Agenda Item 12

# WOLVERHAMPTON CCG

## PRIMARY CARE JOINT COMMISSIONING COMMITTEE
## August 2016

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| **Title of Report:** | **General Practice Forward View** |
| **Report of:** | Steven Marshall, Director of Strategy & Transformation |
| **Contact:** | Sarah Southall, Head of Primary Care |
| **Primary Care Joint Commissioning Committee Action Required:** | ☐ **Decision**<br>☒ **Assurance** |
| **Purpose of Report:** | New guidance was published in April 2016 outlining general practices services for the future.<br>The enclosed summary confirms the key areas where changes will be realised over a 5 year period as detailed within each of the chapters within the document ie investment, workforce, workload, practice infra-structure and care redesign. |
| **Public or Private:** | Public |
| **Relevance to CCG Priority:** | The General Practice Forward View compliments the CCGs Primary Health Care Strategy Implementation that commenced earlier in 2016. |
| **Relevance to Board Assurance Framework (BAF):** | The Board Assurance Framework domains implicated with this new guidance will predominantly align with the better care component and will touch upon sustainability, leadership and better health. |

***N.B. Please use Paragraph Numbering in all documents for easier referencing.***

## 1. BACKGROUND AND CURRENT SITUATION

1.1. The General Practice Forward View provides greater clarity in addition to previous guidance NHS 5 Year Forward View (2014) bringing general practice into the spotlight as a result of an aging population with ever complex and sometimes multiple health conditions that are reliant on person centred integrated care. In order to achieve the objectives the guidance sets out how the pressures on general practice should be addressed.

## 2. GENERAL PRACTICE FORWARD VIEW

2.1. Currently in Wolverhampton we have a Primary Health Care Strategy that has been approved by our Governing Body (January 2016) and implementation is already underway to improve primary medical care and services in the city.

2.2. The pressures within general practice affecting patients and the wider NHS will begin to be tackled by a package of investment and reform in conjunction with practices and patients through delivery of a 5 year program of work. During the reform it will be important to learn and respond to changing circumstances both locally and nationally.

2.3. An overview of measures from each chapter can be found in Appendix 1, some of this work has already commenced, other work will begin to take place following receipt of further information from NHS England that is anticipated in due course. Much of the delivery of the reforms will be in tandem with our local Primary Health Care Strategy implementation.

## 3. CLINICAL VIEW

3.1. As a member organisation the CCG pro-actively engages with its members, this guidance has been considered by the executive team comprising of clinical and non-clinical executives.

## 4. PATIENT AND PUBLIC VIEW

4.1. Patient feedback has been encouraged from our local community since this guidance was published in April 2016, a specific primary care commissioning intentions event was held in June where the guidance was shared and feedback encouraged. This feedback will be utilised over the coming weeks and months to shape services in line with the themes arising from the event.

## 5. RISKS AND IMPLICATIONS

***Key Risks***

5.1. At this stage no significant risks have been identified pertaining to this guidance.

***Financial and Resource Implications***

5.2 Appendix 1 provides a summary of the anticipated financial and resource implications that are foreseen, further information is awaited in some areas.

***Quality and Safety Implications***

5.2. Improving care quality and service effectiveness within the primary care setting are golden threads throughout the guidance, there are a range of perceived quality improvements that will benefits patients and general practice over the duration of the program of work.

***Equality Implications***

*5.3.* The importance of equality of service and care provision across the city is recognised an equality impact assessment has not been undertaken at this stage.

***Medicines Management Implications***

5.4. There are specific new arrangements for prescribing outlined within the guidance, this has been recognised by the relevant strategy implementation task and finish group.

***Legal and Policy Implications***

5.5. In line with the CCGs pre-existing governance arrangements for constitutional standards and associated strategies and policies the Primary Care Strategy Implementation Board and CCG Governing Body will have oversight of this program of work.

## 6. RECOMMENDATIONS

6.1. The committee should note the guidance and be assured that the requirements contained within it have been considered at executive level within the CCG to ensure all requirements are duly recognised and acted upon at local level.

The committee should:-

- **Receive** and **discuss** this report.
- **Note** the action being taken.
- To **accept** the assurance provided within this report
- **Note** that many of these requirements will be addressed in tandem with the implementation of the Primary Health Care Strategy

**Name** Sarah Southall

**Job Title** Head of Primary Care
**Date** July 2016

**ATTACHED:**
Appendix 1 General Practice Forward View – Summary of Requirements

**SLS/GP5YFV-REP2JCC/JUL16/V1.0**

**General Practice Forward View**
**Summary of Requirements**

| Chapter | Lead | Headline | Action |
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| Chapter 1 | Claire Skidmore | CCG Budgets | Primary Care "national must do" to incorporat Primary Care into our STP work<br>If we assume that we take a capitated share of the £171m requirement from CCGs this would be a cost to the CCG in the region of £850k. (£170k per annum growth over 5 yrs)<br>• Increase in GPIT monies this year of 18%. Don't know if this refers to HSCIC (central) money but we kept our figure static this year…<br>• BCF is noted as an avenue for expanded services – new rules this year allow this<br>• £s required for protected learning time and backfill for GP development (chapter 5)<br>• Other implications of developments in GP IT, paper free practices, E-prescribing etc<br>**CCG Action : Awaiting further clarification** |
| | | Other Pots of Money | • £10m for vulnerable practices (announced in 2015). Requires match funding from practices. Not got any practices in Wolves in 2016/17.<br>• £x transitional funds for premises May to Oct '16 (chapter 4)<br>• Up to £45m to support the uptake of online consultation systems in 17/18 (chapter 4)<br>• £x in addition to core IT, CCGs will also have access to funding for subsidiary technology services (with a view that these become core) (chapter 4)<br>• £3.5m multidisciplinary training hubs<br>• £x other existing avenues for bursaries, fellowships etc<br>**CCG Action : Awaiting further clarification** |
| | | Other | Review of Carr-Hill formula (DoH and BMA). Work to be concluded summer '16<br>**CCG Action: none at the moment, await further information. [nb, potential cost pressure if practice funding increases but allocations are not amended]**<br><br>CCG must publish plans for PMS monies reinvestment before the full impact of the switch to GMS is taken by the affected practices<br>**CCG Action: CCG must agree how the monies will be invested and publish the results**<br><br>Indemnity – DoH and NHSE to put reform proposals to stakeholders in July '16<br>**CCG Action: none at the moment, await further information** |
| Chapter 2 Workforce | Manjeet Garcha | Focus on Primary Care workforce<br>• Training<br>• Recruitment<br>• Retention<br>• Return 2 practice<br><br>£508m over the next 5 years to support struggling practices, further develop workforce, tackle workload and stimulate care design. | **Workforce Measures**<br>• Double growth rate in GPs with a further 5000 net GPs in next 5 years through training, recruitment and R2P. This includes recruiting more than 500 overseas GPs.<br>• Investment in 3000 new fully funded practice based mental health therapists by 2020/21 (an average of a full time therapist for every 2-3 typically sized GP practices).<br>• Plans to provide £112m for a further 1500 co funded practice clinical pharmacists with aim of having 1:30,000 population by 2020.<br>• Primary Integration Fund<br>• £15m for practice nurse development<br>• £45m over 5 years for practices to support the training of reception and clerical staff to play a greater role in navigation of patients.<br>• £6m for practice manager development<br>• Investment by HEE in training of 1000 physician associates to support general practice<br>• £16m ?? *have seen two figures for this £56m and £16m* to mental health support for GPs access to 'free, confidential local support and treatment for mental health issues' to tackle stress and burnout. This scheme to start from Dec 2016 with procurement to commence June 2016.<br>**CCG Action : Awaiting further information from NHS England Workforce Lead** |
| Chapter 3 Workload | Helen Hibbs | 30 million releasing time for patients Development programme | Funding will flow through CCGs for new ways of working including demand management, workforce, skill mix and technology. Community pharmacy and interoperability of technology. |



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| | | (Cross reference Chapter 5) | **CCG Action : Local Workforce Task and Finish Group to continue discussions & act on further advice/guidance from NHS England in due course** |
| | | By September 16 | National programme for Care planning for patients with long term conditions.<br>**CCG Action : Continue work already underway in order to fully implement at locality level** |
| | | NHS 111 | Flow(s) into hubs, social prescribing and minor ailment schemes<br>**CCG Action : Continue work already underway & await further guidance** |
| | | Practice Resilience | £10million for 800 already identified vulnerable practices<br>**CCG Action : Response provided to NHSE in collaboration with LMC, awaiting outcome** |
| | | 40 million with 16 million in 16/17 | Combined NHS ENGLAND and RCGP work on practice resilience teams<br>**CCG Action : Awaiting further information** |
| Chapter 4 Practice Infra-structure | Mike Hastings | Estates | • Changing premises cost directions to ensure that up to 100% of the cost of premises development can be funded through NHSE capital investment.<br>• Allowing support for Capital schemes over more than one year<br>• Investment in 'at scale' project support to assist with legal, financial and design elements of project.<br>• Additional support offered for practices with costs relating to Stamp Duty, VAT and transitional support with additional facilities management costs on NHSPS leases. Guidance is awaited on how this will work in practice.<br>• Estates Strategy to address both premises in need of improvement and the overall efficiency of usage of the local estate.<br>**CCG Action : Continue with work/discussions already taking place** |
| | | Technology | The additional GP IT funding includes £45 million to improve uptake of online consultation systems and a greater range of core requirements are being introduced to outline the services that should be provided to practices. These include:-<br>• Access to records inside and outside of practice premises<br>• Specialist support for IG, IT/cyber security, data quality, training etc.<br>• An Annual practice IT review<br>• SMS messaging<br>• Online appointment, repeat prescription and records access facilities<br>• E-Discharge<br>Specialist support and advice on information sharing and consent based records sharing will be available from December 2016.<br><br>Wi-Fi in practices, a national framework for telephone and e-consultation solutions and funding for education for patients and practitioners on the use of digital solutions.<br>[CCG-Controlled GP IT budget however recent guidance has clarified that a number of these services (including IG support) should be commissioned by the DCO team. Further details are required to determine how much work will be directed and how much we will be expected to deliver]<br><br>NHSE will be undertaking national work to stimulate the development of appropriate apps and triage solutions etc. across the market to provide an approved range of solutions for local GPs to address patient needs.<br>**CCG Action : Continue with work/discussions already taking place** |
| | | Inter-operability | Primarily to support collaboration between practices (or within integrated systems).<br>Bids for IT projects through the ETT Programme<br>Standards for ways practices work together across different sites and clinical systems<br>National Data Guardians review of data security and consent/opt-outs that will clarify how models for data sharing will work<br>**CCG Action : Continue with work/discussions already taking place** |
| Chapter 5 | Steven | Over £500m to be made available | • Self-care and direct access to other services (e.g on line self-management and signposting)<br>• Better workforce utilisation i.e. ANPs, clinical pharmacists |



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| Care Design | Marshall | by 2020/21 to commission and fund extra capacity | • Physios & medical assistants<br>• Using digital technology<br>***CCGs will be required to meet minimum requirements before accessing funding& match fund £171m of practice transformational support*** with a view to:<br>• Stimulate the development of 'at scale' providers for extended delivery<br>• Implement 10 high impact changes<br>• Underpin financial sustainability to improve in-hours access<br>**CCG Action : Awaiting further information** |
| | | MCP contract | • The provider (i.e. MCP) holds a single whole population budget for services it provides incl. primary medical and community services.<br>• Intent is to take a population health management approach and challenge current "GP appointment, referral or prescription" approach<br>• The vision is for the MCPs to be integrated community based teams (GPs, ***physicians***, Nurses, therapists, pharmacists) with access to intermediate beds, and redesigning pathways out of acute and on into supported community settings<br>• This intends to go live voluntarily April 2017 but has already some key features:<br>  ○ MCP defined as an **integrated provider**, with a scope of the services it provides itself & not all Acute & Spec. services<br>  ○ Can be CIC, LLP, or JV with local trust<br>  ○ New payment model on a capitation based approach<br>  ○ ***New blended pay for quality and performance replacing CQUIN & QOF which can be arranged by the MCP itself to meet its own requirements and those of constituent clinicians***<br>  ○ Greater practice integration can mean some activities can take place at MCP level i.e. CQC<br>  ○ New procurement process to be introduced to allow MCP contracts to be let on a list based approach<br>• New employment/contractor options offering salaried or equity partnership. Might be instead of GMS/PMS, but these can be held 'dormant' and reactivated/right to return<br>• Adopting new contractual arrangements is voluntary<br>• Common practice policies<br>• CPD, clinical governance<br>• Staff training and workforce development<br>• Improved access and new ways of working<br>• Shared back office, shared BI and shared pools of support staff<br>• Stronger voice/power for Primary Care in the system<br>**CCG Action : Awaiting further information, guidance & framework due late July 2016** |
| | | Releasing time for patients | £30m over three years available for all practices, starting in 16/17<br>Spread innovation (HIA *(Active signposting; New consultation types; Reduce DNAs; Develop team; Productive workflows; Personal productivity; Partnership working; social prescribing; Support self-care; Develop QI expertise)*and address '***inequalities in the experience of accessing services'***<br>Hosting Action Learning Sets<br>Build Change Leadership<br>**CCG Action : Awaiting further information** |
| | | Measuring Workload & Improvement | Provide an online version of a clinical audit tool to identify ways to reduce GP appointments and provide benchmarks<br>Provision of an 'automated appointment measuring interface' to measure activity variation over time to allow for balancing of demand and capacity available to all practices from 17/18 (when in year un specified<br>**CCG Action : Awaiting further information** |
| | | Stimulating Local Support | to 'strengthen arrangements' for PLT for GP backfill that is the backfill paid for by the CCG. The 3 most successful areas for MCP/provider development:<br>• Creating space for practices to meet & plan<br>• Providing expert facilitation for creating improvement plans<br>• Focusing development on improving care before determining any types of organisational form<br>**CCG Action : Awaiting further information** |

**SLS/GP5YFV/ChapSum/Jul16/V1.2**

## REPORT SIGN-OFF CHECKLIST

**This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.**

| | Details/ Name | Date |
|---|---|---|
| Clinical View | Helen Hibbs | June 2016 |
| Public/ Patient View | Pat Roberts | July 2016 |
| Finance Implications discussed with Finance Team | Claire Skidmore | June 2016 |
| Quality Implications discussed with Quality and Risk Team | Manjeet Garcha | June 2016 |
| Medicines Management Implications discussed with Medicines Management team | Manjeet Garcha | June 2016 |
| Equality Implications discussed with CSU Equality and Inclusion Service | NA | |
| Information Governance implications discussed with IG Support Officer | NA | |
| Legal/ Policy implications discussed with Corporate Operations Manager | Mike Hastings | June 2016 |
| **Signed off by Report Owner (Must be completed)** | Steven Marshall | July 2016 |