

Locality Commissioning Meeting North East

Date of Meeting: 10 July 2019		Paper I	Paper No: 11			
Title of Paper: Q4 Sustainability Meeting – notes						
Is this paper for	Discussion	Decision	Info	ormation	✓	

Purpose of Paper:

Sharing output of the meeting for information only. The 2018/19 Primary Care LIS for this element has already been confirmed and payment made – this paper is for audit purposes and circulated if helpful for practices.

Action Required:

None unless practices wish to discuss items with colleagues.

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Practices – compiled by Julie-Anne Howe	Dr Will O'Gorman

North East Locality Q4 Sustainability meeting 13.3.19 15.10 – 17.00 Littlebury Hotel

Primary Care LIS – 2018/19 Sustainability element achieved – YES (JAH)

Q4 Primary Care LIS – Agenda

3.10	Implementation of initiatives to support Primary Care – round table (5 mins per practice)	WO'G	Paper z To follow
3.45	Group Consultations & Patient Engagement Events	Dr Ellen	Verbal
	Primary Care Network discussions	Fallows	
	Central discussion -		
4.00	Break into Neighbourhoods to allow time for open space discussion	WO'G / TQ / All	Paper links
	Feedback on key points from each Neighbourhood - (5 mins per Neighbourhood)		below
4.50	,		
	 29.3.19 – GPC & NHSE release Network Agreement and 2019/20 DES specification details 		
	 2.4.19 – Primary Care Networks Roadshow (North & NE Localities) – 1-5pm Hopcroft Holt 		
	End 17.00		

Documentation: (no need to print – just so you can view it easily if you wish)

Long Term Plan here Summary here

BMA PCN DES document here

QOF guidance <u>here</u> IT Digital guidance <u>here</u> Indemnity guidance <u>here</u>

Presentation <u>here</u>

Maturity Matrix here (final slide) Oxon Health & Wellbeing Board Priorities here

Open Space Thinking areas PCNs might wish to consider:

PCN Clinical Lead

PCN bank account (details coming 29.3.19)

Contiguous boundaries (no gaps in NE Locality identified)

Use of Federations

Service specifications x 7 (2019/20 = End of Life and Safe Prescribing QoF)

Structured Medication Optimisation Care Homes
Anticipatory Community Care Personalised Care
Early Cancer Diagnosis CVD Prevention & Diagnosis

Health Inequalities

PCN profile data – the Tartan Rug from Public Health

Locality main meetings

Other areas?

Q4 Sustainability Notes of the above meeting:

WOG intro – paper z start point here:



paper z - Reporting template Q2 on Trans

EF – presentation on group working here:





EF Group Consultations.pptx

EF ELC group consultation presenta

JD – presentation on PCNs here:



Contract reform presentation March 1

PCN discussion presentation here:



BHC-

PN explained issues in year – change to the EMIS system used as an opportunity to look at every single protocol in the practice and system change. Clinical documents protocol been reviewed – workload to GPs with a view to release clinician time and ensure process is effective. Other processes e.g. introduced new process for patients doing their midwife booking appointments – patient seen by GP, then referred to midwife –standard clinical questions to assess risk can now refer directly to midwife following a triage by receptionist and responses.

Takes information from the record, or patient, and telephone call made or initial appointment for midwife unless red flags. Pre 10 weeks – if after then give MW direct line and she's happy to organise the scan. Can't go on ICE is an issue.

MHS don't' go on ICE. GHMC does go electronically.

Saved 11 GP appointments in a month – will continue checking. MW does the scans - developed the new process with the MW.

KEY also has an in-house template – 5-10 mins. Is iterative prototype. Some reception concern as is clinical – but put together by the clinician and no decisions been made by the receptionist – happy to share process with other practices.

1st question is "have you done a home pregnancy test? – no – then go do one."

Islip - receptionists don't all feel confident to ask why an appointment is wanted.

Test result follow-up – has replicated previous functionality – e.g. test results (some exclusions) but protocol and template so receptionist can give the result and record coded so can find the result – report can be run to check who hasn't called in. If normal take the flag away and no further action is required. Initially some glitches with Reception to click flag but working quite well. 1-2 per week the flag isn't clearing for – those found is an appointment within 7 days for the GP to discuss results. If subsequent results come back and need f/up then flag comes back on. If get a result as part of a suite of tests and comes later in the day then flag is date dependant and trying to sort. If results is normal, then flag is cleared.

Other areas being considered re results and workload.

EQRX – reminding plans made and follow up – reducing calls and follow-up appointments – checking how useful can be. Chain can't say if can't deliver a text but only in a report – so use MJog as can get a code in if can't deliver. So then flags up and ensures Chain / check to patient telephone number.

Templates for lots of clinical conditions – avoids clinical information – ask in consultation so know in future if can include this information so consent verbally.

GHMC – uses paper to sign then legal redress.

Can say please contact the practice re your test result. Or your test result is fine. Receptionists have simple statements to say – some patients take umbrage.

Islip – have a system to check if texts have gone.

KEY - developing the Team re long term sustainability. Skewed in that needs a huge resource for same day demand and this knocks on to GP availability. Patient expectation rises. Routine re disease monitoring impact. Lack of GP resource and can't see changing so diversifying Team – has ANP a year now for same day care – is prescribing. Works out well and hugely valuable asset.

Carried out an audit of telephone lists requests – found large number of calls could be dealt with by suitably skilled non-clinician. Chart – blue showed significant opportunity. Held meeting and decided 2 x non GP clinicians in addition to ANP. Has 2 x paramedic practitioners – 1 with minor injuries, triage etc so skilled at same day – other catching up. 1 doing prescribing qualification over next year.

Finding it really beneficial – work in process and lots of support needed but patent feedback is good and they understand they don't need to always see a GP. Recognise other staff have skills and satisfied. Monitoring in place.

Investing in nursing team is ongoing project. Full time phlebotomist in place – HCA team are increasingly skilled doing nurse area, so used efficiently. Skilled up and nurses now able to do some chronic disease work.

Reconfigured admin side to build up expertise – coded with Admin now rather than clinicians following upskilling of Admin. Reception now split to be front end Care Navigators and others who code and develop prescribing support team to upskill on medicines reconciliation. Can deal with and GP sanctions and signs off – Duty GP can check. Starting to work well.

Lesson is that it takes time and commitment, especially from partners – need to upskill people.

Q re how to do training for prescribing support Team -1 person has done local work - always through GP for checking then signing off. One other person now both been on a course re Prescribing Incentive Scheme and Bally working with them. One partner is developing Admin and prescribing Team. Audit to check quality and check errors and flow. Working well - can see the difference emerging now.

Gosford — SM — no major projects but are doing the freeing up of admin time for GPs, welfare and wellbeing for GPs. Did a survey — looked at what could implement to become less onerous. Signed up to Learning from Excellence programme — GP appraisal. Box in kitchen — cards in to appreciate what someone has done — just to say thank you. Monthly feedback to encourage this. Running for staff then will put out for patients to add their views. Friends and Family same old — but lots of positive receptionist feedback too to reinforce the positive.

About to start a cake day – no big meeting room so close for 30 mins to get together and network / coffee / build team morale.

Restarted nurses clinical supervision sessions – time for the Team to get together and discuss issues in a non-defensive way to Team build. Helps as nurses are generally part time staff. Will help re PCN as DNs meet regularly but PNs are silo working so this will help learning and sharing. Best to do in work time not their own time to encourage value and appreciation.

Blocked off more GP Admin time – looking at workflow management and sign posting management to beef up system. At full complement of staff but HCAs are doing more, so nurse capacity is not the same – dressings to HCAs so balance is shifting. Tension re patient led demand and GP requirements – hidden work internally. F2F v telephone appointments – shifted markedly 1/3 to 2/3. Patients want to be seen sooner.

MHS – views is that telephone triage doesn't make practices more efficient – much easier F2F as patients more satisfied. Do both. Triage is working through lots people need prioritising. Even routine calls are rising as expectation is rising. More convenient for patients but can make same time. Patient can ask for a telephone appointment rather than a visit.

Woodstock model is to have unlimited telephone calls (not appointments) so strict – saves lots of appointments.

Woodstock – EVS now being used. When doing electronic prescribing can see meds – saves minutes each day. Streamlined derma ta / patients called / PN or DN sees – tick boxes discussed dental care. Some very near misses but sorted and works well.

Diabetes weekly clinic with same GP works well. Try to ensure bloods done prior and feet done etc – good QoF points. Dedicated prescription queries, nomads etc means good value.

Multitasking staff – receptionists to be phlebotomists.

READ coding and Scanning backlog cleared by a university person.

Telephone triage – don't do now – patient happy F2F.

Docman - much filed now.

Increased use of Hub to get to extended appointments is hard as can't plan Hub easily – ideas sought.

Hubs and 2^{nd} commission and skill mix – SK did smiley faces for receptionists to allocate jobs – smiley happy to do – grumpy = under pressure. Want to do – can see green smiley face so know if can pass to.

Montgomery House Surgery - general

Building update re prescribing area. Increase reception – wanted scanning pilot but got pulled. Working with Alchester – working well.

Hub – how to plan if not standard.

Group consultations – going well, see slides above and write up below.

Technology use better – use of telephone provider and try new things to improve access to patients and something they can do themselves via telephone or texting so don't need reception.

Econsults being later in the year. EF very excited about this – very user friendly – 2 weeks in. Patients saying they are happy. EF trains minor illness nurses – does AI triage – generates a red flag report so got in black and white – can sort what is safe for who to do. Allows better workload allocation to Reception etc. Staff are much happier too.

Receptionists pull out email report so GP can see – go into notes etc. Can reply back but clinically sensitive and don't know if got it. So read it and GP to call and sort out, or book Reception call to do.

Admin area – can spread the admin throughout the day – forms on website – stick to that on minor illness. Website information giving – this way patients can contact the practice. Trained

receptionists can support patients who need computer training. May direct patients to website to explain request in future. Patients can access at any time, practice can flatten workload.

What happens if website crashes? EMIS contingency. Can signpost people too. Can see who hasn't come through either. Chest pain = 999 and goes directly and GP not informed. No diagnosis made – that's still for the GP. Free for everyone – not just a pilot. OCCG paid for 2 years –

OCCG – expressions of interest to JAH – 1^{st} wave have shaped what's required – especially if MDT teams – burden lifted knowing right patients going to right place.

2nd wave is Q1. Want a good Oxon spread. Change project – Resource training too. Can test but don't hit 'send'.

Open access at present - Frequent patients could do pre-loaded data. Pilot to set up. Inside Health interview on it was very good.

Paramedics not worked out quite so well – learning was very protocol driven and slow – everything was a minor injury.

KEY - Work with the GP on duty so learning – so risk helps and support and discussion around training.

ISLIP – Lots of working around signposting – getting used to it 6-9 months. Patents getting used to it and OK. Helpful re ITUs or photo's in re chicken pox. Eye conditions / physio appointments and direct booking. Created an F12 key to code immediately.

Use of extended hours – many older patients not sure.

Workflow working really well now on Docman 10 – taken a while to get to grips with it. Stopped the roll out as so many glitches - Everyone feels is working well now unless internet is slow. Fewer misfiled documents.

Tips – helpful to have manual templates to match telephone templates. Setting up of templates and agreeing the filing conventions prior to starting helps.

Decided how to classify the documents first which helps with consistency which also helped avoid problems.

Do have to tweak as hospital use different abbreviations.

Patients using better website and patient use is increasing - 2,340 requests come via website so c500 per month.

Alchester – focus is on estate provision. Co-locating with MHS on a site – Kingsmere or Graven Hill main options. PID being worked on. Regular group meetings taking place. Patient engagement started and videos on websites https://www.oxfordshireccg.nhs.uk/your-local-area/north-

<u>east/primary-care.htm</u> and in clinic TV screens. Public meeting being planned. Social media engaged. March 2022 opening for a new building is the target. 3,300sq mtr building wanted.

MHS – write up on Dr Ellen Fellows presentation:

EF has started a diploma on this – especially for patients with lifestyle change. Evidence is there and works – why not doing it? Mechanism to support patients is via group consultations. Slough and Croyden have embedded in practices. NHSe funding for training so attended. Needs a good people person – doesn't have to be a clinician but person needs to be trained to run a group.

Draws out what is important to the patient. Takes the patient question and responds to that person with the whole group listening so learning is shared.

Share in successes – patient stories. Staff find it satisfying – better use of time.

Time for change – and selling it to patients. They lead it so need to own it.

Confidentiality – patients do sign a privacy statement but don't seem to have concerns. EMIS has a template for group consultations. Other items should not be shared - if consultation is for diabetes – keep it to diabetes.

Croydon on TV re 'Trust me I'm a Doctor' coming out.

Links to website. 185.19 Siad business school coming.

Q re optimal size of group? How many groups run?

A = 2 groups - patients feel the need to improve. Book back in 2 months later – repeat each year in plan – want a lot more of these sessions planned e.g. one a week. Option on traditional appointments too – some patients not aligned to working in a group.

Is instead of seeing a nurse for 20 minutes re Year of Care. Doesn't have to involve a Doctor. First group is nurse, 2nd group is GP but doesn't have to be. Some nurses better at this than Drs.

PCNs - JD slides talking about new areas and old areas to highlight the differences.

Q - What new money and what's not? A - OCCG has been investing more than £1.50 per year – e.g. into STF funding.

Q - OCCG can't take any current funding to practices to support the new £1.50. A - GT to check and mechanism in place to tackle practices who are siphoning funding.

Other funding on a non-recurrent basis is being redeployed but remains in primary care.

2019/20 LIS components which remain are the LIS and training. Will review how funding for locality meetings can be reviewed to ensure flexibility to change if time at PCN level is better.

Constitution uses the LCDs as a link to the membership but the model of delivery isn't in the constitution to have a monthly meeting, but seen as the only way LCDs can feed out and back into discussions. Provides an overview of what's going on and to provide feedback into the OCCG Board. With other networks (Kiren's clinical group) forming then maybe these meetings aren't needed in the same way over time. Meetings need to be manageable and not duplicated.

Issue re new funding – needs to be clarified – park this at present.

£14k per practice to set up is not correct – that is now £1.76 per weighted patient Don't always know which bits are weighted or not yet as not clear.

Doesn't take into account the QoF or the Global sum – and doesn't include the indemnity either.

Numbers may change but are indicative at the moment to give an idea of extent of funding.

Extended hours DES - £1.45 in Practice not PCN column as expect it to come back to practices. 76% of practices participate nationally.

So c£3.7m more than previously given to practice.

Patient participation payment is recurrent and paid monthly.

Elements are not felt to be practice benefit as some is payment for Director of the Network, some to Social Prescriber etc - may or may not be wanted and are paid on activity.

First year of PCN is to deal with extended hours – and plan for year 2 – time needed to do this. 100% funding is available for a social prescriber – payment for benefit in kind.

Workshop being held - Note move from Hopcroft Holt to Bicester Golf and Country Club due to number of people who want to attend – limit is the room size. May consider some local events for practice nurses. Aim is to have talk time to set up PCNs.

Allowed every partner + PMgr – some wont' send that many – if have more then send notification through and will try to accommodate, but may be asked to curtail if needed. One issue re awareness raising – can that be done in a different forum to those signing the PCN contract agreement. PCN break out groups will have space available. Phones to 111 funding being put in place.

Not sure if practice boundaries need to be the same as PCN / OCCG boundaries? OCCG will check with our neighbour boundaries to ensure contiguous. Checking maps.

Indemnity – to carry on last year's scheme until the state indemnity kicks in.

PCN agreement by 29.3.19. Q&A document expected from Centre – not here yet.

JAH to share presentation – but note is Draft and figures may change. (at start of document)

WO'G – thanked JD – need to discuss funding and new issue again. Workshops coming and lots more work which will have to be done. Hope for more information re the Network Agreement.

Q – MW – is the OCCG going to have a team of people to liaise with in conjunction with PCNs – a sub-Team re PCNs, like JAH – but making a bottom up approach. A - Others sitting on PCNs to be called on at the Roadshows to ensure a bottom up approach with some expertise.

Q - Facilitation – clinical lead – who is a GP, or not? A - Kiren is keen to lead this work. Some LCDs who have very good networks running at present and can support. Have the Federation running at scale and working for some time, there is JD and team members, and LMC as is a contractual change. Who leads depends on shape and PCN preference.

JD – could have meetings together or at PCN level – can decide depending on topic. Some work across several networks. As time goes on PCNs will have to do some of the work that CCGs are doing but unclear yet. Void between PCNs and STPs – 2-2.5m patients across 3+ counties. So how to speak / share views at the higher level – how to report up and down? No parity on the middle shape yet.

 2^{nd} April meeting - Inform the discussions in April – send comments to JAH so they can be themed and responded to.

Thanks to all and meeting ended.

Example: Mark Spencer from Fleetwood at Lancashire – look up what they are doing – desperate measures to help. Inspirational – JAH to input link below:

http://www.healthierfleetwood.co.uk/about/dr-mark-spencer/

https://www.youtube.com/watch?v=CVEZBaviy_o

http://www.healthierfleetwood.co.uk/

Attending:

Practice	Representative	Present / Apols
Alchester Medical Group	Dr Damian Hannon (DH)	Y
= Langford MP & Victoria House	Dr Toby Quartley (TQ) Co-Chair	Υ
Surgery	Dr Raman Nijjar – LMC rep. (RN)	Υ
	George Thomas (GT)	Υ
Bicester Health Centre	Dr Tim Powell (TP)	
	Dr Jonathan Holt (JH)	Υ
	Paul Netherton, (PN) - P.Mgrs rep	Υ
Gosford Hill Medical Centre	Dr Mark Wallace (MW)	Υ
	Sally Mackie (SM)	Υ
Islip Medical Practice	Dr Matthew Elsdon (ME)	Α
	Dr Sam Hart (SH)	Υ
	Beverley Turner (BT)	Y
Kidlington, Exeter, Yarnton MP	Dr David Finnigan (DF)	Y
(KEY)	Kathryn Muddle (KM)	Y
Montgomery House Surgery	Dr Ellen Fallows (EF)	Y
	Dr Will O'Gorman (WO) Co-Chair	Y
	Steve Sharpe (SS)	Y

Woodstock Surgery	Dr Duncan Becker (DB)	Υ
	Sue Kavanagh (SK)	Υ
Others:	Dr Helen VanOss, (HVO) PPG Forum Chair	Α
	Rosie Rowe, (RR) Cherwell District Council	
	Catherine Mountford (CM) - OCCG Exec	
	Team rep	
	Julie Dandridge (JD) Locality Sponsor	
	Julie-Anne Howe, (JAH) Locality Co-	Υ
	ordinator + Notes	
	Eleanor Baylis (EB), PML	Υ
	+ Speakers	