NHS
Gloucestershire
Clinical Commissioning Group

Gloucestershire CCG ……and other stuff

Dr Jeremy Welch

Introduction

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- Who am I & why I'm here
- Lots going on…..
- Lots of acronyms….
- CCG, LMC, ICS, PCN, STP, IA, EH, GPFV, ILPs…
- 'Demystification'
- Video
- Questions????

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LMC

– Local Medical Committee

- ‘trade union’
- Look after us
- Honest broker
- Practice levy
- Chair – Dr Tom Terburgh
- Sec – Dr Penny West

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CCG – Clinical Commissioning Group

- 2010 White Paper 'Equity and Excellence'
- Health Secretary – Andrew Lansley
- Put GPs in the driving seat

- Buying (commissioning) healthcare in Gloucestershire
- Value for the Gloucestershire pound

CCG

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tinder

Joined up care and communities

£££ The Money £££

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- Funding from NHSE to buy Glos healthcare
- ~ £900m
- ~ £430m – GHFT
- ~ £84m – GP
- ~ £85m – GCS
- ~ £90m – 2g
- ~ £110m – FP10s
- Bristol, Winfield, Oxford etc

How to buy?

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- Tesco – weekly shop or annual subscription?
- PBR (payment by results) or Block ?
- Pros and cons
- Variations – Advice and Guidance, Cinapsis, GP in ED, Paeds advice line, OPAL, extra care home beds, community hospital etc
- Gets complicated!!!!!

Friends Together

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- Why not all work together for the 'greater good' ?
- **STP** – Sustainability and Transformation Plan
- Health and Social Care collaboration
- Next step… **ICS** – Integrated Care System

What about Primary Care?

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- 76 practices currently, ~ 650 GPs
- Who is our GP leader?
- Dr Jo Bayley (Gdoc)
- How do we work together?
- 7 Localities (indicative budgets)
- 16 clusters
- ILP – Integrated Locality Partnerships

General Practice and the Long Term Plan

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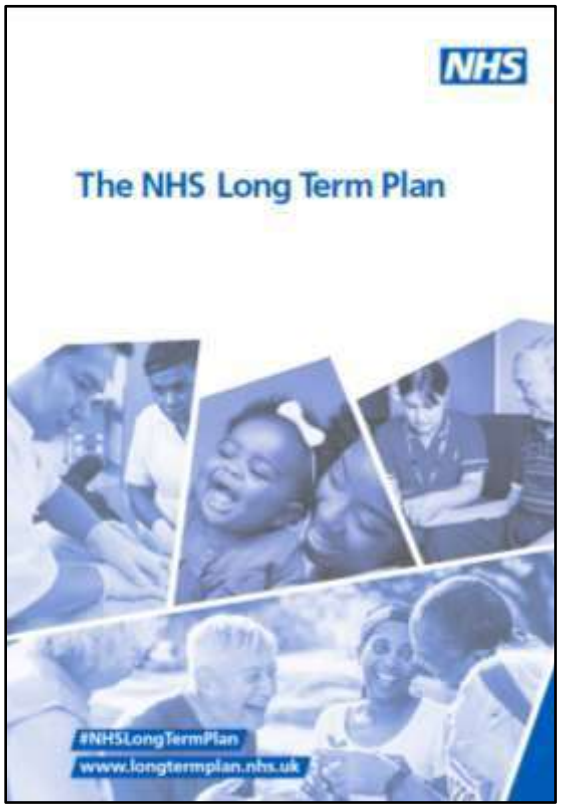
"The biggest reform to GP services in 15 years" **HSJ**

"The most important change to the GP contract since 2004 and a potential game changer" **BMJ**

"These are the most significant changes in 15 years" **BMA**

"The start of a new era for general practice" **NHSE**

The NHS Long Term Plan



Aims:

- Everyone gets the best start in life
- World class care for major health problems
- Supporting people to age well

How:

- Developing integrated care systems with primary care networks as the foundation
- Preventing ill health and tackling health inequalities
- Supporting the workforce
- Maximising opportunities presented by data and technology
- Continued focus on efficiency

https://www.youtube.com/watch?v=SWZBNR4Gks8

Primary Care in an ICS

Individual	Supporting individuals to manage their own care through self-care, care navigation and improving patient activation.
Neighbourhood 30~50k	Primary Care Networks that bring together local health and care professionals around natural local neighbourhoods of care – improving integrated ways of working and more joined-up pathways; and embedding population health approaches.
Place ~250-500k	Groups of local primary care networks that work alongside partners in secondary care, mental health and with CCGs and local authorities, to: • Integrate health and care services • Work preventatively to stop people becoming acutely unwell • Care models to redesign care
System 1+m	Providers and commissioners collaborating to: • Hold a system control total • Implement strategic change • Take on responsibility for operational and financial performance • Population health management

Primary Care Network (PCN)

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The core characteristics of a Primary Care Network are:

- **Practices working together and with other local health and care providers,** around natural local communities that make sense geographically, to provide coordinated care through integrated teams
- **Providing care in different ways to match different people's needs**, including flexible access to advice and support for 'healthier' sections of the population, and joined up multidisciplinary care for those with more complex conditions
- **Focus on prevention and personalised care**, supporting patients to make informed decisions about their care and look after their own health, by connecting them with the full range of statutory and voluntary services
- **Use of data and technology to assess population health needs and health inequalities**, to inform, design and deliver practice and population scale care models; support clinical decision making, and monitor performance and variation to inform continuous service improvement
- **Making best use of collective resources** across practices and other local health and care providers to allow greater resilience, more sustainable workload and access to a larger range of professional groups .

Funding and Support for Primary Care Networks

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- New investment will enable PCNs to attract and fund additional staff to form an integral part of an expanded multidisciplinary team.
- Initially this will focus on clinical pharmacists and social prescribing link workers, followed by physiotherapists and physician associates. Over time, it will be expanded to include additional groups such as community paramedics.
- Expanded neighbourhood teams including GPs, nurses, pharmacists, community geriatricians, dementia workers and AHPs plus social care and the voluntary sector.
- Newly qualified doctors and nurses entering general practice will be offered a two-year fellowship.
- The Government has also committed to a new state-backed GP indemnity scheme from April 2019.

Introducing the Network Contract

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- The **Network Contract will be a large Directed Enhanced Service (DES).** By 2023/24, it is expected to create national entitlements worth £1.799 billion (£1.2bn new funding), or £1.47m for a typical PCN covering 50,000 people, in return for phased and full implementation of all relevant NHS Long Term Plan commitments.

- The Network Contract has three main parts:
  - the national **Network Service Specifications** - these set out what all networks have to deliver (see next slide);
  - the national schedule of **Network Financial Entitlements**, akin to the existing Statement of Financial Entitlements for the practice contract; and
  - the **Supplementary Network Services.** CCGs and Primary Care Networks may develop local schemes, and add these as an agreed supplement to the Network Contract, supported by additional local resources.

- GPC England and NHS England are committed to 100% geographical coverage of the Network Contract by the Monday 1 July 2019 'go live' date.

- PCNs must be no smaller than 30,000 (unless by exception, such as very close to threshold with significant rurality); but can be larger than 50,000

Introducing the Network Contract

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- The seven new specifications for Primary Care Networks, with standard national processes, metrics and quantified patient benefits. First 5 start in April 20, but PCNs encouraged to start earlier in order to maximise income next year (specs to follow):
  - **Structured medication reviews and optimisation**

    Tackling overmedication including antibiotics, withdrawing medicines no longer needed, supporting optimisation. Enabled by additional clinical pharmacists.
  - **Enhanced Health in Care Homes**

    MDT approach, led by GPs and NPs, organised by PCNs. Typically weekly visit. PCNs to work with emg services to provide emg support, including out of hours. EOL planning.
  - **Anticipatory Care Service (with community services)**

    People identified as highest risk of unwarranted health outcomes to be offered targeted support (inc longer GP appts) for physical and mental health needs. To be delivered by a "fully integrated primary and community health team", configured by July 2019.
  - **Personalised care**

    Including shared decision-making, enabling choice, personalised care planning, social prescribing & community based support, supported self-management, personal health budgets and integrated personal budgets. ICS to set out plan for delivery.
  - **Supporting Early Cancer Diagnosis**

    PCNs to play key role in ensuring high and timely uptake of screening and case finding opportunities, working alongside Cancer Alliances and other partners, in delivering personalised care to all cancer patients by 2021, with early progress in 2020.
  - **CVD prevention and diagnosis (starts April 2021)**
  - **Tackling neighbour inequalities (starts April 2021)**

    NHSE expects that CCGs will use additional funding to boost primary care capacity and access in areas of high need and inequalities

Introducing the Network Contract

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- To be eligible for the Network Contract DES, a **PCN needs to submit a completed registration form to CCG no later than 15 May 2019**, and have all member practices signed-up to the DES.

- **CCGs are responsible** for confirming that the registration requirements have been met to NHSE by **no later than Friday 31 May 2019**.

- Once the registration requirements are met and GMS/PMS/APMS contracts have been varied to include the DES, the **PCN can start receiving national investment from 1 July 2019**.

- **A 'typical' practice can also receive over £14,000 each year** from April 2019 as a new SFE payment, in return for their active participation in a PCN (£1.76 per patient)

- In the highly unlikely event that a practice doesn't want to sign-up to the Network Contract, **its patient list will need to be added to another local PCN.**

Introducing the Network Contract

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- All PCNs will have a **Network Agreement**, even those with one large practice. The Network Agreement is also the formal basis for working with other community-based organisations and must be signed by all constituent GP practices include patient data sharing requirement.

- A PCN must appoint a **Clinical Director** as its named, accountable leader, responsible for delivery (see next slide).

- PCNs must **define their business model** – funding will flow to one account and need to determine who will employ new workforce roles.

- **PCNs will also benefit from:**

  - **0.25 WTE Clinical Director** support funding (per 50,000 population);
  - **a recurrent £1.50 per registered** patient from CCG allocations;
  - many CCGs also **provide support in kind for their PCNs** e.g. through seconding and paying for staff to help with particular functions;
  - during 2019, **NHS England will establish a significant new national development programme** for PCNs.

Named Accountable Clinical Directors

- **0.25 WTE/50,000 funding considered a 'contribution**' towards costs
- Not solely responsible for op. delivery of services – this a **collective responsibility**
- **Clinical Directors must play critical role in ICS**
- National leadership development programme being established
- Role **specification, appointment rules and term of office** being developed by NHSE
- Key responsibilities will vary according to maturity of PCN but may include:
  - **Providing strategic and clinical leadership**, developing and implementing strategic plans, leading and supporting quality improvement and performance
  - **Influencing, leading and supporting** the development of excellent relationships across the network to enable collaboration for better patient outcomes
  - **Providing strategic leadership for workforce development**, through assessment of clinical skill-mix and development of network workforce strategy
  - **Support PCN implementation** of agreed service changes & pathways, working closely with practices, the wider PCN and the commissioner to develop, support and deliver local improvement programmes aligned to national and local priorities
  - **Developing relationships and working closely with other PCN Clinical Directors**, clinical leaders of other health & social care providers, CCG & LMCs
  - **Facilitating practices within PCN** to take part in research studies
  - **Representing PCN at CCG and ICS-level clinical & strategic meetings**

Delivery of Network Contract

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- **"Network Dashboard"**
  - Available by April 2020
  - Will set out for each PCN progress against following metrics:
    - Population health and prevention
    - Urgent and planned care
    - Prescribing
    - Hospital discharge
    - Seven new specifications (from previous slide)
  - Additional Roles Reimbursement Fund subject to delivery against the seven specifications and additional funding available through Network Investment and Impact Fund…

- **"Network Investment and Impact Fund"**
  - Starts 2020; fund of £75m rising to £300m by 2023/24
  - Fund linked to performance against metrics in "Network Dashboard"
  - Networks to agree with ICS how funding is reinvested – intended for additional workforce and service expansion
  - NOTE: Savings against prescribing budget (post-savings plan) funded locally by CCG and uncapped

Workforce

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- NHS England making recurrent funding available (through "Additional Roles Reimbursement" scheme) for up to estimated 20,000+ additional staff in five groups by 2024 (linked to training numbers qualifying each year):
  - **Social prescribing link workers** (up to B5) (reimbursement from 2019/20)
  - **Clinical pharmacists** (B7/8a) (reimbursement from 2019/20)
  - **First contact physiotherapist** (B7-8a) (reimbursement from 2020/21)
  - **Physician associates** (B7) (reimbursement from 2020/21)
  - **First contact community paramedics** (B6) (reimbursement from 2021/22).

- Scheme **covers 70% of actual ongoing salary costs of additional clinical pharmacists**, physician associates, first contact physiotherapist and first contact community paramedics. **100% reimbursement of the cost for social prescribing link workers**.

- **For 19/20, PCNs of at least 30,000 population able to claim for one WTE clinical pharmacist and one WTE social prescribing link worker** (CCG discretion allows two CPs and no link worker and vice versa). Above 100,000 PCN size, this allowance doubles.

- **Future years reimbursement for roles will be dependent on delivery of the seven new service specifications** (see earlier slide).

- **NHSE Clinical Pharmacist scheme to be subsumed** into this scheme (details awaited).

- **PCNs to determine employment and delivery model**.

Workforce

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- **GPFV schemes extended until 2023/24:**
  - International Recruitment
  - Retention and retainer schemes
  - Practice resilience (now “often as part of a network”)
  - Specialist MH support for GPs
  - Time for Care programme (now “often in networks”)
  - Nursing initiatives extended (e.g. placements, apprenticeships etc)

- **New fellowship scheme** for newly qualified nurses and GPs

- **Significant proportion of community mental health staff** to be aligned with PCNs

- **Pension:** Annual allowance cap restriction could be solved by a new “partial pension”; Gov’t investigating. Plus no additional cost for general practice to bear as a result of employer contribution rate increase consultation.

PCNs: Digital

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- A digital NHS 'front door' through the **NHS App to all practices in 2019**
- **All patients will have right to online and video consultation by April 2021**; all practices to have access to national funding; select supplier from national framework
- **All patients will have online access to their full record,** including the **ability to add their own information, by April 2020; new registrants by April 2019**
- All practices to have **at least 25% of appts available for online booking by July 19**
- **All practices to have up-to-date online presence with key information standardised as metadata for other platforms by April 2020**
- **All patients have access to online correspondence by April 2020**
- New '**digital first' practices will be reviewed for safety and benefit** to whole NHS. This means reviewing current arrangements including out-of-area arrangements.
- **ICSs to make predictive analytical tools available to PCNs**
- All patients able to **order repeat prescriptions online by April 2019**

Further Changes

- **Direct booking from 111** – one appointment per whole 3,000 registered patients
- **Contraception** now an essential service
- **Duty of Co-operation** – to share data between providers to support care provision
- **Marketing campaigns** – GP practices to support 6 NHSE annual campaign
- **All practices to register an email address and mobile phone** (at least one if not several phones) for MHRA CAS alerts by October 201
- **QOF changes:** 175 points retired, new 175 points relating to:
  - **74 for two QI modules** (CCGs expected to not duplicate payment, so must work with LMC to reinvest in other areas if so):
    - prescribing safety
    - EOL
  - **101 for 15 more clinically appropriate indicators covering 5 areas**:
    - Diabetes (43 points)
    - BP control (41 points)
    - Cervical screening (11 points)
    - Pulmonary rehab (2 points)
    - Weight management for MH patients (4 points)
- **QOF Exception reporting replaced** by "personalised care adjustment" system

Further Changes

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- **Extended Hours** must be commissioned for 100% of patients (in addition to IA) and moved to Network DES from July 2019. To be merged with IA through 2020.
- **Subject access requests costs** - £20m additional funding added to global sum for next three years to cover these costs. By which time, Lloyd-George records fully digitised and patients have full access to digital records.
- **GDPR**: CCGs to offer DPO function to practices, either directly or via CSU.
- **GP activity and waiting times data published monthly from 2021**; to expose variation between practices and networks
- **New measure of patient-reported experience of access**
- **National test-bed established** for PCNs to test new QOF indicators, QI modules etc.
- **Vacs and Imms** – IoS fees uplifted to £10.06 for: childhood seasonal influenza; pertussis; seasonal influenza and pneumococcal polysaccharid
- Further changes relate **to MMR catch-up, HPV, last year of medical records movement payment, use of NHS logo, shared parental leave for GPs**.

What great PCNs look like and how they will develop

Gloucestershire

	Foundations for transformation	*Step 1*	*Step 2*	*Step 3*
Right scale	**Plan:** There is a plan in place articulating a clear end state vision and steps to getting there, including actions required at team, network and system level	**Practices** identify partners for network-level working and develop shared plan for realisation.	**Practices** have defined future business model and have early components in place. Functioning **interoperability between practices,** including read/write access to records. Data sharing agreements in place.	**Network business model** fully operational. **Interoperable systems** Workforce shared across network. Rationalisation of estates.
Integrated working	**Engagement:** GPs, local primary care leaders and other stakeholders believe in the vision and the plan to get there.	**Integrated teams**, which may not yet include social care, are working in parts of the system.	**Integrated teams** in place throughout system and formalised to include social care, the voluntary sector and easy access to secondary care expertise in at least some sites.	**Fully functioning integrated teams** in place across whole system including general practice, access to secondary expertise, nursing, community services, social care and voluntary sector. Care plans and coordination in place for all high risk patients.
Targeting care	**Time:** Primary care, in particular general practice, has the headroom to make change	**Analysis on variation** between practices is readily available and acted upon. **Basic population segmentation** is in place, with understanding of needs of key groups and their resource use. Standardised end state **models of care** defined for all population groups, with clear gap analysis to achieve them. **Prototypes** in place for highest risk groups.	The system can **track data in real time,** including visibility of patient movement across the system and between segments, and information on variability. **New models of care** in place for most population segments, including both proactive and reactive models, with standardised protocols in use across the system.	**Systematic population segmentation including risk stratification**, with in depth under-standing of needs of each population segment. Routine peer review of metrics in and between networks. **New models of care in place to meet needs of all population segments**. Internal referral processes in place.
Managing resources	**Transformation resource:** There are people available with the right skills to make change happen.	Steps taken to ensure **operational efficiency** of primary care delivery.	**Networks have sight of resource use** for their patients, and can pilot new incentive schemes.	Primary care networks take **collective responsibility for available funding**. Data being used at individual clinical level to make best use of resources.
Empowered Primary Care		**Primary care** has a seat at the table for all system-level decision making.		**Primary care network** full decision making member of ICS leadership.

Impact for Gloucestershire

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- Huge programme of work across CCG/ICS required for PCNs – plus ILPs
- Project planning commenced
- Actions from now through to 2021
- Significant impact on practices too
- Some quite short timescales for all involved
- PCN Working Group being established
- Will need to involve community and acute partners through maturity