Meridian Health Group Primary Care Network (FGP0387)

Primary care networks (PCNs) form a key building block of the NHS long-term plan. Bringing general practices together to work at scale has been a policy priority for some years for a range of reasons, including improving the ability of practices to recruit and retain staff; to manage financial and estates pressures; to provide a wider range of services to patients and to more easily integrate with the wider health and care system. PCNs are the gateway to all service support and delivery. The long-term plan has an ambition for more than 90% of services delivered by PCNs either through member practices or in collaboration with other providers.

Our PCN has already implemented many examples of transformational service models including medical outpatient transformation (now part of an NHS national transformation project), supporting individuals to maintain independence and reduce the need for institutional or hospital care, improving mental wellbeing, working with the VCSE sector to support individuals and communities to maintain their wellbeing and post covid elective care recovery.
These transformational service models have been delivered by new innovative workforce roles and a pacesetting digital inclusion approach.

Our PCN membership is as follows:

Core General Practice Members:

- The Roxton Practice
- Care Plus Group Primary Care Limited (Open Door and Quayside Medical Centre)

Associate Provider Members:

- Care Plus Group (provider of community health and social care and support services)
- NAVIGO Health & Social Care CIC (provider of acute and community mental health services)
- Northern Lincolnshire & Goole NHS Foundation Trust (provider of secondary care services)
- Illumina Diagnostics Limited (provider of diagnostics services)
- Ehealthcompass Limited (provider of digital inclusion and technology optimisation solutions)
- We are with you (provider of drug and alcohol services)

Our reasons for submitting evidence include:

- Demonstrate how PCNs can drive transformational service redesign, address the challenge of providing the capacity required to meet demand, improve outcomes for patients and workforce, and embrace digitally enabled solutions.
- Highlight the importance of digital literacy and digital readiness to help address the increasing demands being placed on general practice and primary care networks in the delivery of high quality, person-centred health and care services.
- Highlight the need to maximise the use of scarce resources used in the delivery of care, including staff, estates and technological solutions.
- Seek support for the development of new workforce roles and how these can be indemnified.
- Highlight the importance of shared clinical governance arrangements and patient admin systems.
- Highlight the need to review and update contracting and payment arrangements to reflect the transfer of activity from secondary to primary and community care.

- Consider financial initiatives to address the GP recruitment and retention challenge.
- To show case the work in which we do to support the most deprived areas.

What are the main barriers to accessing general practice and how can these be tackled?

- Provider & system barriers:

    i. Suitably qualified and experienced medical staff.
    ii. Suitably qualified and experienced clinical staff.
    iii. Suitably qualified and experienced non-clinical support function staff.
    iv. Digital skills and training for staff delivering or supporting the delivery of care.
    v. Deployment of additional resources including new or refurbished estates, digital and technological solutions.
    vi. Contractual positions of providers disincentivising innovative ways of collaboration.

- Patient and carer barriers:

    i. Patient and carer education/awareness of services available and access arrangements.
    ii. Digital skills, literacy and readiness of patients and carers.
    iii. Digital training and support for patients and carers.
    iv. Patients being unable to attend due to social issues.
    v. Translation services.
    vi. Chaotic lifestyle choices.
    vii. Service judging patients.

To what extent does the Government and NHS England's plan for improving access for patients and supporting general practice address these barriers?

A lot of current policy is based on traditional service, workforce and access models. The ambition of the policies are good but they are not flexible enough to allow current and future innovation. The policies try to ensure consistent outcomes, systems and experience which is often a barrier to pacesetting innovative approaches that can be the catalysts for systematic change.

Plans are in place to address the barriers for recruitment but these tend to be tweaks around traditional roles. Some PCNs are keen to work with HEE to design, test and implement new portfolio roles working across traditional sector boundaries including physical, mental and social care, VCSE and partners influencing the wider determinants of health. The additional roles reimbursement scheme is an opportunity to pilot new and innovative roles working across these boundaries. As more services are delivered by the extended PCN teams there are opportunities to develop research and education capability and capacity as an opportunity to improve recruitment. The pension limits are a barrier to taking on additional roles, hours and years of service. Some PCNs would be keen to explore piloting defined "essential services" that would be exempt from annual allowances and would create incentives for additional capacity in the NHS with the current workforce and could be applied to other "essential settings". In 1948 general practice was barred from selling goodwill unlike other primary care providers. A review in 2009 recommended scrapping MPIG, seniority and the sale

of goodwill. The first two recommendations were adopted but not the latter. If the government were to consider repealing this law on the 80th anniversary of the NHS it could retain the GP workforce who are considering retirement in the next 6 years and create potential opportunities for new and more efficient GP corporate models.

Current policies acknowledge the need for digitally enabled service models to improve access however there continues to be a lack of focus to address the digital literacy and readiness gap for patients in receipt of services. The pandemic has driven further rapid adoption of digital health solutions (digital first approach) which has left many patients with reduced access or no access to services. At MHG PCN we have identified this as a significant issue and have worked with our digital partners Ehealthcompass to develop a tool to capture the time and condition specific digital readiness of patients so that we can ensure services are provided in the most appropriate way. Some of the key findings follow survey of 10,000 patients have highlighted following:

- 24% of patients do not use apps and have no interest in learning how to use them.
- 20% of patients do not have an email address and have no interest in learning how to use one.
- 47% of patients do not use video consultations and do not wish to learn how to use them.

Extended access schemes have not learnt the lessons of covid, who benefits from services out of core hours and how are these best delivered between traditional and digitally enabled remote models of care.

Deprivation is a significant barrier and in order to improve access to our deprived patients we offer open access clinics such as leg ulcer clinic drop in. These sessions are held twice weekly at specific times for patients to be able to drop in and have their wounds dressed. This works well for our patients due to their chaotic lifestyles.

We also undertake outreach sessions to be able to reach the sex workers and also homeless population.

We have open sessions for drop-in sessions such as smears, blood pressure checks etc – these appointments and drop-in sessions tend to be well attended.

<u>What are the impacts when patients are unable to access general practice using their preferred method?</u>

As we move to more digitally enabled service delivery we need to systematically know; who can access care without help, who will always require traditional models of care and who are patients who need help at what that help entails. At MHG we measure the digital literacy of our patients and have put measures in place to address possible access issues. This includes remote and face to face training, digital access points across the borough, mobile digital solutions for the hardest to reach including the homeless, working with VCSE.

Impacts we see across the system includes:

- Attend A&E or telephone out of hours services unnecessarily or ambulance services.
- Deterioration in health and social care needs
- Impacts other areas of social needs and mental health
- Complaints
- Socio-economic impact with increased work-related absences
- None engagement with services.

What role does having a named GP—and being able to see that GP—play in providing patients with the continuity of care they need?

Patients benefit from continuity of care with a registered practice and PCN which address all of their primary care needs from a comprehensive team. Within that team they benefit from a named lead practitioner who will be accountable for any time limited or long-term condition.

What are the main challenges facing general practice in the next 5 years?

General Practice needs support to develop the capability and capacity to understand the needs of its registered population and collaboratively with other providers to address these needs. Key enablers need to be implemented to support this new approach including workforce, management and leadership development, estates and diagnostic support, digital infrastructure, shared clinical and administrative systems and new commissioning and contracting approaches for individuals and services.

How does regional variation shape the challenges facing general practice in different parts of England, including rural areas?

With the imminent levelling up White Paper this is an opportunity to address regional variation with incentives for new roles, services, capital developments, research and academic posts and financial schemes to be piloted in areas with the biggest challenges including rural, coastal and deprived neighbourhoods.

Regional areas of deprivation impact on the increasing health complexities which has a direct correlation with increased demand and spend for those practices. For those in NE Lincs, although we have less of a negative of impact for rurality, the close proximity of our local acute provider for most patients provides challenges for general practice to address with frequent users of urgent service from the hospital site.

To support our deprived patients and those living chaotic lifestyles we have a number of outreach services, for example for sex workers, we undertake evening outreach and also visits to parlour to deliver protection. We also screen every 3 months for any STI's. We work closely with public health if there are any specific issues. Our services include social elements including supporting any patient within NE Lincolnshire with any issues such as housing, benefits, employment, counselling, debt management. We have an immunisation outreach team working with all practices who are struggling to get their registered children in for immunisations.

What part should general practice play in the prevention agenda?

General practice can work with individuals, families, communities and the VCSE to promote the advantages of adopting a prevention approach. This can be through traditional prevention service models and digitally enabled prevention apps and services. Alongside the role of promotion and signposting, general practice can also identify those who would benefit the most and monitor the impact of the prevention initiatives

General practice needs to change the way we work to adapt to what the patient needs re increasing access, such as increased drop-in sessions for patients who are struggling with making specific appointment times this to include drop-in blood clinics, wound clinics, smear clinics, blood pressures.

Access to different professionals based within genral practice to be able to meet the needs of all patients to help support both health and social element.

General Practice need capacity within their PCN to look at the population health and associated determinants of health which directly relate to poor health outcomes, for example isolation in older people, education housing, employment, finances these areas which primary care having difficult in access as are often part of the social agenda,

What can be done to reduce bureaucracy and burnout, and improve morale, in general practice?

In our practice an audit showed that we spent 44 weeks of a WTE GP issuing sick notes. The responsibility for assessing fitness to work should be transferred to employers and the job centre.

The appraisal system is often a tipping point for GPs to take early retirement. It takes up a lot of time and most GPs feel it adds little value. With the advent of PCNs we could use the PCN clinical directors to effectively become the responsible officer for ensuring GPs and the clinical workforce are safe and up to date. Instigating local PCN responsive systems to support training, development and evaluation. Most statutory and mandatory training is considered to be a waste of time and adds no value.

An integrated clinical system across providers supporting a "one team" approach would improve safety, outcomes and experience for patients, professional satisfaction and reduce the bureaucracy of transferring clinical that is just for information alongside the inappropriate transfer of action and risks onto general practice. Within MHG we have been piloting this one team approach through a model called connected health network, it has received national recognition. We are now scaling the model for cardiology across our ICS and starting to develop the same approach in other areas such as dementia, elective recovery in MSK, end of life and frailty, anxiety and depression.

A priority needs to be given to promote, educate and support patients, families and communities to manage their own health and wellbeing. This should include a greater use of the VCSE alongside improved accessible apps and technology

How can the current model of general practice be improved to make it more sustainable in the long term? In particular:

i. Is the traditional partnership model in general practice sustainable given recruitment challenges, the prioritisation of integrated care and the shift towards salaried GP posts?

The GP partnership model is one of the few remaining organisational arrangements that makes GPs accountable for the outcomes, experience, and efficiency of the registered population. The GP partners' behaviour in the consulting room, managing and leading the practice is a key lever to drive improvements. There is a direct link between personal responsibility for individual patient care, service design and delivery and overall practice accountability. The GP partner has unique operational and clinical knowledge to inform the development and running of the practice alongside implementing and dealing with the consequences of decisions made.

The GP partnership model can be flexed within the PCN arrangements to accommodate the plurality of ambition and priorities of the practice workforce. This can support those who want the accountability and ownership of the whole practice, those who want reserved accountability for a discrete service area, those who want responsibility for specific areas with a risk and reward compensation package and a defined compensation package for those who want to control their areas of responsibility.

A forward-looking professional partnership model can be a key enabler to drive improvements for patients, efficiencies for the commissioner and professional satisfaction for the workforce

The GP partnership model provides invaluable clinical ownership for part of the NHS that sees the greatest proportion of workload in the NHS. Partners are invested in the success of all parts of the system as any failure in any sector directly impacts on the day-to-day activity seen within general practice, and therefore their own and wider teams workload and satisfaction.

It therefore drives innovation that can be rolled out quickly and respond to the unique needs for their registered populations.

The challenges of workforce do mean in some areas partners feel overwhelmed whilst they try and plug the gaps. Our own partnership is successful in ensuring the skills and interests of individuals are harnessed to ensure individual job satisfaction whilst deploying the most appropriate individual to meet the needs of the varying roles required within the running of the practice.

The wider system can help the PCN and partnership model but redistributing workforce to work more effectively at the neighbourhood level making for a more robust and sustainable workforce. Removing the various levels of bureaucracy that make new ways of working possible with much faster decisions being made would make being a partner a more attractive prospect for the younger GPs stepping up.

ii. <u>Do the current contracting and payment systems in general practice encourage proactive, personalised, coordinated and integrated care?</u>

Innovative changes to services are often delayed or prevented from being scaled to larger populations due to the current contracting and payment systems in place, particularly those linked to secondary care that are paid via the PBR tariff. Incentives are required to focus attention on commissioning, contracting and payment for services at the healthcare pathway level including the clinical steps, assets in use and support functions across the different sectors of healthcare provider. A practical example of this is a palpitations pathway within cardiology services. As part of the connected health network project undertaken by MHG a revised pathway has been agreed across primary and secondary care including the use of digital diagnostic devices where appropriate. General practice staff now play a key role in the onboarding of the digital devices and providing support to patients, an activity traditionally undertaken within secondary care.

iii. <u>Has the development of Primary Care Networks improved the delivery of proactive, personalised, coordinated and integrated care and reduced the administrative burden on GPs?</u>

- Joint working helps to provide services such as urgent care, extended access availability.
- Opportunity for different clinicians to work within primary care.
- Given the ability for other services such as DWP, Drug and alcohol services to be based in primary care.
- Development and delivery of covid vaccinations
- Minor surgery to be delivered by other clinicians such as ANP's.

iv. To what extent has general practice been able to work in effective partnerships with other professions within primary care and beyond to free more GP time for patient care?

By expanding and broadening the workforce and developing these roles, ANP, Practice Nurses, care coordinators, HCA, clinical pharmacists, social prescribers.

Having other team members based in primary care from mental health, drug and alcohol services, debt management services and counselling, this fully helps to support all elements of health, social care and wellbeing to our patients. Being able to support patients with social elements such as housing, benefit forms, CV and food issues. Development of links with probation services is an area in need of development

Care co-ordinators within primary care have helped with the signposting of patients to free up time for clinicians to provide care.