NHS
North Cumbria
Clinical Commissioning Group

NHS North Cumbria CCG Primary Care Commissioning Committee	Agenda Item
12 July 2018	7

General Practice Forward View Transformation Funding

Purpose of the Report

This report sets out the expectations of the CCG in the General Practice Forward View (GPFV) to support GP transformation. It summarises the actions taken to date and proposes the approach that the CCG should take to deliver on this GPFV commitment.

Outcome Required:	Approve	x	Ratify		For Discussion		For Information	

Assurance Framework Reference:
1, Better Health – There is a need to ensure that Cumbria's children & young people (including children looked after are kept safe and transition into health adulthood.
2, Better Care – Commission services that ensure the delivery of high quality and safe care patients.
3, Sustainability – Commission services that ensure the delivery of high quality and safe care for patients in a manner that is sustainable for the whole health economy.
4, Leadership - The CCG needs to develop and implement robust governance and management arrangements to operate in a safe and sound manner.

Recommendation(s):

The Primary Care Commissioning Committee is asked to: approve the recommendations set out in the paper to ensure the effective use of this resource and to deliver this GPFV commitment.

Executive Summary:

1. Introduction
The CCG is required to support General Practice as part of the NHSE GP Forward View with non-recurrent transformational funding. The scope of the expectation is:

Practice transformational support
Description CCG investment to be used to stimulate development of at scale providers for improved access, stimulate implementation of the 10 high impact actions to free up GP

time, and secure sustainability of General Practice.
Funding £3 per head in 2017/18 or 2018/19, or split over the two years as a one off non – recurrent investment. CCGs will need to find this funding from within their NHS England allocations for CCG core services. In total for the CCG this equates to £968,000

The CCG in agreement with the LMC spent a proportion of the required funding in 2017/18. This paper sets out the proposals for delivering the rest of the CCG commitment in 2018/19.

2. CCG Commitment to date

In 2017/18 in agreement with the LMC the CCG allocated £1/head of the transformational support to a workload agreement. The agreement lasts for a full year with the expectation that in its current or a revised form it will continue and be a recurrent commitment for the CCG. The scheme has a built in review at 6 months to assess the level of investment and activity.

3. Overall Approach

The specific objectives of the GPFV transformation funding include securing the sustainability of General Practice. The workload agreement that is in place was recognition of local pressures. In developing the workload agreement we specifically made the funding available on an ICC footprint and it is proposed (with one exception) that this approach is continued for the further use of any funds in keeping with our view that working in primary care networks increases the sustainability of General Practice in addition to stimulating the development of at scale provision.

We have a number of local ambitions and programmes in place as part of our wider work on GP development in N Cumbria. It is proposed that this funding should be targeted at activities that support practices to accelerate those activities rather than to generate new areas of work, particularly as the funding is non recurrent to ensure that the best value is gained from the deployment of the funds. Through concentrating on established priorities General Practice is better supported rather than having a large fragmented scheme of programmes. It is also the view that the most effective use of the funding is through offering a menu of options. This has the advantage of focussing work and impact whilst enabling ICCS to locally determine what is most beneficial in local circumstances.

4. Proposed Approach

The CCG has committed £326,000 funding to the 2017/18 workload agreement and thus has a further £ 642,000 to invest in 2018/9.

The following proposals are made following work undertaken by the Primary Care Team and discussions at the ICC GP leads Group and the CCG Executive Committee.

1. Workload Agreement

All practices are participating in the workload agreement introduced in November 2017. There was a commitment to review this after 6 months to see if the levels of activity or remuneration demonstrated a need to refine the scheme. An early assessment of the data shows significant

variation across practices and it is very difficult to see how any informed judgement can be made at this time.

It is therefore proposed to review and re-promote the scheme across practices. As a consequence it is proposed to extend the scheme for a further 6 months to allow this to take place.

Funding
The CCG is committed to this scheme as a recurring scheme should the review demonstrate the need for that. The extended 18 month scheme will continue to operate as part of the GPFV transformational funding. This means that in total £1.50/head of the GPFV funding will be allocated to the workload scheme. (£320,000 in 2017/8 and £160,000 in 2018/9)

2. Workforce
NHSE have made available this year free of use to CCG and GP practices) a workforce modelling tool. A detailed description is included as Appendix 1.

The adoption of this tool across North Cumbria is considered to be an important development in supporting practices and in articulating clearly for the wider health care system the issues for General Practice and how system wide working can best be directed to support primary care.

Funding
Although the tool is free to use 2 half day training sessions will be needed per practice for the practice manager. It is therefore proposed that each practice will receive £1000 funding to support this time commitment. Total Commitment £40,000.

3. Increasing Capacity in General Practice

There are a number of potential schemes that taken forward at scale might free up capacity in General Practice and thereby improve access for patients. It is proposed that the remaining GPFV funding is made available to ICCs (GP practices working together) to facilitate the development of new ways of working. The list below describes the options available to ICCs. Where the GPFV funding is used to pump prime schemes there would be a requirement for the scheme once implemented either to be revenue neutral or for a local agreement on funding e.g. through practice funding or partnership agreements with other providers within existing resources.

- **Technology**

Digital technology based projects can be an effective use of non-recurring funds and at the same time can be an effective way to manage workload or improve efficiency. There are a number of developments that could be supported from investment. Examples include laptops to support agile working, extending the core model of e- consulting and investment in apps that help patients better manage their own care.

- **Pump priming establishing community dressings clinics**

There is an increasing demand for staff to undertake chronic and complex wound management

in the community. Some ICCs have established arrangements in place, whereas in other ICCs this work is done in practices by the practice nurse. The work is time consuming and requires a significant degree of expertise and competency. District nursing teams undertake the complex dressings for house-bound patients.

There is real opportunity to develop community based clinics to free up practice time as well as utilise the skills & expertise of the nursing staff.

- **Pump Priming establishing children's clinics in General Practice**

Two ICCS have established secondary care children's clinics in ICCs. The approach offers good patient experience as well as an opportunity for secondary and primary care clinicians to work together, improving education, advice and guidance and a better understanding of secondary and primary care services.

- **Extend the pilots for ICC Mental Health services**

ICC GP leads have prioritised the development of mental health as part of the iCC for both patient impact and the impact on workload in primary care. Four PDSA cycles are being run to test out aspects of a new model , funding for which will be applied for at scale through phase 2 of the iCC programme development. Non recurrent funding could be used to escalate the scale and scope of the PDSA work.

- **Development of Social prescribing**

This is a key part of ICCs and important for practices in managing workload. A number of ICCS are developing their links with community organisations to develop signposting to other services, improving patient experience and directing patients to the most appropriate services for them

- **ICC based development of community ambulatory services**

Across N Cumbria we have a variety of different services in place . Some ICCs are keen to develop these further including near patient testing. The funding could be directed to ICCs to implement local schemes targeting population need

Funding
Funding of £1.40/head per iCC would be available to approved schemes. Total £448,000.

5. Summary and Recommendations

The CCG needs to progress with its implementation of GPFV funding. The Primary Care Committee are asked to approve the recommendations set out in this paper to ensure the effective use of this resource to deliver this GPFV commitment

Strategic Objective(s) supported by this paper:	Please select (X)
Support continuous quality improvement within existing services including General Practice	x
Commission a range of health services, including an increasing range of integrated services, appropriate to our population's needs	x
Develop our system leadership role (in the context of an integrated health and care system) and our effectiveness as a partner	x
Continuously improve our organisation and support our staff to excel	x

Impact assessment: (Including Health, Equality, Diversity and Human Rights)	n/a

Conflicts of Interest Describe any possible Conflicts of interest associated with this paper, and how they will be managed	Any interests will be addressed at the Committee.

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Appendix 1:

1. Insight/Apex Workforce Tool **Workload analysis and modelling** - looking at current and past demand for appointments against practice patient demographics and 'illness' alongside which healthcare professional saw and treated the patient. Enabling capacity planning, population demand analysis, appointment activity scheduling, and assessment of patient and clinical activity. Enabling answering questions such as:

    - Which patients are driving our work?
    - How do I improve access?
    - How do I measure our demand?
    - How do I measure our activity?
    - Who is doing the work?
    - Are we getting value from locums?
    - What effect did extending our hours have?
    - How do we monitor extended hours?

2. **Future workforce planning** - enabling practices to model different roles by developing capability of existing staff (role development) or by use of different clinicians working in or with the practice e.g. Clinical Pharmacists or the attachment of Paramedics. The impact of direct access to other clinicians outside of the practice could also be modelled e.g. diversion to access hubs or patient access to physiotherapists. Enabling answering questions such as:

    - Do we need more doctors?
    - If we can't find new doctors, what effect do other staffs have?
    - How is our workload changing?
    - How do we compare with others?
    - How do we assess the impact of other clinicians working to support care of our patients?

3. **Secure technology** - which enables practices to share or report practice aggregated (anonymised patient) information and supports collaborative working, streamlining reporting across practices, Federations or to CCG commissioners. This is through an Enterprise (an organisation which requires reporting capability across several GP practices e.g. CCG.) enabling practice based information to be extracted through the reporting tool, with daily extracts and data anonymised at source controlled by the practice. This enables practices to consider:

    - How do I compare with others?
    - What is the impact of collaborative working with other practices/GP Network or other providers?
    - How do we minimise recording and reporting information for federation/ CCG reports?

The tool will therefore provide practices and CCGs with the ability to focus on the following areas:

<u>Workforce</u>

- analyse activity and patient demand, to explore different ways of staffing their practices and how this may impact on the practice operationally, in terms of how many sessions can be offered to patents, and financially, in terms of employing and increasing numbers of other healthcare professionals with their practice/s e.g. clinical pharmacists, mental health therapists, nurses and physiotherapists.

- view historical activity levels, at granular and high level across the services they provide. Practices can explore future workforce needs by varying types activity and determining whether their practice population will change.
- explore the impact of decisions about how best to allocate the workforce based on the services to be provided and the skill mix required to meet the expected demand/level of activity.

- use the data and the insights to explore how they could reduce the burden on GPs, while increasing the role of other health practitioners.

Patient activity

Provides practices with essential data to help inform patient activity and trends, showing:

- clinicians the profile of the patients accessing a service, including the demographic of the patient cohort and clinical breakdown (providing details of patient caseload across long term chronic disease groups),
- individual activity reports, including unused appointments, DNAs, use of extended hours appointments, home visits and telephone contacts,
- an anonymised list of the top frequent attenders and their profile and
- a breakdown of re-attenders by rate and return period and movement across other clinicians within the practice.

Capacity planning

This allows providers to look forward, to quickly identify potential issues with appointment activity/availability and make the necessary changes to improve access. This provides insight across the practice of any potential shortfall in appointment availability across all session holders. Other benefits include:

- allows the practice to better understand the correlation between capacity and demand over time to help plan services to ensure access is in line with predicted demand,
- practices can assess the impact of changes to staff rotas and holidays to ensure continued access and can clearly see the impact of any change implemented through clear visibility of the data,
- services can be aligned to demand, improving capacity and patient satisfaction,
- the ability to quickly identify the effectiveness of same day bookable vs scheduled appointment to improve capacity. This balance has had a big impact on some GP practices where the balance is misaligned,
- being able to understand at clinician and practice level the levels of continuity of care (to increase patient satisfaction) and
- identifying which patients are being seen and their frequency across the practice (to free capacity).

Clinical activity

Clinicians will have access to:

- information to support personal development and appraisals for clinical staff,
- a comparison (activity, capacity, patient needs) against other clinicians within the practice and against the local practice average comparator and
- real time, front line data which helps to highlight where capacity can be adjusted to improve access.
- information which can help them to understand their patients profile, activity and appointment capacity.
- view how their decisions affect their practices/s
- shared information enabling them to compare and benchmark key practice differences or changes in working.

This enables a detailed view by individual health care professional, they are able to see where their appointments could be diverted e.g. musculoskeletal (MSK), respiratory conditions to be treated by a physiotherapist and clinical pharmacists could undertake COPD reviews, manage the repeat prescribing process. This in turn reduces their workload, improves morale and enables better delivery of care