Buckinghamshire Primary Care Networks

Your community Your care
Developing Buckinghamshire together

1. COVID Challenges & Recovery
2. Patient participation groups
3. PCN Overview & PCN Progress

HASC meeting 10 September 2020

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NHS Buckinghamshire Clinical Commissioning Group
NHS Buckinghamshire Healthcare NHS Trust
FedBucks
Buckinghamshire County Council
NHS Oxford Health NHS Foundation Trust
NHS South Central Ambulance Service NHS Foundation Trust

Primary Care Recovery & Restoration

- Primary Care responded rapidly during COVID-19 including moving to remote working, digital consultations, hot hubs and additional support for care homes. The response advanced quickly and effectively as a result of joined up partnership working across health and care providers and commissioners. As plans are developed in Buckinghamshire for Recovery and Restoration in Primary Care we are looking to 'lock in' new ways of working and review previous Long Term Plan and financial recovery goals.

- In Buckinghamshire we conducted a survey of general practice and worked with Time For Care, part of NHSE/I, to understand the challenges faced from COVID, suggestions for support and what changes and benefits to 'lock in'. (See full report attached)

- Primary care continues to manage the delivery of both COVID-19 and non COVID-19 services. Like other providers there is a backlog of patient care that needs to be managed and met and this will be managed through the recovery and restoration groups and clinical harm forum.

- A Primary Care Restoration and Recovery Group is advancing the primary care recovery plan. The plan will address COVID-19 recovery including content of the Phase 2 and 3 letter, feedback from the survey and learning events and the requirements of the Long Term Plan. These actions will need to be set in the context of the financial regime we expect to see announced as a part of Phase 3 announcements.

- The CCG is advancing work with the respect to restoration and recovery of all health and care services including primary care. This is being driven by the ICP and the supporting Executive Group.

General Practice Recovery & Restoration

What Has Worked Well ?

* Digital Transformation Solutions – remote consultation and patient contact
* Home working / flexible working
* Building willing, flexible strong teams working together to achieve common goals
* Total triage - reduced patient footfall and ability to ensure appropriate patient access
* Good communications across practices and with partner organisations – a sense of working together as a health system
* Less bureaucracy and administrative burdens

What was paused that needs to re-start?

* Heath checks and LTC reviews
* Cervical Screening
* B12 Injections
* Blood Pressure monitoring
* F2F consultations for vulnerable and complex patients
* Medication reviews
* QOF Work
* Internal HR functions

What have practices done during the pandemic which they can now stop doing?

* Nothing the pandemic has not stopped – we still need to continue to be cautious to protect our patients and our staff
* Screening patients at the door
* Welfare calls
* Discouraging some patients from accessing general medical services in the normal way

What support do practices and practices and primary care staff want?

* Continue to enable flexible working / working from home
* Continue to provide / provide more PPE
* Patient education campaign to encourage patients to continue accessing services appropriately as we come through / out of the pandemic
* Further digital solutions / improved digital solutions
* Good communication across the system

Phase 2 Actions Progress

Quote	Status	Proposed Ops lead	Area of work	Next steps	Notes
"Ensure patients have clear information on how to access primary care services and are confident about making appointments (virtual or if appropriate, face-to-face) for current concerns."	Done and assured	Louise Smith	6) Primary Care	Ensure that surgeries continue to provide clear guidance for patients - provision of sufficient PPE in line with guidelines	MJOG text messages funded for practices and Website check for key messaging
"proactively contact all those in the 'shielding' cohort of patients who are clinically extremely vulnerable to Covid19, ensure they know how to access care, are receiving their medications, and provide safe home visiting wherever clinically necessary."	Done and assured	Louise Smith	6) Primary Care	Practices provided with communication for Shielded patient and a range of services they can access.	Communication to practices regarding list of "shielded" patients self registration process publicised out by the Council. Medicines drop off for shielded patients organised
"Bring forward a package of support to care homes drawing on key components of the Enhanced Care in Care Homes service and delivered as a collaboration between community and general practice teams. This should include a weekly virtual 'care home round' of residents needing clinical support."	Done and assured	Louise Smith	6) Primary Care	Work with practices re : implementation of Care Home PCN DES Monitor and act to address any gaps/ queries that emerge, supplementary network service being coproduced - all patients to receive recorded ward round - identify clinical leads for care homes at PCN level	CCG Monitoring Report underdevelopment to show practice performance against requirements Care Home Tracker in use provides daily updates from Care Home re their risk status ICP care home group established to ensure coordination of activities Clinical Lead for Care Homes appointed Care Home Intelligence group established to review coordinate Outbreak Response Care Home Visiting Covid Response Service established Funding identified to support enhanced care in care homes provision and communicated to PCNs.
"Make two-week wait cancer, urgent and routine referrals to secondary care as normal, using 'advice and guidance' options where appropriate."	Done and assured	Louise Smith	6) Primary Care	Ongoing monitoring of advice and guidance usage - regular conversations and updates with secondary care colleagues as to usage	Regular report received on referrals made by GPs and communications out to Primary Care regarding referral mechanisms and areas of coverage of Advice and Guidance
"Deliver as much routine and preventative work as can be provided safely including vaccinations immunisations, and screening."	Done and assured	Louise Smith	6) Primary Care	Monitor waiting lists and ensure that administration tasks for practices are kept to the minimum - support from the new Ardens suite of forms and services and manage ensure functionality of DXS is transitioned accordingly Work with NHSE SE Region on the screening expectations	Admin tasks have been reduced for Primary Care and pro-active support for elective care referrals and management maintained
"GP Practices should continue to triage patient contacts and to use online consultation so that patients can be directed to the most	Done and	Louise	6) Primary Care	Extend and develop use of secondary	Intermediate care services prioritised. Continue with

Phase 2 Actions Progress

Quote	Status	Proposed Ops lead	Area of work	Next steps	Notes	Assurance chased
"Complete work on implementing digital and video consultations, so that all patients and practices can benefit."	Complete - assurance required	Balvinder Heran	6) Primary Care	Ensure that there is a standard offering across all practices	Primary Care usage of ACCURX across the board	
"Given the reduction of face-to-face visits, stratify and proactively contact their high-risk patients with ongoing care needs, to ensure appropriate ongoing care and support plans are delivered through multidisciplinary teams." and "In the absence of face-to-face visits, primary and secondary care clinicians should stratify and proactively contact their high risk patients to educate on specific symptoms/circumstances needing urgent hospital care, and ensure appropriate ongoing care plans are delivered."	Up to date and ongoing	Louise Smith	6) Primary Care	5 PCNs of 12 working with optum and national team on population segmentation and risk stratification related to COVID. It is a 20 week programme with accelerated learning for other PCNs. Data will be from acute, primary and council systems.	In the initial operational context of COVID this has been addressed and is complete. Further work will continue to ensure that any continued risk is managed in an appropriate and adaptive way.	Clinical Harms group focussed on where the greatest risk sits and how these patients are being managed by providers. Various reporting from general practice including vulnerable patient coding, frailty assessments, care planning etc. Care home (including LD/MH) support available The next steps on risk stratification in relation to COVID will be monitored through the primary care recovery group.

Phase 3 Actions Progress

Requirement	Quote	Status	Notes
Restore cancer presentation levels	To reduce unmet need and tackle health inequalities, work with GPs and the public locally to restore the number of people coming forward and appropriately being referred with suspected cancer to at least pre-pandemic levels.	In progress	Coms exercise underway across bucks to encourage patients to attend screening, report on suspected cancer (and other) presentations and access to general practice - 2ww and screening attendance to be use as proxy measure Support from Macmillan sponsored lead GP
GP activity to usual levels	General practice, community pharmacy and optometry services should restore activity to usual levels where clinically appropriate	In progress	As part of recovery and restoration, the CCG has supported practices to implement good practice guidelines on how to open up safely and financially supported practices in improving infection control standards where needed. Activity tracked as appts and compared with baseline
Community Pharmacy activity to usual levels	General practice, community pharmacy and optometry services should restore activity to usual levels where clinically appropriate	In progress	It is assumed that this should read 'community pharmacy'. Community pharmacy and optometry services are commissioned by NHSE.
Optometry activity to usual levels	General practice, community pharmacy and optometry services should restore activity to usual levels where clinically appropriate	In progress	Community pharmacy and optometry services are commissioned by NHSE.
Proactive approach to vulnerable	Reach out proactively to clinically vulnerable patients and those whose care may have been delayed.	In progress	Practices asked to ensure that they had a support plan for all those identified through the extremely vulnerable list (shielded list). Contact also made via PCN and CCG Social Prescribing Link Workers working with Buckinghamshire Council. The CCG is supporting practices with risk stratification toolkits in order to identify those most vulnerable (diabetes and respiratory complete) Text Messages have been developed that target patients with differng LTCs to signpost and encourage them towards self help support and services. inc weight/ smoking, exercise Risk Stratification work has been started to identify & prioritise those most at risk of Diabetic/ Respiratory and CVD disease and to re-engage them back into General Practice. Virtual Clincal Training has been developed in the areas of Diabets & Respiratory to ensure clinicans are kept up to date as well as guidelines/ protcols for best practice remote monitoring and enagegement of patients.
Dental practice back to F2F	Dental practices should have now mobilised for face to face interventions.	n/a	Dental services are commissioned by NHSE
Childhood immunisations and cervical screening backlog initiatives	GP practices need to make rapid progress in addressing the backlog of childhood immunisations and cervical screening through specific catch-up initiatives	n/a	Childhood immunisations and cervical screening is commissioned by NHSE. The CCG will support the NHSE Public Health plans to address the backlog of childhood immunisations and cervical screening as required, especially with reference to supporting those practices with previously low uptake, once the data is available.

Phase 3 Actions Progress

Requirement	Quote	Status	Notes
Care home medication reviews	GPs, primary care networks and community health services should build on the enhanced support they are providing to care homes, and begin a programme of structured medication reviews.	In progress	SMR referral pathway and support page set up on Bucks TeamNet webpage SMR process defined and reporting template developed– Arden's SMR template SMR Pilot in progress with expected full roll out date: September 2020. SMR trajectory should be back to pre-covid level by Xmas if PCN DES is implemented. Risks/Mitigations Understaffing and lack of capacity of senior PCN pharmacists and pharmacy teams in MOCH and local hospital trust to delivery SMR Define IT systems support for remote consultation required for SMR and linking SMR process in locals hospitals to primary care/ community.
F2F GP appointments	All GP practices must offer face to face appointments at their surgeries	In progress	In Buckinghamshire, the aim is to deliver 230,000 appointments a month by September 2020 (750,000 appointments across BOB) across all modes (face to face, home visits, telephones video/online. NHS Digital data will be monitored monthly.
Identify all LD patients	GP practices should ensure that everybody with a Learning Disability is identified on their register	In progress	Place based support offer for GP practices to deliver the LD QOF to be finalised and mobilised in 20-21 Q2 as described in LDA Recovery and Restoration plan.
LD annual health checks	GP practices should ensure that everybody with a Learning Disability has their annual health check completed;	In progress	Annual health checks completed is monitored quarterly as part of claims made against the Learning Disability DES. Check sign up to DES and follow up with practices who are not signed up. RAG based on risk to health check target not in status of workplan progress, which would RAG as green. Primary care to continue to deliver AHCs with reasonable adjustments made as appropriate. Bucks Actions 1. Trajectories reviewed- end of year target 75% 2. Practice and PCN dashboards in place to support monitoring and uptake. 3. Comms has gone to each practice in Bucks and each PCN re importance of resuming LD AHC. 4. Education, Webinar to LD leads (July) . session with PCN CDs in Sep , PLT in October . 5. Primary care LD TeamNet page – with resources, data and tools to support AHC uptake 6. Staying Healthy Workgroup resumed and supporting uptake of AHC . 7. Optimising all available levers to support uptake- LD AHC DES, QOF QI domain , PCN IIF , PCN Des Care Home.
Proactive LD screening and flu vaccinations	GP practices should ensure that everybody with a Learning Disability has access to screening and flu vaccinations proactively arranged.	Further work to be done	LD will be captured within the cohorts for screening and flu vaccinations. Patients not attending are followed up. Bucks Actions 1. Comms to practices and PCNs to improve Flu Uptake in LD population (including reasonable adjustments) 2. Working with Ardens to develop a local prompt for LD flu vaccination on clinical systems (EMIS) 3. Staying Healt hy Group supporting uptake via networks . 4. Linking comms with wider Flu Campaign in Bucks

Primary Care Recovery & Restoration

As we move into a recovery phase for Covid, a Primary Care plan, including public and patient engagement, is being developed to feed into Buckinghamshire and BOB ICS plans. The results of an initial survey of general practice are shown below.

Key Changes to Lock In:

- Remote consultations
- Home working
- Total Triage

Key Challenges:

- Managing patient expectations
- Opening up general practices in a way which is safe for staff and patients

The CCG will establish a task and finish group to look at the outcomes from our general practice survey and the Time for Care workshops. From this we will develop a comprehensive recovery and restoration plan.

The CCG Can Help By:

- Maintaining Covid hubs and visiting service
- Securing sufficient availability of PPE
- Ensuring general practice is actively involved in recovery plans
- Support and continually improve the new way of working and encourage sustainable use of technology
- Engage patient representatives in the process of embedding new sustainable and safe ways of working
- Reinforce a consistent message that general practice will not go back to how it was – to protect patients and staff coming into the surgery is no longer the default position
- Support self – help communications for the general public
- Reducing unnecessary reporting and bureaucracy

Primary Care Recovery & Restoration - What Next

- **Communication with, expectation management of and advice for patients** – explore opportunities to share expertise and consistent messaging. This could be an ask of the communications group.

- **Planned approaches to winter including capacity, surges and flu** – many practices raised this as a concern in the surveys. COVID-19 will require novel approaches to flu immunisation and management and plans for winter capacity. There is scope to plan this collaboratively.

- **Further development of multidisciplinary integrated care teams** – this is a proven mechanism for maximising workforce for delivery of patient care. There a number of services where MDT working will yield benefits. Specifically by 30 September 2020 Community Services providers are required to become party to the PCN Network agreement. The Enhanced Health in Care Homes service requires an integrated MDT to be operating from 1 October 2020.

- **Advanced advice and guidance** – building on direct contact with Consultants, looking for new ways of working in out of hospital settings. Primary Care involvement in work to recover Planned Care services. This will enable full pathway discussion and shared management of patients (waiting lists, risk of harm).

Primary Care update

August 2020

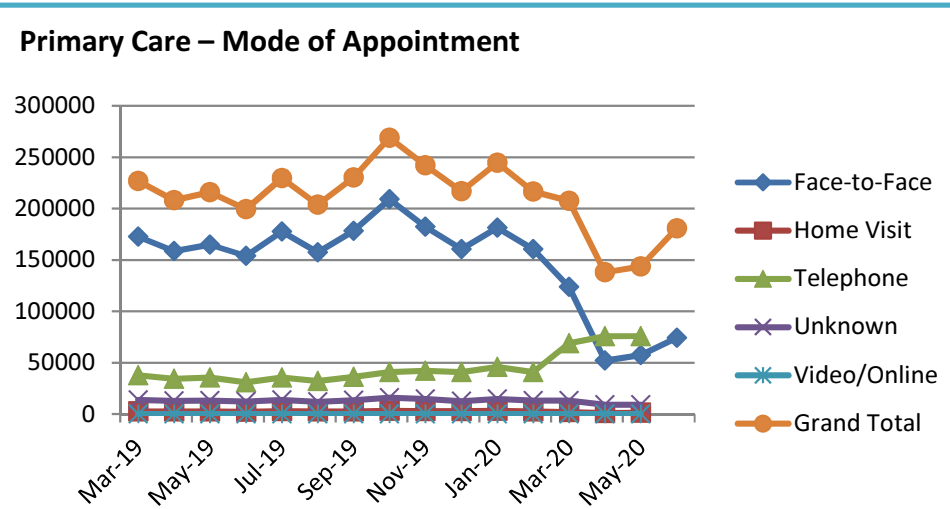
Lead: Louise Smith **PM:**

Comments & escalation

Primary Care Recovery Group has met 3 times since July and created 5 workstreams:

- Workforce
- Digital
- General Practice Recovery (Phase 3 response)
- Primary Care Network Development
- Population Health Management programme

Each group, working on a task and finish basis, will develop a workplan and report into the Primary Care Recovery Group.



Top 3 actions in last period

- Development of metrics for measuring primary care activity as part of Phase 3 recovery.
- PCNs drawing up workforce plans.
- Agreement of a Care Homes Supplementary Network Service to support PCNs to meet the care homes element of the PCN DES.

Top 3 actions in next period

- Population Health Management programme starts 20.08.20 until 28.01.21.
- Recruitment of additional roles as per PCN workforce plans.
- Delivery of flu vaccinations as part of Winter Plan.

Workstream	Status
Workforce	Green
Digital	Green
General Practice Recovery	Amber
PCN development	Amber
Population Health Management	Green

Risk	Score	Next action/ date
General Practice Recovery; resilience of general practice	20	To November, review of practice resilience and impact of covid. December, allocation of General Practice Resilience Funding as indicated.
General Practice Recovery; access to primary care	16	Monitoring of access is part of metrics, agreement of right mix of digital v face to face. On-going. Second wave of covid could de-rail restoration.
PCN development; delivery of PCN DES	16	Creating robust PCNs to enable delivery of the PCN DES. Confirmation of OD funding needed, due August.

Role of Primary Care Networks

What are PCNs

- PCNs are still relatively new, but in time networks will consist of **groups of general practices working together with a range of local providers**, including across primary care, community services, social care and the voluntary sector, to offer more personalised, joined up care to their local populations.
- Relationships will be key and PCN Accountable Clinical Directors (ACD) have a key leadership role
- One of these relationships will be with the Unitary Community Boards

Achievement to date - See next slide

20/21 Post Covid-19 Expectation

- Recurrent organisational development funding to support PCNs to progress and mature
- Additional roles reimbursement Scheme (ARRS) – 11 new roles to support care delivery
- New nationally mandated services
  - Enhanced Health in Care Homes
  - Structured Medication Review and Medicines Optimisation
  - Early Cancer Diagnosis
- Review what local services could be provided by a PCN
- Delays to
  - Improved access review
  - Personalised care
  - Investment and Impact Fund (Oct 20)

PCN Progress Update

PCN	Social Prescriber	Pharmacist	PPG Engagement	OD Events
North Bucks PCN	1	1	√	√
Westongrove PCN	1	2		√
Central BMW PCN	1	1	√	√
Central Maple PCN	1	2	√	√
AVS PCN	2	1	√	√
Chesham & Little Chalfont PCN	0	0		TBC
Mid Chiltern PCN	3 (starting 05/10/20)	0	√	√
Cygnet PCN	1	2		√
Dashwood PCN	1	Recruitment planned / underway	√	√
South Bucks PCN	1.5	1	√	√
Chalfonts PCN	1 (will cease Oct 20 with no plans to continue)	1		√
Arc Bucks PCN	1	Recruitment planned / underway	√	√

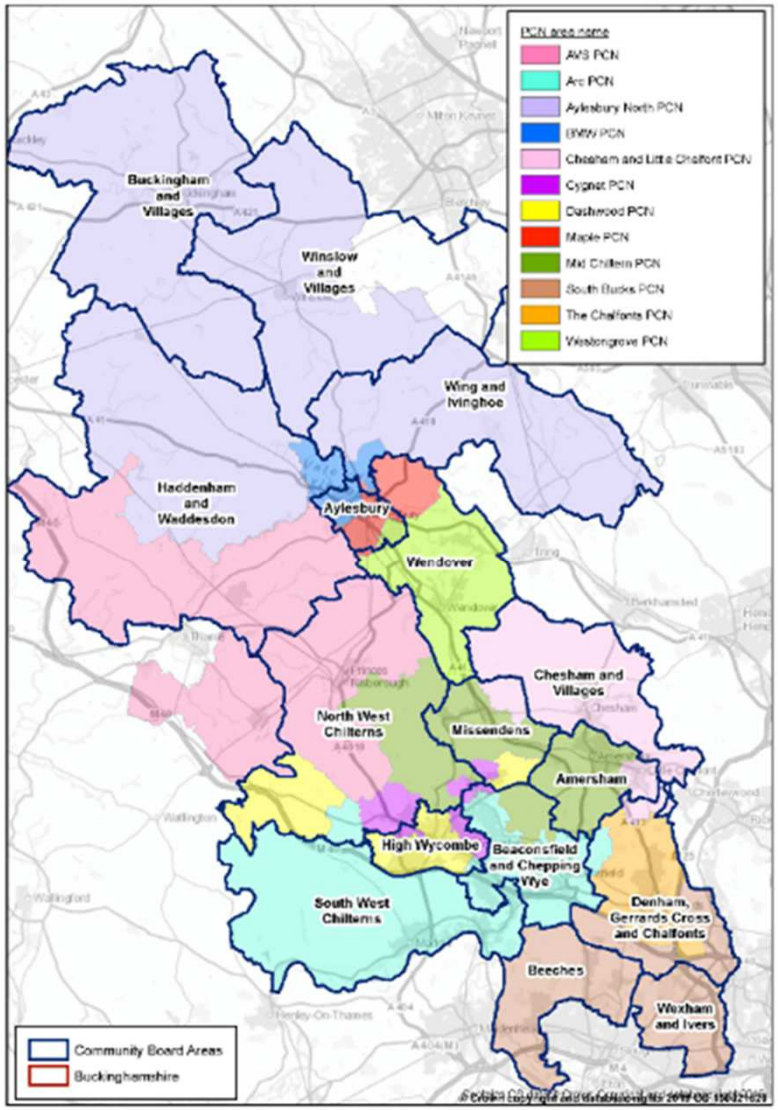
Additional Roles Reimbursement: In 2020/21 PCNs have the opportunity to recruit to 10 eligible roles:

- Clinical Pharmacists
- Pharmacy Technicians
- Social Prescribing Link Workers
- Health & Wellbeing Coaches
- Care Co-ordinators
- Physician Associates
- First Contact Physiotherapists
- Dieticians
- Podiatrists
- Occupational Therapists

PCNs have submitted workforce plans on 31 August 2020 outlining their recruitment intentions for the above eligible roles for 2020/21.

PCN & Community Board Alignment

Community Board	PCN
Buckingham and Villages	North Bucks
Winslow and Villages	North Bucks
Wing and Ivinghoe	North Bucks
Haddenham and Waddesdon	North Bucks/AV South
North West Chilterns	AV South
Aylesbury	BMW/Maple
Wendover	Westongrove
Chesham and Villages	Chesham and Little Chalfont
Amersham	Mid Chilterns
Missendens	Mid Chilterns
High Wycombe	Dashwood/Cygnet
Beaconsfield and Chepping Wye	Arc Bucks
South West Chilterns	Arc Bucks
Denham, Gerrards Cross and Chalfonts	Chalfonts/South Bucks
Beeches	South Bucks
Wexham and Ivers	South Bucks



PCN & Community Board Activity

- Original engagement with the PCNs whilst agreeing the Community Board configuration
- Pre Covid-19 expectation that there would be an opportunity for bringing parties together in the July
- Post Covid-19
  - the BC Community Board Team is going out to PCNs Directors to update them on progress and agree how best to get engagement and representation on meetings – who and how
  - Need a two-way communication approach to problems, projects and priorities
  - Shared understanding of population Health needs - original public health needs assessments but moving to a population health management approach including risk stratification and segmentation (project in own right).
  - Investment potential – Not just health directly but recognising the many health needs are influenced by the social determinants of health
  - Supporting the community board level Covid-19 response
- Next Steps
  - Identifying the key areas of focus
  - Wider public engagement – PPG involvement
  - September community board meetings scheduled and need health representation

Pre Covid-19 Challenges & Support Required

Challenges

PCN Specific Are the expectations too high?

- Pace of delivery versus strengthening of relationships & collaboration
- New services specs – considerable challenge

- How prepared are they
- Are they sufficiently resourced
  - Management support

Integrated Working

- Varied progress by groups of practices and community partners in integrating
- Lack of capacity to develop above BAU
- Persistent 'tricky' issues that are never resolved such as single system wide templates and process e.g. access to records/ACPs, trusted assessor

Community Engagement

- How do we meaningfully engage with our communities

Support

Support for PCNs and Community Providers

- Time
- Management support to PCNs
- Specialist expertise
- Transparent funding arrangements and fair funding allocation in line with local need
- Focused implementation plan
- Targeted support to deliver
- Reliable data and BI support
- Commitment to meeting community investment allocations
- Community engagement in codesign of services - unitary council / community boards

Commissioning Support

- The ICS, aligned to national guidance, to set out direction of travel – high level deliverables/outcomes
- Aligned service outcomes across community providers
- The Health and Social Care Joint Commissioning function to be strengthened at place through ICET
- At Place providers to become self regulating informed by reliable data and BI support
- Utilisation of any alternative funding arrangements to maximise collaboration and integrated delivery