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Clinical Commissioning Group

G&W ICP Primary Care Update November 2020

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Surrey Heartlands CCG

17th November 2020

What is an Integrated Care Partnership?

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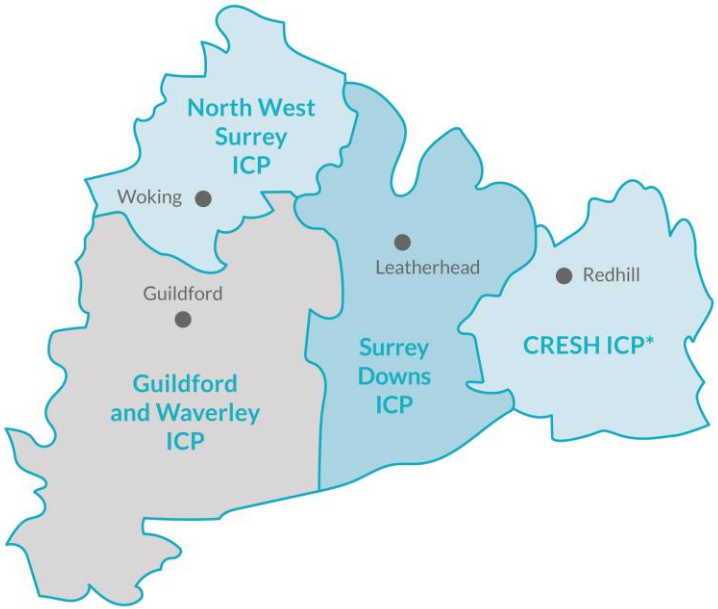
Integrated Care Partnerships (known as ICPs) are groups of local health and care organisations, also including borough councils and voluntary/community sector members, working across populations of around 250 – 300,000 people. Each partnership is developing its own priorities, reflecting the different needs of each local population, and thinking about how they will work differently in the future. Across Surrey Heartlands we have four Integrated Care Partnerships. These local partnerships are responsible for the planning and delivery of services at local level; each ICP has its own Board with representation from local partners and sets its own local priorities.



What is Surrey Heartlands CCG?

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Surrey Heartlands Clinical Commissioning Group (CCG) is a GP-led organisation, responsible for planning and buying health services for the local population out of a budget of around £1.5 billion.

This includes care from hospitals, community and mental health services, social care, ambulance services and other providers. To do this we work closely with other local health and care providers to make sure people in our area have the support they need.

Surrey Heartlands CCG covers around one million people across the following boroughs and districts: Elmbridge, Epsom and Ewell, Guildford, Mole Valley, Reigate and Banstead, Runnymede, Spelthorne, Tandridge, Waverley and Woking. This represents around three quarters of the Surrey population.

We have a membership of 104 GP practices, who work together across four local areas to make sure we are responsive to the needs of each local population.

The CCG was formed on 1st April 2020 following the merger of four previous CCGs in Surrey; East Surrey, Guildford and Waverley, North West Surrey and Surrey Downs CCGs.

What has been happening in Primary Care?

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1. Response to the COVID Pandemic
    - Successes
    - Covid Response and Activity
    - Supporting BAME staff
    - Covid Vaccination Programme
2. Flu Programme
3. Primary Care Network (PCN) Development
    - Care Homes
    - Additional Roles Reimbursement Scheme (ARRS)
    - GPiMHS
    - Digital Roadmap
    - Population Health Management – West of Waverley PCN Pilot
4. Estates

Primary Care COVID Successes

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Celebrating successes across Surrey Heartlands primary care during COVID-19

>1000
Laptops sourced and deployed to support remote working

Headsets, webcams and video monitors also deployed to support virtual consultations

650,000 text messages sent through accuRx Apr-Sept

Weekly requests
20k - May
50k - Sept

846,000 Footfall requests received

40,000 shielded and vulnerable patients supported

All practices have appropriate infection prevention control measures in place

Highest utilisation in the SE

>28k video consultations carried out Apr-Sept

Clinical leads have been identified across 100% of Care Homes in Surrey Heartlands

Three quarters of practices introduced home working for staff who were shielding

Home working was supported by a **remote working tool**, which was rolled out to support practices.

Practices in all PCNs are working collaboratively

Supporting communication
>80 newsletters sent to staff since March 2020
>25 local webinars since March
Local Total Triage guidance well received
Teamnet deployed

104 Practices
25 PCNs
100% **Offering total triage**

Primary Care response to COVID Pandemic

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- Throughout the response there have been a core set of services that didn't pause such as face to face appointments, immunisations and cytology. However, we did experience some resistance from patients to attend routine appointments.
- The pandemic accelerated the delivery of digital modes of contact for patients complementing the existing more traditional modes, such as telephone and face to face.
- Over 90% of the population have access to a practice website that allows for self-care, self-referral (to services such as IAPT) and to submit an 'online consulting' request to the practice about non-urgent issues.
- The response times set in most practices for online services is 48hr (with many offering a quicker turnaround)
- Patient feedback from recent Healthwatch Surrey research has been very positive about both the practice websites and the improved digital access
- A Surrey Heartlands citizen panel survey from July 2020 highlighted that only 2% of respondents did not want to use any digital services, nearly 71% saying they had already used one or more digital services, and the remainder saying they would be willing to.

G&W ICP Primary Care Appointments

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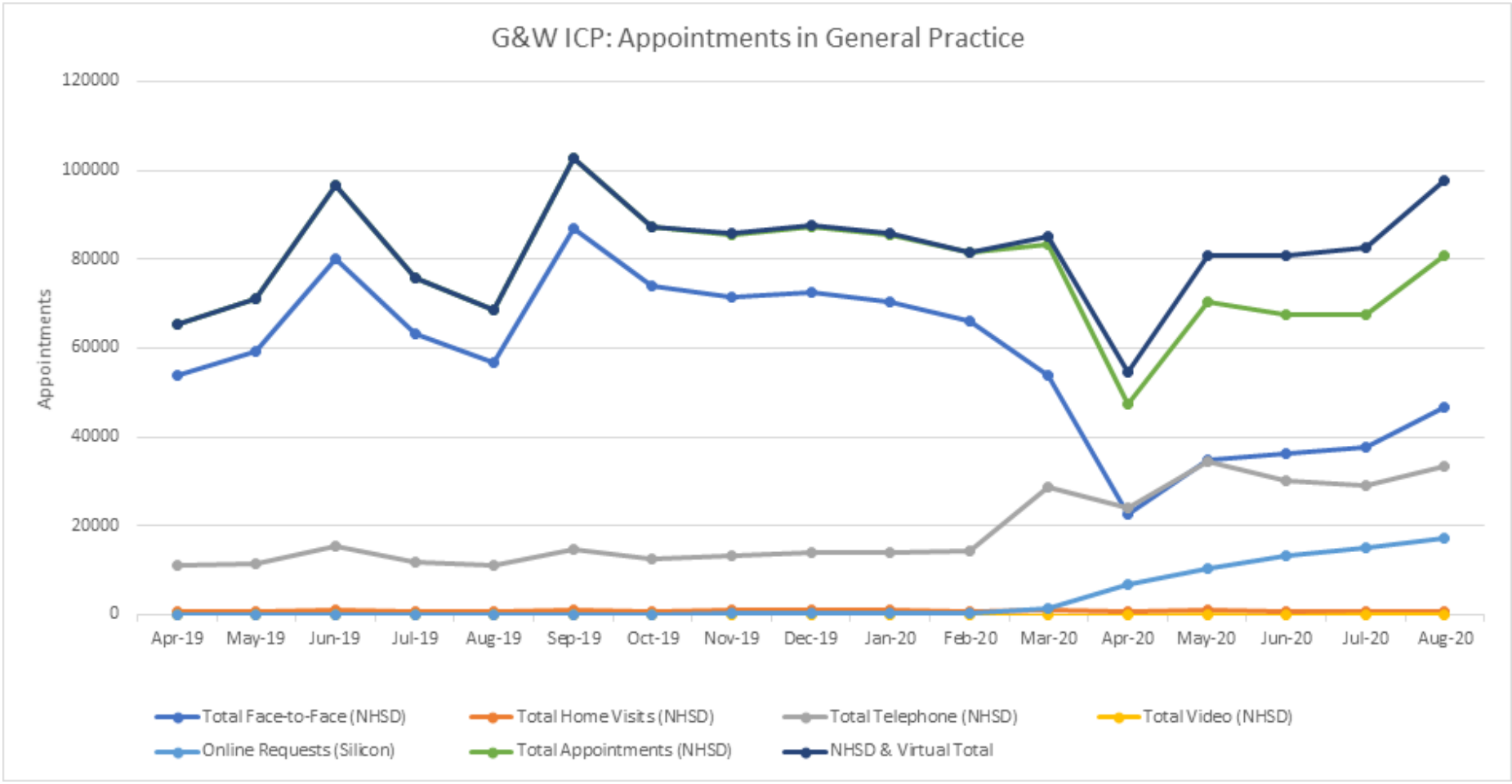

Supporting BAME Staff

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In line with the NHS Guidance and Standard Operating Procedures, SH CCG ensured practices offered a risk assessment to all their staff in order to protect the workforce, in particular BAME staff. The risk assessment identified those at increased risk from COVID 19 and highlighted reasonable steps to ensure the safety of employees.

All practices in G&W completed assessments for all staff and reached 100% compliance. Any issues that arose from the assessments were supported.

Covid Vaccination Programme

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- There are several vaccines in development and of these two (Courageous and Talent) will probably be licenced in the next couple of months.
- Providers should plan on the assumption that two doses of COVID-19 vaccinations will need to be administered to each patient, subject to confirmation from the Joint Committee on Vaccination and Immunisation (JCVI).
- Preparing for delivery in G&W ICP from 1st December 2020 as part of a wider Surrey Heartlands ICS programme.
- Fast moving and changing programme for delivery.
- Local vaccination site identification in G&W ICP to be completed by 17th November, with a local vaccination site in each PCN area.
- The population will be prioritised in nationally agreed cohorts.

Flu Programme

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Data up to Week 44 (1st Nov 2020)
Cumulative uptake this week has increased in 2020/21 compared to 2019/20 in the Over 65s, Under 65 at risk, 2 year olds and 3 year olds.

2020/21 Seasonal Influenza PCN Level Vaccination Progress Report: Guildford & Waverley ICP
Cumulative data to 01 November 2020
Children aged 2 years

	Uptake (Target: 75%)	
	Week 44	No. to vaccinate to reach 75% target
East Waverley	48.8%	152
Guildford East	51.7%	95
Guildford Renaissance in PC	22.8%	296
West of Waverley	48.4%	123
Guildford & Waverley ICP	42.0%	
KSS	39.6%	

2020/21 Seasonal Influenza PCN Level Vaccination Progress Report: Guildford & Waverley ICP
Cumulative data to 01 November 2020
Children aged 3 years

	Uptake (Target: 75%)	
	Week 44	No. to vaccinate to reach 75% target
East Waverley	56.0%	113
Guildford East	48.3%	107
Guildford Renaissance in PC	27.8%	266
West of Waverley	51.7%	110
Guildford & Waverley ICP	45.6%	
KSS	41.8%	

2020/21 Seasonal Influenza PCN Level Vaccination Progress Report: Guildford & Waverley ICP
Cumulative data to 01 November 2020
Patients aged 65 years and over

	Uptake (Target: 75%)	
	Week 44	No. to vaccinate to reach 75% target
East Waverley	68.4%	869
Guildford East	72.2%	322
Guildford Renaissance in PC	62.5%	1,074
West of Waverley	71.2%	376
Guildford & Waverley ICP	68.9%	
KSS	66.3%	

2020/21 Seasonal Influenza PCN Level Vaccination Progress Report: Guildford & Waverley ICP
Cumulative data to 01 November 2020
Patients aged under 65 years AND in a clinical risk group

	Uptake (Target: 75%)	
	Week 44	No. to vaccinate to reach 75% target
East Waverley	38.3%	2,308
Guildford East	38.0%	2,067
Guildford Renaissance in PC	25.8%	3,285
West of Waverley	38.7%	1,743
Guildford & Waverley ICP	34.8%	
KSS	32.3%	

2020/21 Seasonal Influenza PCN Level Vaccination Progress Report: Guildford & Waverley ICP
Cumulative data to 01 November 2020
Pregnant Women

	Uptake (Target: 75%)	
	Week 44	No. to vaccinate to reach 75% target
East Waverley	25.6%	235
Guildford East	23.6%	283
Guildford Renaissance in PC	14.8%	441
West of Waverley	22.4%	155
Guildford & Waverley ICP	20.8%	
KSS	25.2%	

Issues

- Vaccination for the 50-64 year old cohort is pending National Guidance due in November 2020
- Supply of vaccine, now coming from the DHSC National Store
- National Call and Recall Programme

G&W Primary Care Networks (PCNs)

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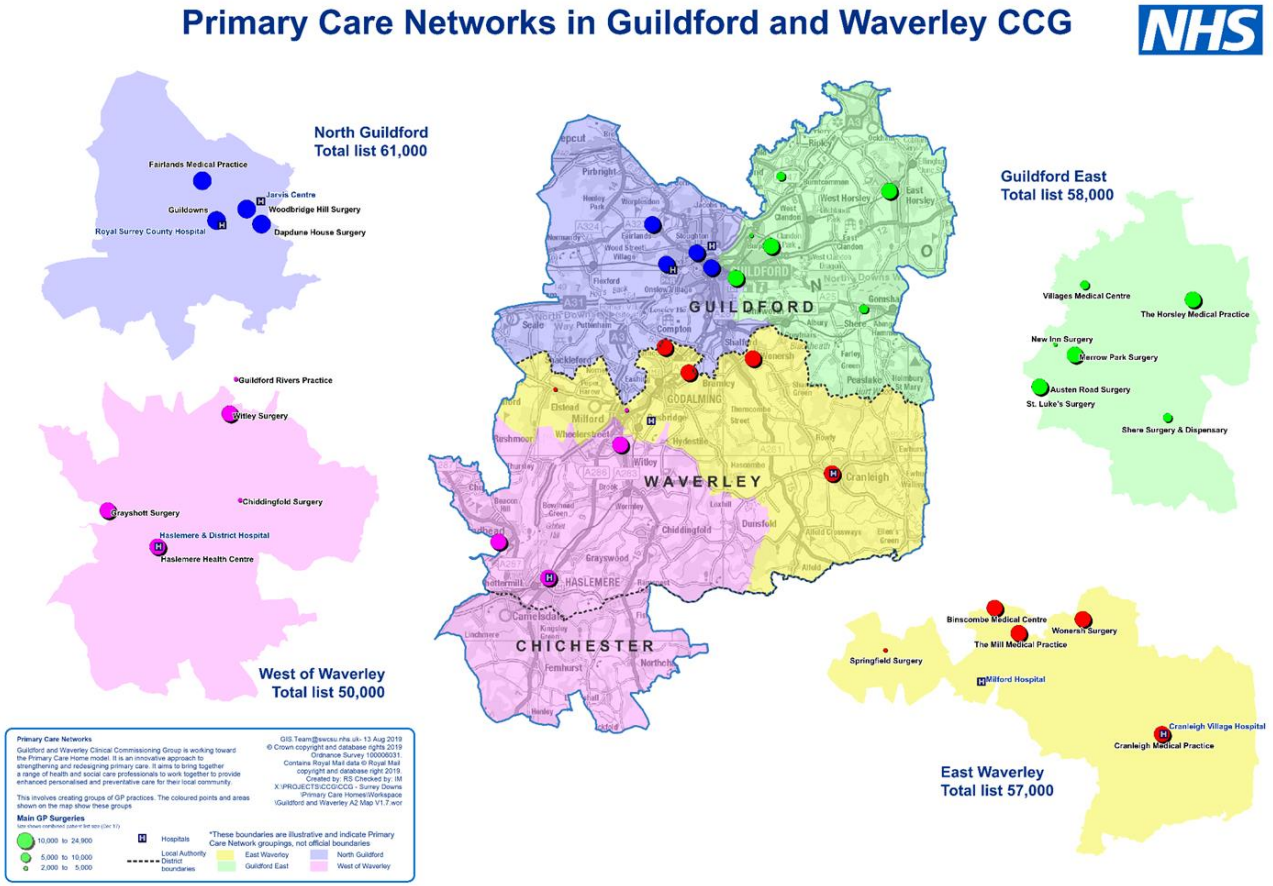

Where are we now?

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Guildford and Waverley ICP PCN Achievements				
PCN Name	**North Guildford**	**East Guildford**	**East Waverley**	**West Waverley**
Maturity Level	1	1	1	1
Extended Access (at scale)	●	●	●	●
OC & VC Capabilities	●	●	●	●
Population Health				●
GP Connect Enabled (111 direct booking)	●	●	●	●
Pharmacy Lead Link	●	●	●	●
Care Home named GP Support	●	●	●	●
GPHiMS	●	●		
Digital First - Long Term Conditions	Diabetes			
Dental Pilot				
Paediatric Pilot				
Digital First Primary Care Roadmap	Due 30th September 2020			
ARRS (planning template)	Due 31st August 2020			

Enhanced Health in Care Homes (EHCH)

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Enhanced Health in Care Homes Direct Enhanced Service (EHCH DES) was introduced on the 1st October 2020. This new service replaces the current Locally Commissioned Service, which was commissioned in Surrey Heartlands as a response to Covid as an interim measure before the national contract commenced.

The EHCH DES provides a similar level of care to patients resident in care homes. People living in care homes should expect the same level of support as if they were living in their own home. This can only be achieved through collaborative working between health, social care, voluntary sector (VCSE) and care home partners.

The CCG has agreed with each Primary Care Network (PCN) the care homes for which the PCN has responsibility and has communicated with each care home the PCN to which they are aligned, the practices in that PCN and the named clinical lead for their care home.

PCNs and community services will work with care home staff to provide the following services for the residents:

- Deliver a weekly 'home round' for the PCN's patients, prioritising residents for review according to need based on an MDT clinical judgement and care home advice.
- Develop and refresh as required a personalised care and support plan with the PCN's patients.
- Support with a patient's discharge from hospital and transfers of care between settings.

Additional Roles Reimbursement Scheme (ARRS)

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The ARRS commenced in 2019. A PCN is entitled to funding as part of the Network Contract Direct Enhanced Service (DES) to support the recruitment of new additional staff to deliver health services. The scheme is designed to support primary care in 2 ways:

1. Create resilience in Primary Care workforce
2. Support the implementation of the Primary Care Networks DES specifications

There are 14 roles that PCNs can choose from

	Cumulative number of Planned WTE in post																
ARRS Roles	2020/21				2021/22				2022/2023				2023/24				WTE in post by end of 2024
	GE	GRiPC	EW	WoW	GE	GRiPC	EW	WoW	GE	GRiPC	EW	WoW	GE	GRiPC	EW	WoW	
Clinical Pharmacists	3.00	4.00	2.00	2.00	3.00	4.00	2.00	2.00	3.00	4.00	3.00	2.80	4.00	4.00	3.00	3.00	14.00
Social prescribing link workers	1.00	1.00	2.00	1.00	1.00	1.00	2.00	1.00	1.00	2.00	2.00	1.00	1.00	3.00	2.00	1.00	7.00
First contact physiotherapists	4.00	1.30	2.00	0.00	4.00	1.30	2.00	0.00	4.00	1.30	2.00	0.00	4.00	1.30	3.00	1.00	9.30
Physician associates	0.00	0.00	2.00	3.50	0.00	0.00	2.00	3.80	2.00	2.00	2.00	4.50	3.00	3.00	2.00	6.00	14.00
Pharmacy technicians	2.00	1.00	1.00	3.50	2.00	1.00	2.00	3.50	2.00	2.00	2.00	3.50	4.00	3.00	3.00	4.00	14.00
Occupational therapists	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Dietitians	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00	1.00
Chiropodists / podiatrists	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Health and wellbeing coaches	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.00	1.50	0.00	3.50
Care co-ordinators	6.00	5.00	4.50	2.00	6.00	5.00	4.50	2.00	6.00	5.00	4.50	2.00	6.00	5.00	4.50	4.00	19.50
Nurse Associate (October 1st 2020 onwards)	0.00	1.50	0.00	0.00	0.00	1.50	0.00	0.00	3.00	2.00	1.75	0.00	3.00	3.00	2.00	0.00	8.00
Nurse Associate Trainee* (October 1st 2020 onwards)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.00	0.50	0.00	0.00	2.50
Community Paramedic (FY21/22 onwards only)	0.00	0.00	0.00	0.00	0.00	1.00	2.00	1.00	0.00	2.00	3.00	2.00	2.00	3.00	5.00	3.00	13.00
Mental Health Practioners (FY21/22 onwards only)	0.00	0.00	0.00	0.00	0.00	1.00	0.00	1.00	0.00	1.00	2.00	3.00	0.00	2.00	4.00	4.00	10.00
Total WTE per PCN	16.00	13.80	13.50	12.00	16.00	15.80	16.50	14.30	22.00	21.30	22.25	18.80	30.00	29.80	30.00	26.00	

General Practice integrated Mental Health Service (GPiMHS)

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GPiMHS is an emotional and wellbeing service for adult patients over 18. Patients are offered extended consultation times, quick and easy access to practical advice and tailored support for their mental health needs from Mental Health Practitioners (supported by Clinical Psychologists) or Community Link Workers. Referrals are made via local GPs and Practice Nurses.

Practices in the North Guildford PCN have piloted this programme since October 2019 with great success having on average 55 requests a month. There is a further pilot programme in the early stages in East Guildford PCN. This started in May 2020 and despite a few set up issues, it is going well so far.

The majority of requests are from 26 to 64 years females and the qualitative feedback has been very positive.

This is a link to our video Transforming community mental health services in Surrey Heartlands https://www.youtube.com/watch?v=AsVdmkEfO3I

Digital First Primary Care - Road Map

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The NHS Long Term Plan commits that every patient will have the right to be offered digital-first primary care by 2023-24.

To achieve this commitment, the GP Contract has set out a number of digital primary care requirements, including:

- all practices will ensure at least 25% of appointments are available for online booking.
- all patients will have the right to online consultations by April 2020 and video consultation by April 2021.

Since July, Surrey Heartlands ICS has been developing a Digital Roadmap with the ICPs and GPs to move towards a digital first approach, where patients can easily access the advice, support and treatment they need using digital and online tools. These tools need to be integrated to provide a streamlined experience for patients, and quickly and easily direct them to the right digital or in-person service.

Evidence to date and case study findings show that where online consultations are implemented as part of a comprehensive primary care service, they enhance the experience of care for patients and support general practice in managing time and workloads, improving both access and sustainability.

PHM Pilot

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Population Health is an approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population. Population Health Management is an emerging technique for local health and care partnerships to use data to design new models of proactive care and deliver improvements in health and wellbeing which make best use of the collective resources.

West of Waverley PCN is currently piloting PHM. They have selected a cohort of people who would not normally come under the scrutiny of health and social care services in an effort to prevent deterioration of both mental and physical well being and improve quality of life. The patient cohort list is currently being finalised and once available, will be reviewed by the team.

Thriving Community Networks with Primary Care & Citizens at the centre

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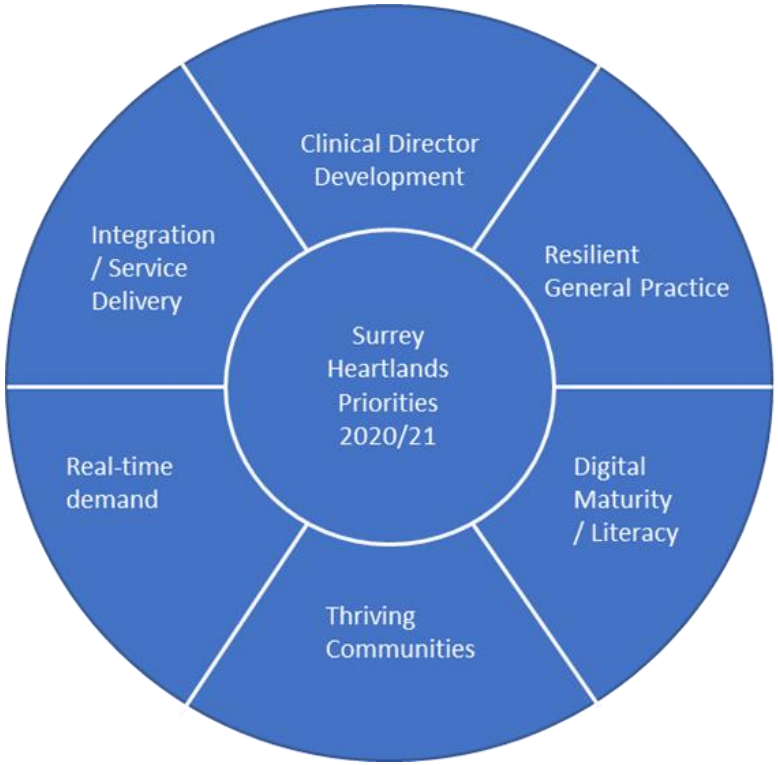
Surrey Heartlands Primary Care Networks

Ambition

By working together, GP Practices and other care providers can deliver better care for their patients and better lives for their staff, than they can by working in isolation.



Key Areas:

1. Develop collaborative leadership; working within and across complex hierarchical structures we need to create teams and organisations that work together to drive change
2. Creating resilience by working as communities of providers
3. Improving modes of contact using digital technology to compliment the more traditional approaches
4. Create thriving communities by enabling partnerships between health, care and VCSEs that are not arduous to form and maintain
5. Develop SH early warning system and demand and capacity modelling in General Practice to support operational and strategic decision making
6. Using population health to drive service delivery, improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across a population

Thriving Community Networks

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Long Term Priorities…

Key Areas:

- Develop collaborative leadership working within and across complex hierarchical structures we need to create teams and organisations that work together to drive change
- Create resilience by working as communities of providers
- Improving modes of contact using digital technology to compliment the more traditional approaches
- Create thriving communities by enabling partnerships between health, care and VCSEs that are not arduous to form and maintain
- Develop SH early warning system and demand and capacity modelling in General Practice to support operational and strategic decision making
- Using population health to drive service delivery, improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across a population

Rapid Delivery Priorities…

Rapid delivery

- **Community Mental Health –** accelerating the delivery of GPimhs model to support aftercare and developing the digital touchpoints to create a more cost effective model
- **Population Health –** simple segmentation and risk stratification analysis, community review of finding to define services/workforce
- **Community Network MDTs –** Led by the results of the above to align consultants to PCNs
- **Social Care –** with SCC PCNs start designing the multiagency delivery units

Immediate Steps

Community Mental Health

1. 1st T&F group meeting 6th August
2. Roll out GPImhs
3. Blended digital approach

Population Health

1. Meeting with NAPC to explore rapid delivery model
2. Buddy arrangements with Wave 2 PHM sites

Community Network MDTs

1. Anticipatory Care – segment and stratify cohorts at risk of future ill health
2. Investigate the identified cohort through an MDT approach

Social Care Collaboration

1. SPLW employment and supervision.
2. Identify cohorts using PHM and priority wards dataset

G&W PCN Estates

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- University registrations – The Guildowns Group uncapped their list and the CCG supported practices in the North Guildford PCN with student registrations in September 2020.
- Chiddingfold Surgery – A fire closed this practice in January 2019 and the CCG supported the practice and following a full rebuild they reopened on the 19th November 2019.
- North Guildford Estates plans – the initial feasibility study for GP space requirements has been completed and a project steering group has been set up to progress the business case for this development. In addition, the CCG has commissioned a demand and capacity study for GPs in Central Guildford to ensure we get a balance between the needs of both areas, and the likely impact of new housing in the area.
- Wisely/ Ockham new village development. The CCG and PCN are in dialogue with the developers and the Planning team on future needs.
- New Inn Surgery – closed and the patient list was dispersed to local GP practices
- Guildford Rivers – Branch site at Buryfields closed as part of practice sustainability programme. However Practice registration boundary remains unchanged.

Primary Care Risks/Issues

NHS Surrey Heartlands Clinical Commissioning Group

ICP Partner Organisation Name	Date	ICP Lead
Primary Care	8th September 2020	Rhian Warner

Risk/ Issue no.	Top quality and performance risks or issues	RAG	Mitigation/s	Action/Support required from the ICP (meeting of relevant partners)
1	Surge/2nd C19 Wave/Winter		Winter Planning underway, lessons learned, Hot sites, primary care data used in EWS, agility to move to digital front door	Awareness of the demand in GP
2	Delivery of Flu Programme for 2020/21		G&W Indicative number 128,586 Developed delivery options and considerations SH and G&W Planning	Target of 75% coverage – whole system delivery, 'at-scale' model requires estate/space for mass vaccination
3	Workforce – if we cant recruit to the roles in the ARRS		ARRS planning and support to recruit (at scale recruitment drive)	System recruitment drive, HR support
4	NHSEI submission deadline for Digital First Primary Care		Accenture commissioned, project plans in place	
5	High Demand and capacity limited		Appointment data planning and engagement for pilot sites (NHSEI) meeting to understand the formal 'Access Review'	
6	Becoming PCNs and not just GPs at scale		Move from PCNs to "Community Networks", creating teams and organisations that work together for the benefit of the patient	Population health approach
7	Primary care estates issues are not addressed will lead to greater pressure on primary care and impact on practice resilience.		Process underway to review. Priorities being established.	

How can we work with you to deliver transformation in Primary Care ?

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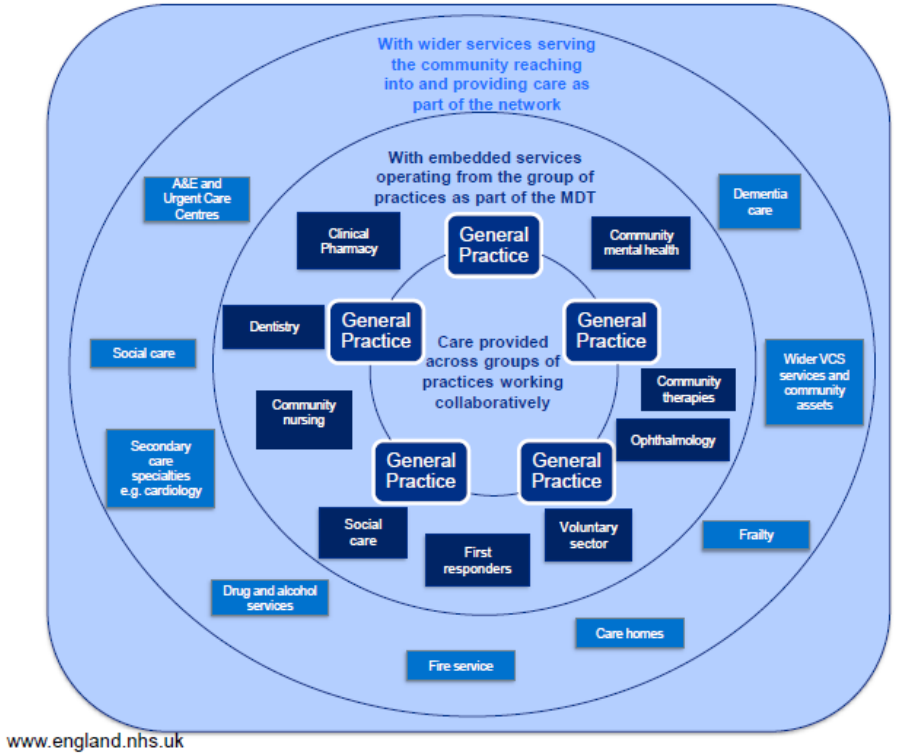
The successes over the last 6 months demonstrate how well we are working together.

The NHS Long Term Plan sees Primary care networks as the foundation for Integrated Care Systems.

We need your support to ensure that our GPs come together as thriving community networks and how Primary Care takes a position in the G&W system.



www.england.nhs.uk

Specifically from you we are looking for support with:

- The North Guildford Estates – being a key stakeholder
- New housing developments