (GP) estate



Developing new investment principles
to enable us to both prioritise investment and find new opportunities to develop estate

Identifying opportunities to potentially consolidate existing sites
to deliver wider objectives, for example, releasing value to support reducing system inequalities

Developing a Blueprint Framework
for the governance and delivery of multi-partner place-based projects

Outcomes for Surrey Heartlands

Move to an approach that make **estates a catalyst to integration**

Focus on patient needs when thinking about how we use our buildings in the future

Understand and explore the potential for new opportunities, especially around the use of commercial estate

Create a positive working environment for staff - including adequate space for activities like training and teamwork.

Building Expertise, Developing Talent & Transforming Recruitment

Investing In Our Most Valuable Resource- Our People

The NHS' most valuable asset is its staff and future success depends on building expertise, developing talent and transforming recruitment processes across primary care. Modernising processes will enable us to build new capabilities, ensure fulfilling careers, support continued learning and development, and establish a 'Surrey Offer'.

Modernising and integrating recruitment

By integrating recruitment across a range of partners we can help attract and share candidates across settings, ultimately ensuring individuals can benefit from access to multiple opportunities without having to complete multiple applications

Building new capabilities

The **Surrey Heartlands Health & Social Care Academy** will help to build, develop, share, and nurture talent across all settings. Using rotational programmes for students and other roles, we will augment the exposure to primary care, community health and social care settings to help attract and retain talent.

Developing fulfilling careers

Expanding Additional Roles Reimbursement Scheme in primary care and integrating workforce activities with social care will help enhance career opportunities in community settings. We're also trialing a Career Guarantee - offering two jobs at the same time in some career pathways – an initial role and a conditional offer for the next role

Establishing a 'Surrey Offer'

Teams of Teams will be more effective if we work toward ensuring equity of opportunity, access to support and experience – closing the disparity that currently exists. Also prioritising how access to things like affordable accommodation and financial well-being services can be accessed by all staff.

Supporting Learning and Development

The Health and Care Professional Leadership Framework will support leaders from across health and care through a 'system leadership' support offer, access to leadership academy programmes and profession-specific leadership development.

Transforming Digital Infrastructure and Data to Accelerate Change

Cross sector data sharing to achieve change

Surrey Heartlands' **data integration and warehousing programme** will be used to help create a platform for **central data and analytics ecosystem.** This is built on the use of shared shared data across a range of partner organisations throughout Surrey including health, local authority and third sector.

Latest position

All major providers on the Surrey Care Record have been integrated

Successfully rolled out remote monitoring and virtual ward platforms across the system

General Practice is promoting the NHS App and NHS.UK to reach **60% adult registration by March**

Linking the Surrey Care Record to our Population Health Management platform will improve segmentation and give us the knowledge and information to enhance direct care of patient cohorts and support personalised, anticipatory preventative care, leading to:

- An Integrated Data & Digital Platform — Initially focused on developing a population health-based approach to health and wellbeing
- A System Intelligence Function — To support place & neighbourhood teams to use our Integrated Data Platform to improve our predictive capability to support planning
- A Population Health Hub — To work with the wider system to promote, sustain and spread successful interventions and innovations

Sustainability and Future Success

Approach

Ensuring that the changes made to primary care systems are both **sustainable and holistic** will be key to future success. Our approach will focus on **localised decision-making**, continuous care **quality improvement** and a series of **access visits** to gain greater insight into the pressures and challenges faced by General Practice.

Making our approach more sustainable

Governance & Decision Making.

Decision making as local as possible, with the broader system leading on accountability and ensuring improvement, innovation, investment and support is targeted where it will have the greatest impact on patients and communities.

Quality Improvement.

Committed to continuous care quality improvement at every level of our system and have established the **Quality Improvement Collaborative** to drive our quality governance model across Place-Based areas and ICS. The Health and Care Professional Committee providing system-wide leadership across the spectrum of the quality agenda.

Supporting practice sustainability.

Undergoing a series of access visits to understand pressures and challenges that may be faced by General Practice to determine what additional support and improvements that may be made.

WHAT WILL FUTURE SUCCESS LOOK LIKE?

Continuity.

An increase in personalised care being provided by multi-agency, multi-disciplinary teams with care co-ordinators: enabling patients to see the same clinicians or teams, reduction in ED attendances for defined cohorts of patients, a reduction in GP contacts and the number of outpatient contacts

Access.

When every patient is able to access primary care easily, efficiently and receive the appointment type of their choosing

Reducing inequality.

A measurable impact in addressing the C20+5 gap.

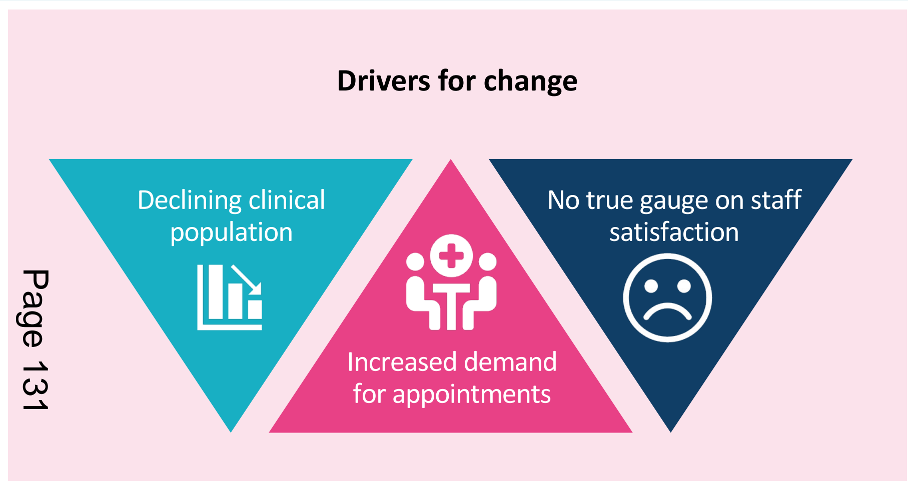
Staff Safety and Staff Experience

1. Keeping General Practice Safe
2. Staff Survey

Setting the Context: Providing a mechanism for our Primary Care workforce to feedback

Staff satisfaction is imperative to creating and sustaining a resilient workforce. General Practice isn't included in the NHS Staff Survey, and therefore isn't featured in the 'NHS People Plan'. We want to create an opportunity to gather specific and detailed insight to influence the wellbeing, career progression and workforce planning support for the future.

Drivers for change



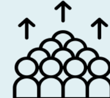
Survey Objective

Each autumn everyone who works in the NHS in England gets an opportunity to complete the NHS Staff Survey. We want to offer the same opportunity to GP and Primary Care. The outcome of the survey will give us a snapshot in time of how people experience their working lives. Its strength will be in capturing a baseline that can be built on annually and it will influence support required.

Identifying the need for staff to have their voice heard

Addressing the gaps caused by a declining clinical population

The clinical population within Surrey Heartlands is diminishing due to an ageing GP population, coupled with a low uptake of GPs. The Staff Survey provides an opportunity to gain understanding of the challenges faced and to implement strategies to improve future provision of services.



Supporting staff to serve an increasing patient to GP ratio

The proportion of patients per GP has increased across Surrey Heartlands compounded by the pressures associated with patient backlogs. These challenges need be addressed to enable effective provision of care.

Supporting staff through a challenging winter

Winter pressures including flu and backlogs caused by Covid-19 are set to compound existing shortages and infrastructure limitations in clinical practices. The time to act is now in order to engage NHS staff and establish a baseline against which to improve services.

Improving staff retention and satisfaction

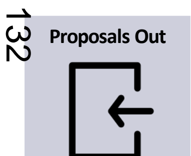
In the wake of the pandemic, staff increasingly expect flexibility in their work. Emerging technologies provide a key opportunity to develop flexible working conditions for staff and to increase staff satisfaction across Surrey Heartlands. Ensuring the technology is in place to support this is a key priority.

Recognising that the National NHS Staff Survey does not encompass Primary Care, Surrey Heartlands as trailblazers are developing their own, with the intention to engage the entire workforce

Keeping General Practice Safe: Mechanisms to recognise abuse and approaches to counter

Developing a Safe and Respectful Working Environment across General Practice…

Feeling safe at work is not just a priority for the NHS, but a right for its workforce. Unfortunately, at times there are occasions where staff members across general practice become exposed to verbal threatening behaviour, or even physical abuse. This type of behaviour is not tolerated by the NHS and therefore Surrey Heartlands are in process of developing an auditing process to record and evidence abuse, escalating these to national bodies where required, in addition to exploring additional security protocol across Primary Care.

	Category		Description – *turning concept into action*		Progressing to *next steps*
Proposals In	**Audit** Conducting regular audits to ensure practices have the opportunity to report abuse, with channels to escalate advanced cases		• Development of a simple and rapid audit process to quantify abuse cases across all 104 practices which can be used to provide tangible evidence to NHSE / Healthwatch. • Alternatively, qualitative / narrative audits can be developed on a quarterly basis to report abuse received to the ICB. • In turn, this would support evidence to reflect and escalate to NHSE for regional support in General Practice.		Audits to be conducted utilising a range of mediums: **1.)** Simple OPEL dashboard submissions, or 2) Alternative digital submission if preferred, or 3) Narrative reports of individual incidents to be supplied to commissioner By conducting audits, targeted interventions can be implemented into General Practice to attack the root-cause
Proposals Out 	**Security** Developing a series of physical and protocol based and procedures in General practice to keep the workforce safe		• Enhanced security within General Practice could be supported through TIAA (ICB security company) tutorials. This organisation are already available on an 'ad-hoc' basis to support practices to deal with difficult situations with ICB approval. *Funding has been made available nationally this year to enhance security, therefore possible security enhancements need to take this into account.*		All practices should undertake an assessment of their current security measures so informed decisions can be made to enhance security. Following this, analysis of the support and possible funding requirements can be undertaken. The ability to enhance security may be driven by estate constraints and landlord limitations.
Proposals Out	**Comms** Sharing best practice and ensuring communication exists across Primary, Secondary and Community Services to identify abusive patients		• Centrally developed comms, including statements and posters should be supplied to practices to support them and their staff in dealing with abuse. • Communication to contains strong and concise messaging, including consequences of patient actions		**Latest position:** There is a large piece of work currently being undertaken that aims to communicate the importance of providing clear warnings to abusive patients as well as recognising and actioning immediate removals (SAS referral) for the safety of practices and their staff.

Audit: There is a need to support General Practice from the top down, with regional colleagues ensuring national support is provided as required to protect General Practice. Through the development and regular undertaking of audits, it will be possible to evidence the need for support.

Security: Hospitals have on hand security who are able to step in and operate a comprehensive zero tolerance policy. This doesn't exist in General Practice, and patients are only able to be removed once clear and chunky regulations have been met, often compromising staff safety. Through enhancing security, there may be an opportunity to overhaul current regulations, ensuring General Practice are able to protect themselves at all times.

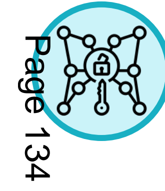
Comms: It may be advantageous to include Healthwatch in the development of these initiatives to widen the knowledge of what is happening in General Practice and gather national support.

Patient Experience

Description

There are multiple ways of capturing patient experience. The main way we gather this currently is via the General Practice Patient (GPPS) but there are other ways that we need to start to test. NHSE are currently working on Patient Reported Experience Measures (PREM) – this is targeted to those who have just used a NHS services. This is a national product and is in build currently. Practices should be reviewing and building their customer services from the GPPS and building a strong PPG.

Category	1) Whole population – GPPS	2) Live Patient Experience Survey	3) Local focused insights	4) Patient Participation Groups (PPG)
Target / Output	Whole population: to identify people experiencing access challenges, ideally monthly insights to practice level	Targeted: recent users of GP Practices. Ideally monthly insights to practice level	Focused support: Qualitative or 'boost sample' approach to provide additional insight where required. Ad hoc	Connecting with your community to support the a bi-directional conversation.
Delivered by	Ipsos MORI – using existing research tools (e.g. omnibus), potentially linking into live experience survey (widening reach where practices aren't live)	NHSI/E & Ipsos MORI using GPPS access questions as refined for the live experience survey	TBC – ICS level (e.g. Healthwatch or other local research partner – potentially supported by ICS's with appropriate research and insight expertise) OR Ipsos MORI	ICS support pack attached to guide practices through setting up & maintain. ICS communication plan to support sharing of interesting data & NHS structures (e.g. ARRS roles)
General Practice Task	▪ Review annual (published July) practice position & PCN position via practice meeting to discuss and address metrics ▪ GPPS will move to a more regular reporting cycle – at which point practices will be able to see any changes to experience more frequently	▪ NHS England have been working on 'real-time' patient experience for those who have used services ▪ Patient Reported Experience Measures (PREM) once in place will be a critical tool for practices. Once the tool is delivered we will ask that practices use this to gather further service user feedback	▪ We are looking for one PCN per place to start to test this approach with us and share with the ICS the outcome	



Modernising Access

1. Data into Action
2. Patient-Initiated Contact
3. Practice-Initiated Contact
4. Cloud Based Telephony
5. NHS App
6. Back office (eHUB)

Turning Data into Action: Creating data that supports the right action

Offers to support primary care leaders

There are three offers which will help support primary care leaders to turn data into action.

1. Programme of work with LSBU to undertake a deep dive into practice and PCN data
2. Enrolling into the NHS Confederation to support CDs influence the direction of travel & tap into a community of support
3. Offering CDs to receive a session from Dr John Kilpatrik on how to easily navigate Graphnet (based on the 3 building blocks of the Fuller Stocktake)

Creating data that supports the right action

Turning data into action

Practice | PCN | Place | ICS

Data to inform action

- E.g. continuity, skew, failure, demand
- Integration of ARRS roles
- Blending in patient input
- Differentiating urgent work

Data to inform action

- PCN level data interrogation
- Integration of ARRS roles
- Urgent Care Hubs
- Neighbourhood teams

Creating the required starting conditions and data to question the work

Community of practice events

- Collective understanding data insights
- Collective conclusions on the work, and required new models
- Learning to ask more of the data

What does our current data tell us about out models of care?

Monthly insight sessions with the ICS primary care team, developing:

- Big picture conclusions and questions
- Keeping the focus of work
- Measures that matter
- Cross-practice decision support systems
- Institutional learning on how to use data more effectively in primary care

Source: The Primary Care Networks Academy

Patient-Initiated Contact

Defining the Model

The Patient-Initiated Contact (PIC) model is designed to look at the most efficient and effective way for patients to access General Practice, and to ensure a consistent response, no matter what channel is chosen. This model utilises best practice from across the country and incorporates the technology we harness in Surrey

Current Position

We know that demand in General Practice has increased. The reason is multi-faceted; patients staying away during the peaks of the pandemic, backlogs in long term condition care, spikes in acute infections, increased mental health presentations, and increased demand due to the delays and waiting times to access other services, in turn leading to patients seeking additional support from their Practice.

Coupled with an increase in the channels that patients can use to access the service such as online access, these have directly contributed to the distortion of urgent vs continuity. This has resulted in a need to create a model that swings us back into the right proportions.

The 'co-design' work highlight the 3 main areas that we have incorporated into our thinking for the patient initiated contact:

1. Access – inconsistent 'modes' and availability
2. Total Triage – lack of patient understanding of roles and 'control' of how and who they are directed to
3. Consultation Mode – patient preference

Where we want to get to

Agnostic front door

'Channel agnostic' approach provides benefits to both practices and patients through:

- Supporting streamlined workflow in practice
- Supporting patients to access care in a way that suits them best

Triage

- Ensuring most efficient process for "PIC" activity
- Utilisation of the wider team to 'sift' out administrative issues
- Internal & external alternative to a GP (GPCPCS, INT…)
- All information ('work up') is done before requests are received by a member of the clinical team

Technical tools

- All channels have the same/similar questionnaire

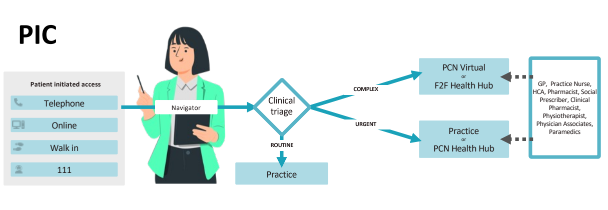
EXAMPLE:

Please watch this short clip to see how one of our Practices in Surrey Heartlands has arranged patient-initiated contact:
https://www.youtube.com/watch?v=z_Sp5Rzwb8o

PIC – *managing route & urgent patient contact*

***Seamless Triage** - The patient-initiated contact IUC model creates an opportunity to utilise clinical navigators within General Practice, alongside clinical triaging lists, to direct and redirect patients to the most appropriate care setting, without placing a burden on clinical time*

PIC



Online Consultation – in addition to patients ringing the practice, by utilising the Footfall solution, clinicians can manage patient with a navigation tool which indicates the next course of action for care

Metrics used for assurance

Online consultations → **DES IIF**: threshold has been set at a modest level, corresponding to 5 online consultation submissions received by the PCN per 1,000 registered patients per week

F2F → Triage to other services from access points

Telephonic → Seamless phone access for in & out of hours (eg into enhanced access & 111).
Implementation of cloud telephony in PCN level(practices of the same PCN procure same cloud solutions)
Set up of a centralised call centre

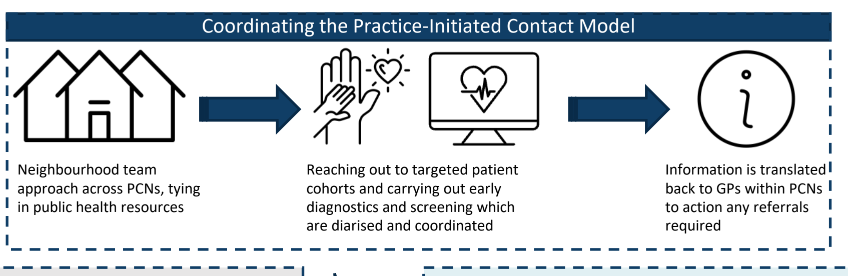
Practice Initiated Contact

Defining the Model

There are two aspects of the Practice-Initiated Contact model:

- The first refers to **proactive case management of long term conditions (LTC),** ensuring patients with LTCs have diarised blood tests and relevant diagnostics which are coordinated and organised in line with the requirements of the patient's LTC. Diagnostics will be pre-booked and followed-up with a relevant clinician. Following this (if required) a holistic review will be undertaken with their GP / clinical pharmacist.
- The second refers to **preventative work** to ensure early diagnostics (e.g. smears, prostate cancer diagnostics) are coordinated in a timely manner and all relevant 'work-up' has been carried out. Furthermore, the identification of high-risk target groups (e.g. high risk prostate cancer cohorts) are to be referred in to hospitals. Ensuring this is done without overwhelming them is imperative.

Coordinating the Practice-Initiated Contact Model

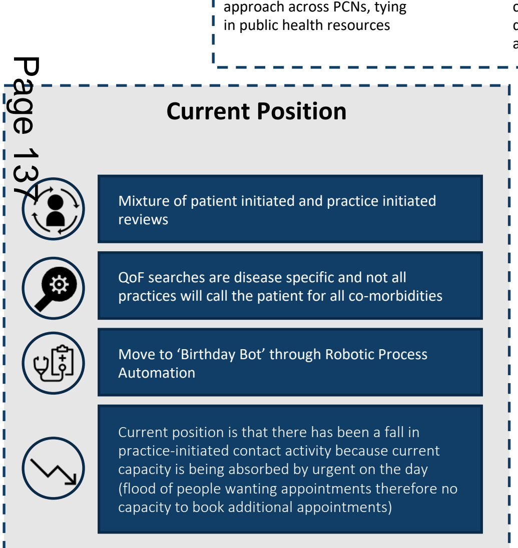


Neighbourhood team approach across PCNs, tying in public health resources

Reaching out to targeted patient cohorts and carrying out early diagnostics and screening which are diarised and coordinated

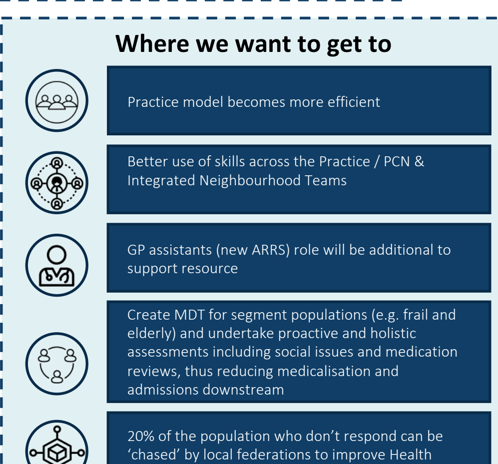
Information is translated back to GPs within PCNs to action any referrals required

Current Position



- Mixture of patient initiated and practice initiated reviews
- QoF searches are disease specific and not all practices will call the patient for all co-morbidities
- Move to 'Birthday Bot' through Robotic Process Automation
- Current position is that there has been a fall in practice-initiated contact activity because current capacity is being absorbed by urgent on the day (flood of people wanting appointments therefore no capacity to book additional appointments)

Where we want to get to

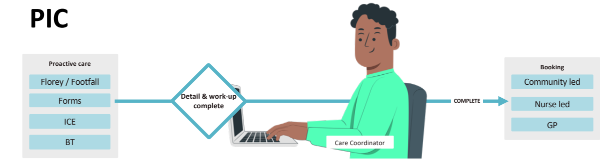


- Practice model becomes more efficient
- Better use of skills across the Practice / PCN & Integrated Neighbourhood Teams
- GP assistants (new ARRS) role will be additional to support resource
- Create MDT for segment populations (e.g. frail and elderly) and undertake proactive and holistic assessments including social issues and medication reviews, thus reducing medicalisation and admissions downstream
- 20% of the population who don't respond can be 'chased' by local federations to improve Health Inequalities

PIC – *Chronic Disease & Long-Term Management*

The PIC model approach promotes a proactive stance towards managing LTC patients, taking a cohort of patients who are case managed by a care-coordinator, who uses a series of technical tools to collate all the information required.

In turn, this information is then reviewed by an appropriate clinician who either closes the review (letting the patient know), or who requests that an appointment is booked with the most appropriate clinician, in a timely manner.



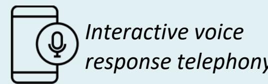
In addition to providing more capacity through relieving pressure at 'patient initiated contact' channels – PIC channels also look to streamline medication reviews and utilise ERD to avoid unnecessary review

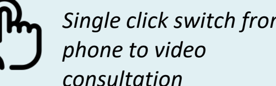
Metrics used for assurance

- QOF and DES target met (80% of all criteria or topmost criteria based on max points
- PHM data point improvement
- LD, SMI, NHS Health Check % improvements

Advanced Telephony: Developing wider integration and advanced function across Surrey Heartlands

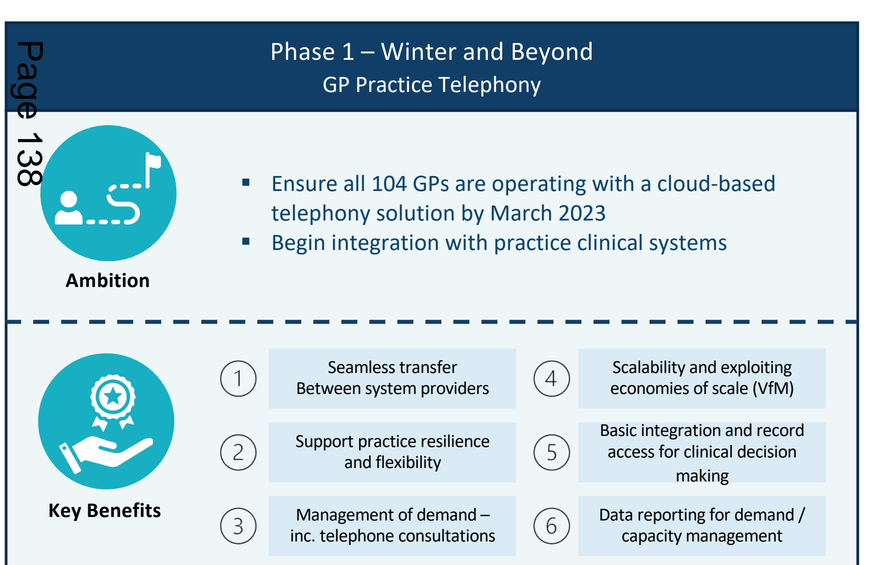
Call queueing, redirection and records access is only the beginning …





Operation within a Virtual Desktop Infrastructure (VDI) environment

Integration with NHS Mail and MS Teams



Phase 2 – July '23 > Nov '23
'System Working'

- Begin integration with OC and VC platforms
- Redefine the use of 111 solutions and Single Virtual Contact Centre (SVCC) at regional level

Key Benefits

Maximising on estates spatial capacity

Consistent patient experience across PCN

Improve staff recruitment & retention with flexible working

Advanced data reporting for demand / capacity management

Support planning at system level with better information / data on telephony-based patient interactions

Advanced integration into third party digital solutions, promoting joint up data and care pathways

Phase 3 – Dec '23 onwards

- Ensure each PCN is operating on one solution
- **Scalability in call handling -** Looking into PPG hubs for call answering
- **Interactive voice response telephony**

Developing a stepped approach to advancing Cloud-Based Telephony across Surrey Heartlands ICS

Meeting SH Ambitions

It is recognised that there is a varying level of maturity across the system, as well as desire to upgrade telephony solutions. Therefore, to achieve all of Surrey Heartlands ambitions, a stepped approach to the implementation of Cloud-Based Telephony will ensure the system caters for all as communication channels are implemented and advanced. The overarching Change Management work will be undertaken by Redmoor. Work is due to begin at the end of Oct '23, therefore these steps will be confirmed once Redmoor is fully engaged.

Step 1 – the immediate ask

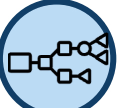
Development of Core Principles for adoption by all Practices

Development of a set of core standardised principles with exceptional variance as required in line with Practice demographic.

Standardised principles will include:

- Consistent call answering across all Places
- Clear, succinct messaging for in hours and out of hours
- Queue busting to start once 3-4 people are in the queue to better manage expectations (depending on telephony solution)
- Automated options to enhance customer experience (e.g. routing to enhanced access)
- Bypassing numbers for ambulances and A&E who currently struggle to reach Practices.
- Seamless data sharing into OPEL

Step 2

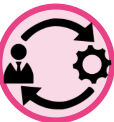


Introducing more complex redirection pathways to Practices

Once core principles have been developed, step 2 will involve engaging an internal change management parachute team who are able to implement each of the principles into each Practice.

- Alternative routines into NHS 111
- Develop approaches to messaging and circulate as best practice

Step 3



Utilising initiatives and third-party technology to trial innovative redirection solutions

As part of Redmoor's offering, a number of change initiatives will be fully supported at Practice level to support practice and PCN ambitions. This will include workflow overhauls, patient engagement and digital platform integration such as integrating advanced telephony and remote consulting workflows, amongst others.

Delivery Team

Local Resourcing

Regional Team

External Supplier (Redmoor)

Acute respiratory (ARI) Hub model

A Redistribution of Funding to ARI Hubs

Due to increased pressures, Surrey Heartlands ICB is redistributing the money that was assigned to Federations for additional Winter and Bank Holiday Capacity and is coupling this with funds received from NHS England to support the facilitation and establishment of **Acute Respiratory (ARI) Hubs**. This programme will be in place over winter to help manage pressures, including but not limited to the current rise in Strep A type presentations. The proposed model is best delivered by Federations, given the established robust infrastructure and the NHSE recommendation to have approximately one hub per 250,000 patients.

At Scale Respiratory Service - Surrey Heartlands

Patient
Practice
Patient presses an option for Child with Resp issues
Call transferred
"Call Centre"
Footfall
Practice
Cross Org Booking (similar to EA)
Florey Survey sent to patient
Triage List
Consultation via telephone
Patient treated face to face

Emphasis on keeping from patients waiting in a call queue, being able to press an option and be diverted directly to the ARI Hub. Reducing the amount of patients hanging up and contacting another service.

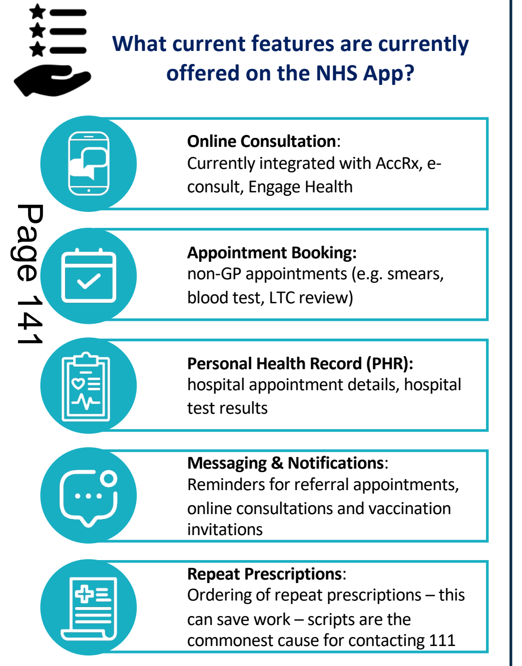
"Call Centre" type model increases the amount of calls taken, by processing patients in the most efficient method. Enabling staff to maximise on calls taken.

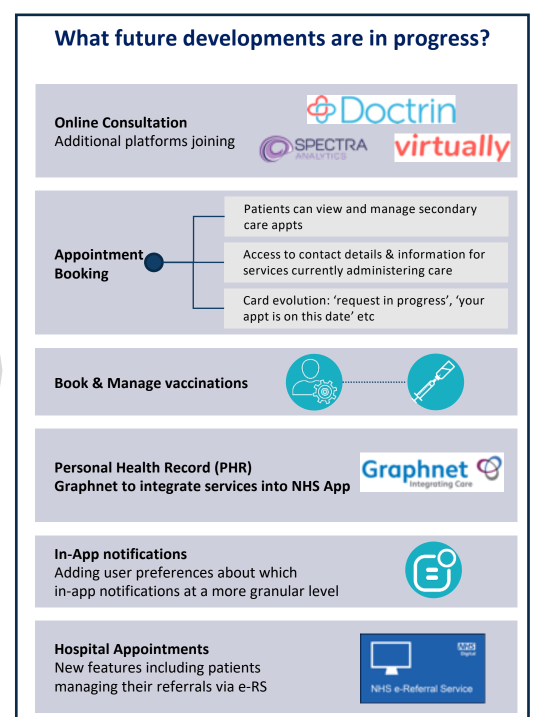
Tech based "pre triage" ensures that the patient is contacted by the most appropriate HCP, while enabling clinical staff to work throughout the full range of their skill sets

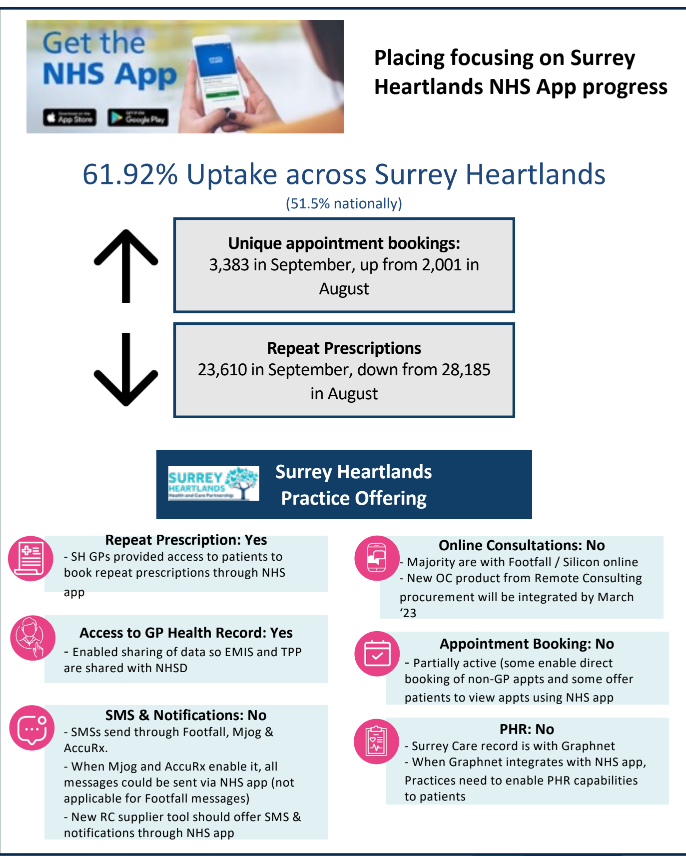
Patient is seen as quickly as possible, by the most appropriate clinician. Clinician is going into the consultation with a wealth of information ensuring the patient is not repeating the same information to multiple parties.

Improving NHS App features across Surrey Heartlands to release practice capacity

Nationally, the NHS App offers a multitude of features, which improve efficiency and reduce workload. Future developments mean that NHS App will rapidly become an essential tool to help Practices care for patients. We need to rapidly further increase uptake of the App from the current excellent level.







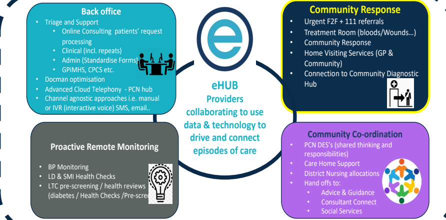
Back Office eHub

Defining the Function

eHubs are an emerging model for delivering online consultations at scale across General Practice. Traditionally, individual practices received and processed consultations from patients on their own lists, with all requests being handled ‘in-house’. By utilising a centralised eHub model, practices are able to ‘pool’ their resources and manage demand more efficiently by working as a collaborative cluster.

Back office

- To be defined by each Place but a central virtual hub that supports back office at scale. Possibilities include:
- Triage and Support
  - Online Consulting patients’ request processing
  - Clinical (incl. repeats / repeat dispensing), SMI & LD Health checks,
  - Admin (Standardise Forms) , NHS App utilisation. Docman optimisation
  - “Surge” interpractice and inter-PCN working
  - GPiMHS, CPCS etc.
  - Proxy access care homes, NHS @ Home
- Advanced Cloud Telephony - PCN hub
- Channel agnostic approaches i.e. manual or IVR (interactive voice) SMS, email..



eHub - Place Based Back Office Element

Each place will be supported to accelerate the ‘Back Office’ offer to support its practices. The Federations and CCG Primary Care Teams have worked up a menu of support to generate ideas but this should be developed in conjunction with member practices.

A key clinical area to consider is the 20% of individuals who typically do not respond to LTC review requests – the hard to reach

Alongside the back office one-off sum, each place will receive additional finances for a care co-ordinator and Bank Holiday appointments.

Identifying the Benefits

- Developing a consolidated administrative function to process online consultations
- Promoting the ‘Neighbourhood’ partnership model through utilising MDTs to treat patients
- Utilisation of integrated technologies to process patient data and to support clinical decision making
- Maximising use of clinical time to treat those patient with the greatest need (including LTC pro-active, care)

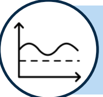
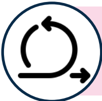
Quality Improvement

Continuity of Care – Quality in Consulting

Addressing continuity of care at practice level

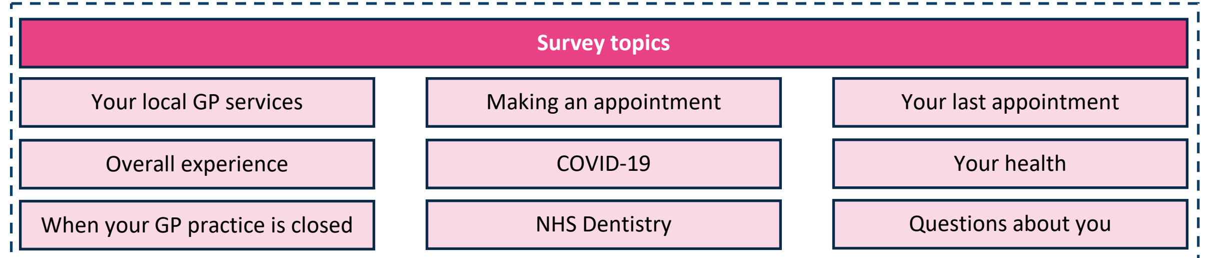
Quality matters, and too often clinicians are frustrated by fragmented care and a lack of time. Take a look at the RCGP 'Continuity of Care Toolkit'. It shares the learning and experiences from practices who have been improving their continuity over a two-year period, with support from the Health Foundation. Based around 6-steps from setting out your ambition to implementation, the practices involved in bringing this resource 'Toolkit' to you range from 35,000 to 45,000 patients, located in urban, rural, affluent or deprived areas. The result is a resource that can be tailored to your practice.

Watch the introduction here before you start your journey: https://www.youtube.com/watch?v=KJJjsnreva4&t=163s

Practice Need	Why	Methodology
Considering the importance of continuity of care within individual Practices	Developing trust & relationships at patient level but also familiarity at the clinical level to best serve patient need based on prior knowledge	Meet and discuss continuity of care with Practice teams
Understand how each Practice is currently performing on the continuity aspect of Relationship-based care	 To establish a relationship baseline and 'as is' ways of working	Review Practice continuity of care data set. This will be facilitated by the ICS
Identify any barriers that may be faced when enhancing continuity of care	Understanding the level of effort required to implement and dot continuity measures	Summarise thoughts and plans around continuity of care based on Practice discussions. Summaries should be no longer than a single side of A4.
Identify opportunities to change and make changes with Practice teams	 Promoting an Agile iterative way of working to harness the best out of local GP teams	Implement Practice continuity of care plans through clear change management methodology
Understand and address the impact on any changes made	Establishing KPIs to measure success	Review Practice continuity of care plans after 6 months which will be informed by the updated data set (ICS facilitated)
Reflect and review Practice plans for continuity of care	Creating an environment that promotes reflective environment and ensure any changes made are worthwhile	Summarise Practice thoughts and provide a clear, concise report to the ICS. Summaries should be no longer than a single side of A4.

GP Patient Survey (GPPS)

The GPPS is an annual England-wide survey focusing on patients' experience of their GP practice, administered by Ipsos on behalf of NHS England. The survey is sent to over 2 million people per annum to track change over time and to monitor the quality of GP services. Results from the survey directly help the NHS to improve GP practices, as well as other local NHS services, ultimately to better meet patient needs.



The survey provides data at **practice level** using a consistent methodology, which means it is comparable across organisations. The survey also provides data at **Primary care network** (PCN), **Integrated care system** (ICS) and **National** level.

Minor changes were made to the questionnaire in 2022 to ensure that it continued to reflect how primary care services are delivered and how patients experience them. This followed more substantial changes in 2021.

The effect of the pandemic should be taken into account when looking at results over time.

In 2018 the questionnaire was redeveloped in response to substantial changes to primary care services as set out in the GP Forward View.

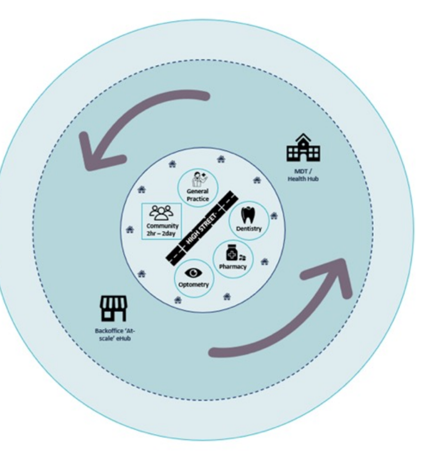
Professionals Integration - PCN & INT Organisation Development

Strategic Context:
Team Alignment

There is an ambition to align teams between PCNs and Integrated Neighbourhoods. Place leaders will be enabled to financially support back-fill where necessary to enable the development of a vision. This will be followed by a period of change management and organisational development to transition into the newly established Target Operating Model.

The Ambition:

Successful delivery of out of hospital care within the community



Enablers

There are some key areas that need to be focused on to achieve the vision

Establish strong relationships between the professional leads in each neighbourhood

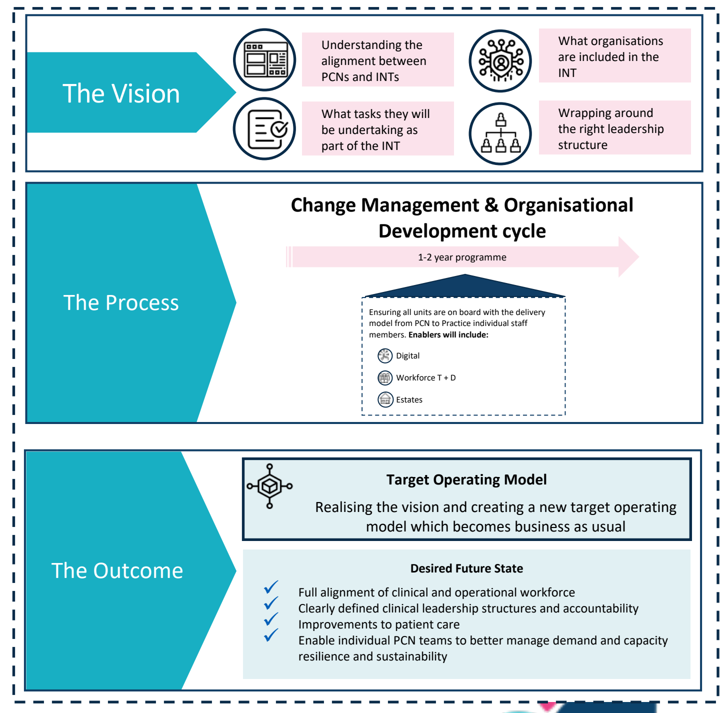
The system will establish a Primary Care Advisory Forum using professionals from each of the following areas; GP, POD, CSP, 111 and Healthwatch to drive a new way of working cohesively to deliver services

Algin clinical and operational workforce from across providers

Foster an improvement culture and safe environment for teams to test ways of working and innovation

Ensure the best use of workforce across providers

Understand the demand, capacity and workforce in neighbourhoods to drive the shared purpose and outcomes required



Bringing together once siloed teams of professionals through a single forum, Primary Care Advisory Forum, to build strong professional relationships that in turn will provide the leadership to our integrated neighbourhood teams. Primary Care providers (GP, POD, 111 & Community Service Providers) will work together to improving access, integration and modernisation of the out of hospital environment.

Winter Access Fund

Redistribution of Winter Access Funding (WAF)

Letter from Amanda Doyle ‘Supporting General Practice, primary care networks and their teams through winter and beyond’ sets out the support package which you can read in full here….https://www.england.nhs.uk/wp-content/uploads/2022/09/B1998-supporting-general-practice-pcn-and-teams-through-winter-and-beyond-sept-22.pdf

IIF redistribution Explaining changes to the previous funding distribution model	➢ Annex 4 sets out the Investment & Impact Fund (IIF) indicators that will be stopped or where thresholds have been amended and releases £37m that will be reinvested into a PCN Support Payment…… *“In total, the above equals £37m of funding to be released to PCNs as a **PCN Support Payment**. The PCN Support Payment will be paid on a monthly basis and will be based on the PCN’s Adjusted Population. In line with the reinvestment commitment relating to IIF earnings, the PCN capacity and access support payment **must be used to purchase additional workforce and increase clinical capacity to support additional appointments and access for patients.”***

IIF - how much and when will this funding land? This equates to a total of **£646k for Surrey Heartlands**, paid on weighted capitation. The national request is that this is paid monthly via the usual PCN payments. *The next slide sets out the total payment* for each PCN.PCNs have to work together to decide on how best to use this payment in line with the above quote!

- **The ICS will also fund a Practice level scheme (£1.7m) & Public Holiday support (at Place level) (£368k)**

  Payment will only be made if all additional ICS appointments are coded WAF as per previous year (Automated via Search & Reports)
- Practice level sessions are based on list size as per below:
  - 0-4,999 = 1 additional session per week for 18 weeks (So capped at 18 sessions in total)
  - 5,000 – 11,999 = 2 additional sessions per week for 18 weeks (so capped at 36 sessions in total)
  - 12,000 – 17,999 = 3 additional sessions per week for 18 weeks (so capped at 54 sessions in total_
  - 18,000+ = 4 sessions per week for 18 weeks (so capped at 72 sessions in total)

IIF Funded Winter Access Fund (£646k)

Capacity and Access Support

0.602 By:- PCN Adjusted Population

Place	Network	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Total	Adj. Pop	
		£	£	£	£	£	£	£	#	
East Surrey	Care Collaborative	4,423	4,423	4,423	4,423	4,423	4,423	**26,541**	44,088	
	Healthy Horley	2,990	2,990	2,990	2,990	2,990	2,990	**17,940**	29,801	
	North Tandridge	4,518	4,518	4,518	4,518	4,518	4,518	**27,110**	45,033	
	Redhill Phoenix	2,618	2,618	2,618	2,618	2,618	2,618	**15,708**	26,092	
	South Tandridge	3,462	3,462	3,462	3,462	3,462	3,462	**20,773**	34,507	
Guildford & Waverley	East Waverley	5,878	5,878	5,878	5,878	5,878	5,878	**35,266**	58,581	
	Guildford East	5,494	5,494	5,494	5,494	5,494	5,494	**32,961**	54,753	
	Guildford Renaissance in Primary Care	5,911	5,911	5,911	5,911	5,911	5,911	**35,465**	58,912	
	West of Waverley	4,897	4,897	4,897	4,897	4,897	4,897	**29,384**	48,811	
North West Surrey	COCO	4,354	4,354	4,354	4,354	4,354	4,354	**26,126**	43,399	
	SASSE 1	5,364	5,364	5,364	5,364	5,364	5,364	**32,187**	53,466	
	SASSE 2	3,818	3,818	3,818	3,818	3,818	3,818	**22,911**	38,058	
	SASSE 3	4,293	4,293	4,293	4,293	4,293	4,293	**25,757**	42,786	
	Walton	2,210	2,210	2,210	2,210	2,210	2,210	**13,257**	22,022	
	West Byfleet	2,989	2,989	2,989	2,989	2,989	2,989	**17,937**	29,795	
	Weybridge & Hersham	4,287	4,287	4,287	4,287	4,287	4,287	**25,719**	42,723	
	Woking WISE 1	3,010	3,010	3,010	3,010	3,010	3,010	**18,060**	30,000	
	Woking WISE 2	3,842	3,842	3,842	3,842	3,842	3,842	**23,050**	38,289	
	Woking WISE 3	3,208	3,208	3,208	3,208	3,208	3,208	**19,248**	31,973	
Surrey Downs	Banstead	4,790	4,790	4,790	4,790	4,790	4,790	**28,742**	47,744	
	Dorking	4,600	4,600	4,600	4,600	4,600	4,600	**27,600**	45,848	
	Epsom	5,563	5,563	5,563	5,563	5,563	5,563	**33,379**	55,447	
	Integrated Care Partnership	2,953	2,953	2,953	2,953	2,953	2,953	**17,720**	29,435	
	Leatherhead	6,451	6,451	6,451	6,451	6,451	6,451	**38,704**	64,292	
	East Elmbridge	5,770	5,770	5,770	5,770	5,770	5,770	**34,619**	57,506	
Total		**107,694**	**107,694**	**107,694**	**107,694**	**107,694**	**107,694**	**646,163**	**1,073,360**	*646,163*

Defining Focus Areas for WAF Intervention

Winter IIF & ICS Funding

Nationally, it has been agreed that some IIF indicators will be repurposed. This means that 37m will be repurposed to support winter workforce and additional clinical capacity.

As of 4th October 2022, this looks to be the only national funding to support Primary Care Winter Access (WAF).

National - £646k PCN additional capacity
Local – £2.6m Practice additional capacity
Public holiday cover (Federation) -

£37m of the IIF funding will be repurposed and released to PCNs as a PCN Support Payment. The PCN Support Payment will be paid on a monthly (based on the PCN's Adjusted Population). This payment must be used to purchase additional workforce and increase clinical capacity to support additional appointments and access for patients.

SMI / LD Health Check Completion

Reminder
Annual Health Check % 22/23
Learning Disabilities: 75%
SMI: 60%

Please remember the national targets for LD & SMI.

With numbers initially low before the Jan '22 intervention, Winter Access Funding successful saw SMI Health Checks increase and a 71% completion rate of LD Health Checks (exceeding the National target).

Practice Access Visits

In addition to providing funding Winter Access Funding, Surrey Heartlands ICS conducted a series of visits to practices to better understand 'access requirements'.

In addition, the Primary Care team requested that GP Managers filled out an online questionnaire on their experience
Ppv VISIT WILL BE THE ACCESS VISIT

Qualitative – no associated costs

Practice Manager - 'All in all it was a great success, the WAF clinics were a huge help during February and March and had we had more room capacity we would have utilised them further'

GP Partner - 'The process of claiming back through the Portal was easy and funding was received quickly'

Winter Access & Development Toolkit Support

Distribution of Funding Allocations

The Winter Access and Development Toolkit support finance schedule sets out the funding available at practice, federation, PCN and ICB level. The central team will utilise primary care forums to share best practice. However, local PCNs and they affiliated practices will be required to develop solutions with the provided funding.

Supporting Winter Access and Development Toolkit

Scheme	Payment To	Total Payment	Practice Payment per Head
Inbound/ Outbound: Re-Engineering Patient Pathway	Practices	£1,484,000	£1.31
Cloud- Based Telephony	Practices	£260,000	£0.23
Driving Activity through NHS App	Practices	£104,000	£0.09
Relational Based Care – Continuity (GP Toolkit	Practices	£159,744	£0.14
Engagement – Docking Primary Care into INT	PCN	£100,000	-
Back Office E-Hub	Federations	£1,450,000	-
Data into Action	ICB Commissioned Contract/ PCN support	£200,000	-
Total GP Developmental Toolkit Funding		**£3,757,744**	**£1.77**

Overall scheme: £6m

(raw population)

Practice

Practice level additional capacity:

Dec 1st — Mar 31st

Monthly payment with Feb & Mar reconciliation

- 16 appointments per session
- Only paid on coded WAF appointments

Development Toolkit

- £1.77 per head of population
- 18-month delivery
- Post payment verification

PCN

- £4k per PCN – Place led to support INT development, support and supervision

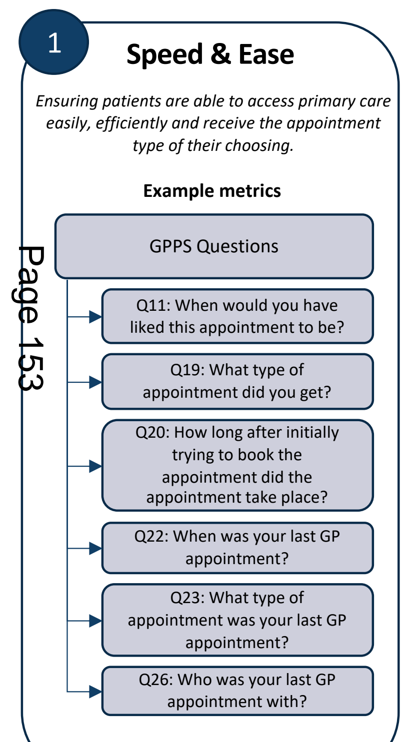
Fed & ICB

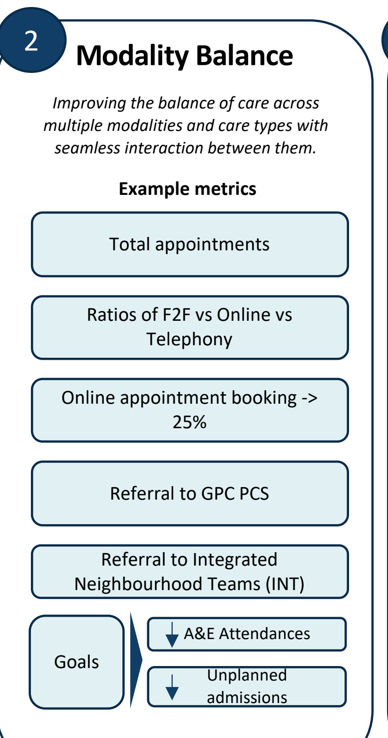
- Back office
- OPEL (£150k OPEL & £200k DIA)

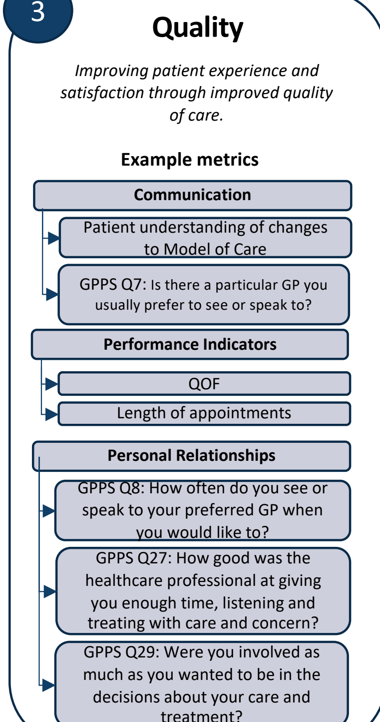
Metrics & Assurance Reporting

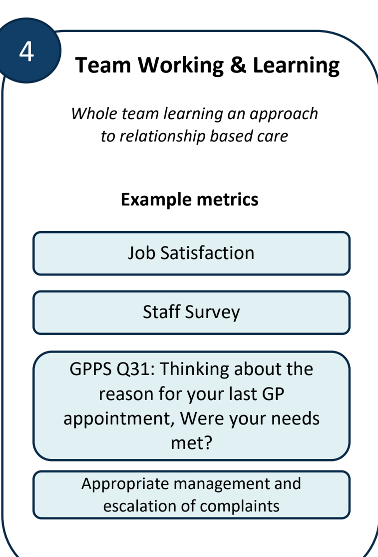
Measuring What We Do

Good quality data helps drive change. We need to measure the right things to know if what we are doing is working, whilst avoiding data collection burden. Knowing the speed at which patients can access care, how (mode) they are accessing care, what it feels like (quality) to patients, and how clinicians feel about their job is important. The ICS will develop these metrics and will never externally report below PCN level.









Sources of data

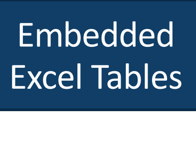
Operational Pressures Escalation Levels Framework

GP PATIENT SURVEY

NHS Staff Survey

NHS Digital

Care Quality Commission



The embedded file provides stock question from the GPPS

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