**HWOSC 11 June 2014 Agenda Item 6**
**GP Challenge Fund**

**Date: 04/06/14**

## 1. Executive Summary

A Primary Care Collaboration in Brighton and Hove, keen to provide a more patient-focused service, giving more information and control back to patients and increasing the number of ways and places patients can access primary care services has been successful in accessing £1,871,149 from The Prime Minister's Challenge Fund for Primary Care to deliver the Extended Primary Integrated Care (EPiC) project.

The Project will deliver long lasting patient-centred transformational change and create capacity for General Practice to provide longer appointments for patients with more complex health needs.

EPiC will deliver extended access to primary care by:

- Changing the skill mix to meet patients' needs
- Increasing points at which patients can access primary care
- Creating a shared patient record
- Reconnecting practices to their community

Beyond Primary Care, other savings are expected to be demonstrated by EPiC through reduced spend on A&E and unscheduled care admissions. Funding for Out of Hours (OOH) services is expected to be released to support extended hours primary care beyond the end of the pilot.

## 2. Context

In October 2013, the Prime Minister announced the Challenge Fund to improve access to general practice and test innovative ways of delivering GP services. NHS England was asked to lead on selecting and managing the pilot schemes.

In December 2013, NHS England invited GP practices to submit their 'expressions of interest' (EOIs) to be one of the pilots, before selecting the final list of schemes.

Brighton and Hove practices, pharmacies and third sector organisations collaborated to put forward an EOI facilitated by Brighton and Hove Integrated Care Services (BICS), the primary care provider collaborative vehicle for General Practice in the city.

The EOI was supported by the NHS Alliance and Brighton and Hove Clinical Commissioning Group (CCG).

On the 14th April, 2014 the successful applicants, including EPiC, were announced.

## 3. The EPiC Pilot Project

EPiC delivers extended access by rethinking how General Practice delivers all of its functions by

- changing the skill mix to meet patients' needs
- increasing access points
- creating shared patient record
- reconnecting General Practice to local community assets.

This pilot pump-primes this transformation providing safe "same day access" and freeing GPs to focus on more patients with complex needs.

**Changing Skill Mix**
Practices will pool their workforce creating Primary Care Modules (PCM), of

- Nurse Practitioners
- Pharmacists
- Voluntary Sector Care Navigators (AGE UK and Neighbourhood Care)

The PCMs will deliver "same day access" giving patients a responsive, flexible service 8am until 8pm during the week and for 6 hours on each of Saturday and Sunday. Initial assessment will be through GP-led triage, delegating administrative work to practice staff and increasing the number of patients supported by Pharmacists, Nursing Practitioners, and our Third Sector Partners. EPiC integrates Pharmacies within PCMs to support groups of Practices and will better harness the Pharmacy skill mix, enabling access to a named pharmacist for those who would benefit, and being able to provide services including the treatment of minor ailments and medicine reviews.

**Increasing access points**
People will have a choice of face to face consultations at home, in their pharmacy, or in the GP practice. PCMs will support the delivery of an integrated "same day" service by introducing the option of a single PCM phone number, email, web, and opening hours from 8 until 8 during the week and for 6 hours on Saturday and Sunday. By utilising GP-led triage and performance analytics, we will improve patient response times and focus on continuity of care. We will connect consenting people to the patient record every time they touch our service.

**Creating Shared Patient Record**
Each PCM will be connected to the GP clinical notes system and work to agreed pathways of care, providing a convenient, effective, and safe response for every patient episode. Care Navigators will extend the reach of Primary Care outside of the surgery, co-producing plans with patients and support them to use a patient held record, Patient Knows Best, while providing advocacy and support in maintaining healthier lifestyles and reducing social isolation.

**Reconnecting Practices to their community**
Age UK with Neighbourhood Care will provide Care Navigators (CN) service to each PCM that will be reactive to same day demand. Through analysis of whole system data, they will be pro-active to provide longer-term outreach support to higher-needs patients. All staff across a PCM will be supported with training to improve workforce integration and provide a common level of knowledge of local community support options.

**4. Objectives and Outcomes**
Our project outputs are designed by patients themselves. We have used patient feedback to create a set of outcomes against which EPiC can be measured ensuring that 'what patients want' is delivered. These are measures in their own right and will be included as metrics for the change we intend to create

The service changes and expected benefits of the project are outline in the table below;

| High-level Outcomes/ Outputs | How will the service change for patients? Project Outputs | Expected benefits? |
|---|---|---|
| **EFFICIENT**<br><br>**1.Our money is** | • Reduction A&E and non-elective care admissions through implementation of Age UK Care Navigators and | • Realignment of existing resources so that they are |

| High-level Outcomes/ Outputs | How will the service change for patients? Project Outputs | Expected benefits? |
|---|---|---|
| **used wisely and we can see how it benefits the community** | Neighbourhood Care staff.<br>• Changing the skill mix of first contact with patients and improving access. | used more effectively, freeing resources in the local health economy. |
| **EQUITABLE**<br><br>**2. The services are accessible to everyone in our community** | • Multiple modes of contact, from home (using innovative technology solutions), pharmacies, GP surgeries and Voluntary and Community Sector partners (VCS).<br>• Higher need patients supported in accessing services by community partners.<br>• Vulnerable people will be pro-actively identified and assessed<br>• GP time for case managing patients with complex needs improved. | • Tackling health inequalities taking "same day access" beyond traditional care settings<br>• Using data to target support to higher-needs patients and contribute to their care management. |
| **SAFE**<br><br>**3. The services I use keep me safe and do me no harm"** | • Increased scope for Pharmacists linked to GP Practices, to manage common illness and carry out medicine reviews with more patients.<br>• Patients will access online standardised care management and pathway information.<br>• Every team member can access the patients record with patient consent<br>• Online Patient controlled Personal Health Record; patients can share their record with a wide range of pharmacists, nursing staff, extended-scope receptionists, and VCS partners. | • Extended role of pharmacists improves time spent with more complex patients.<br>• Improved self-care and self-management.<br>• Interactions between professionals is safer |
| **EFFECTIVE**<br><br>**4. The services I use help me and make a difference** | • Patients will be able to interact with PCM team to determine and manage appropriate care.<br>• Patients will have increased knowledge of available care.<br>• Integrated Care Navigator (CN) support. | • Improved utilisation leads to improved outcomes and lower cost.<br>• CN extend reach of Primary Care |
| **PERSON-CENTRED**<br><br>**5. My care is** | • All patients will have "same day access" to a Primary Care Practitioner 8-8 during the week and for 6 hours at weekends | • Improving patient satisfaction<br>• Improved ownership and responsibility improves |

| High-level Outcomes/ Outputs | How will the service change for patients? Project Outputs | Expected benefits? |
|---|---|---|
| **tailored to my needs as an individual** | • Patients will have access to a patient held record.<br>• Patients with more complex needs will spend longer with their GP.<br>• Patients lead the development of their own care will be able to self-refer to appropriate services.<br>• Seamless transition to Frailty, Better Care, long-term condition pathway and Wellbeing Services | outcomes and lowers cost.<br>• Improving case management. |
| **TIMELY**<br><br>**6. I can access services when I need them** | • Increased numbers of people using email, internet and single PCM helpline and walk-in appointments<br>• Increase the availability of the service from an 8.30-6.30 (Mon-Fri) to an 8.00-8.00 (Monday-Friday) and for 6 hours on each of Saturdays and Sundays. | • Improved access, reducing service costs. |

5. **Implementation**

The Project has been scoped and planned as a 12 month pilot scheme so although funding finishes at the end of March 2015, delivery will continue into May 2015. Please see Appendix 1 for high level timescales.

Our high level deliverables are:

- Pharmacy service redesign process complete by 21/7/14 (to include new workflows/policies/regulatory frameworks/protocols/access to medical record/scope of treatment etc).
- GP triage service redesign process complete by 21/7/14 (to include workflows/system issues/assurance /protocols etc)
- Care Navigation service redesign process complete by 21/7/14 (to include recruitment and training of volunteers / policies / protocols/ assurance / training package for practices etc)
- Workflow redirection service redesign process complete by 21/7/14 (to include workflow pathways/process mapping/ assurance/protocols etc)
- extended hours and skill mix service redesign process complete by 21/7/14 (to include assurance/workflow pathways/training/policies/protocols etc)
- Service redesign packages to go through governance (EPiC project Board) on 31/7/14 and 28/8/14
- Action learning sets for fast starters start August 2014
- Go live for fast starters 1 September
- Action learning sets for early adopters start September 2014
- Go live for early adopters 26 October

The participating GP Practices, Pharmacies and Care Navigators are grouped and assigned to Primary Care Modules. The proposed modules are as outlined in the table below;

| Primary Care Module | Practice | Practice Population | Care Navigators |
|---|---|---|---|
| **Module 1** | Mile Oak Medical Centre | 7500 | |
| | Benfield Valley Healthcare Hub | | |
| **(Pop. 30,790)** | (Portslade County Clinic & Burwash) | 5140 | |
| | The Practice PLC (Hangleton Manor) | 2000 | 14 |
| | Hove Medical Centre | 8850 | |
| | Brighton Health and Wellbeing Centre | 7300 | |
| **Module 2** | | | |
| **(Pop. 38,958)** | Ardingly Court Surgery | 6138 | |
| | Stanford Medical Centre | 15500 | 18 |
| | Brighton Station (Care UK) | 5600 | |
| | Sackville Road Medical Centre | 11720 | |
| **Module 3** | Charter Medical Centre | 17500 | |
| **(Pop. 79,523)** | Sackville Road Medical Centre | 11720 | |
| | Wish Park Surgery | 6500 | |
| | Boots, The Practice PLC | 2000 | 37 |
| | St Peters Medical Centre | 11000 | |
| | Beaconsfield Medical Centre | 10003 | |
| | University of Sussex Health Service | 16300 | |
| | The Practice PLC (Morley Street) | 1000 | |
| | The Practice PLC (Whitehawk) | 3500 | |

## 6 Governance

The Project is held accountable to a Project Board whose membership will include representatives from:

Clinical Commissioning Group, GPs, Pharmacists, Healthwatch, Age UK, Brighton and Hove Integrated Care Services (BICS) alongside a Citizens Board.

The Project Board will be accountable for

- Workstream development for each of the service redesign areas; GP Triage, Pharmacy, Care Navigators, Workflow Redirection , and Extended Hours and Skill-Mix;
- Cross-cutting areas of IM&T, engagement, co-production, training and continuous learning and finance;
- Action Learning Sets comprising Practices, Pharmacy and Voluntary Sector Leads;
- Financial management

The Operational Implementation and Sustainability Group, chaired by Project Director, is responsible for delivering the Project.

EPiC will be accountable to people who use services throughout the project. Citizens will be a key part of the service redesign process and will attend service redesign workshops and the EPiC Project Board will be accountable to a Citizens' Board (representatives from PPGs and Healthwatch).

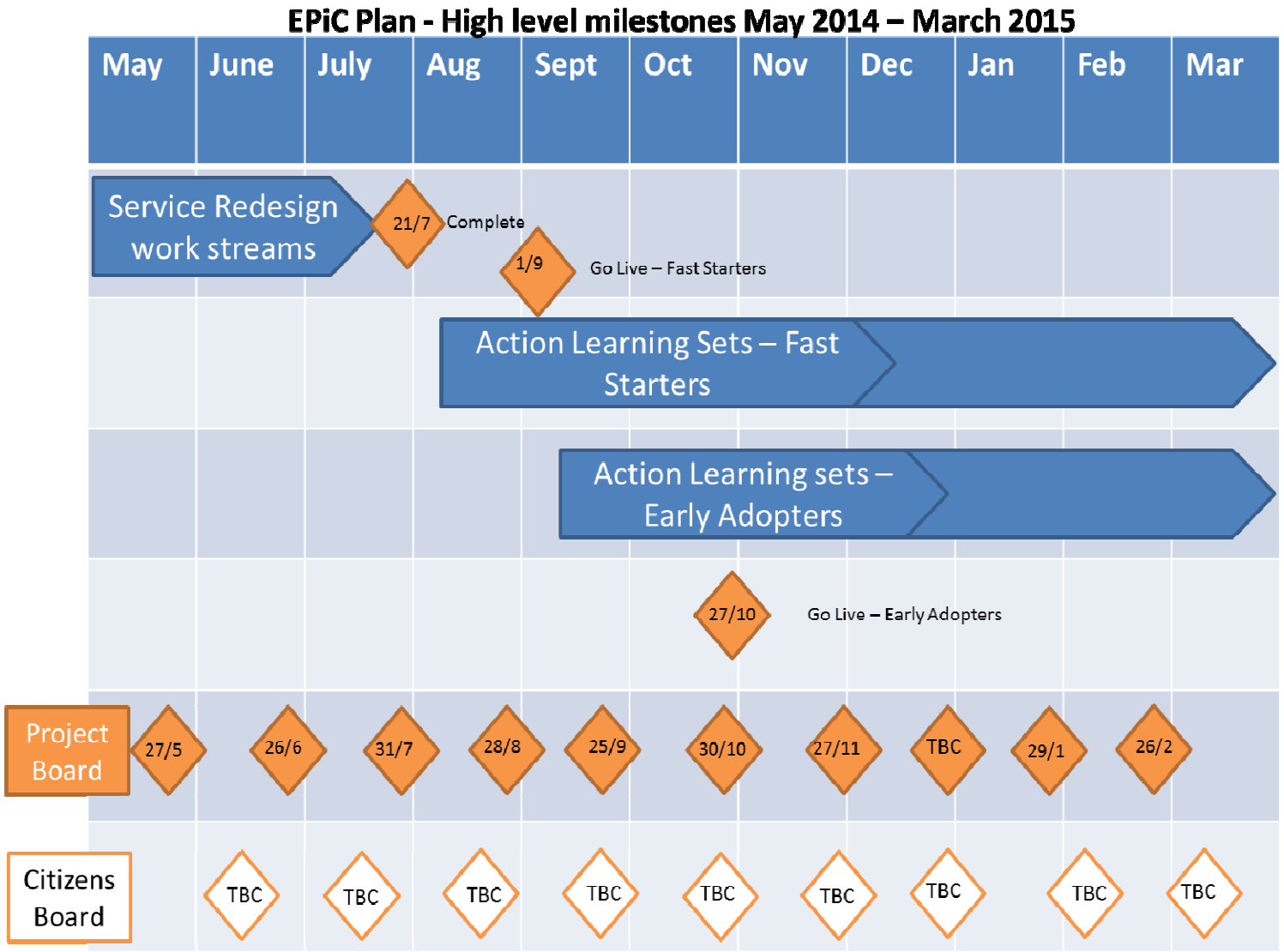
See Appendix 2 for overarching governance structures.

We will have strict governance processes for each service redesign workstream:

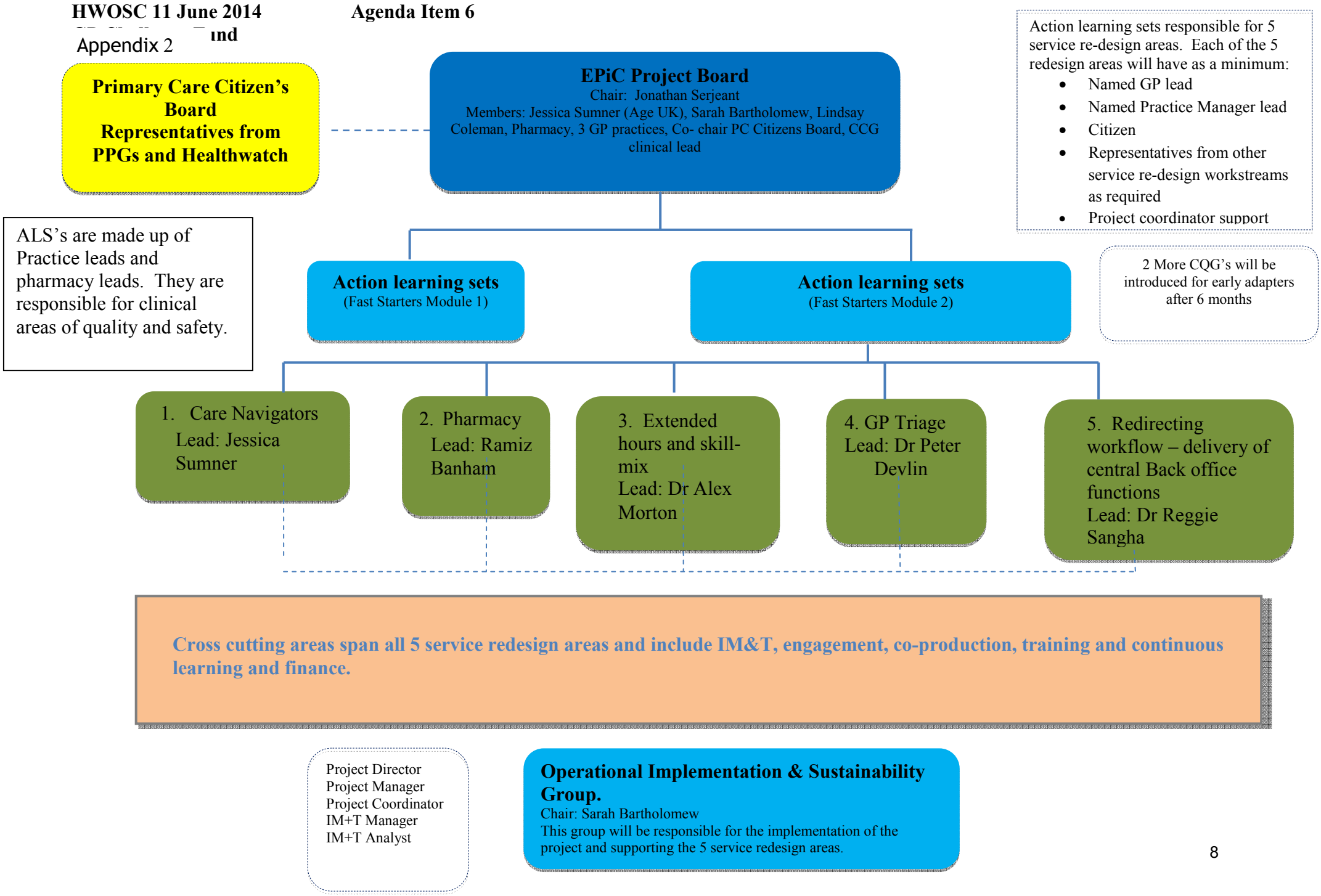
- The EPiC service will develop an overarching Information Governance protocol, which will encompass all staff working within the service, including pharmacists and volunteers. This will identify necessary training requirements and levels of access to information. Volunteers will be inducted and work to the IG policies of one of the partner organisations, including undertaking NHS on-line IG training. The service will take responsibility for IG, including responding to complaints and incidents and feedback from patients as is necessary
- We will capture consent for sharing of information at each point that sharing happens. This will be recorded in the clinical and other recording systems in use (e.g, GP clinical system, Personal health Record). This approach is supported by the clinical systems themselves (for example, the Enhanced Data Sharing Model in SystemOne)
    - Where information is shared out, patient consent will be recorded at the point of 'sharing out'
    - Consent will also be record at the point of 'sharing in' – e.g. where a pharmacist asks the patient if they have their consent to share information
- Pharmacists may have access to the full patient medical record (or part of it, depending on the work carried out by the pharmacy redesign workstream). They can only access the record if patient consent is given on each occasion, and the pharmacist will make the patient aware of this
- Volunteers will have access to the Patient Health Record, which will have a more limited record, generally relating to current issues, care plans. The patient will directly control access to this record, and who it is shared with
- General information about sharing will be made available to patients, both within the GP surgery and the pharmacy. Volunteers will provide this information to patients for reference
- We will conduct audits of clinical systems to ensure records have been accessed by appropriate staff, and that protocols have been followed
- All volunteers recruited will go through a rigorous selection process based on their suitability for the role and they are required to undergo DBS checks to ensure they are cleared to work with vulnerable older people. There is an established complaints procedure and the project co-ordinator will ensure problems raised by patients or practices are dealt with. Volunteers will be required to meet the requirements of a role description and personal specification for the role. They will be provided with training to carry out the role and in how to interact with vulnerable people. All information will be kept confidential and will only be passed on where the patient's permission has been sought except when their personal safety is under threat and consent cannot be obtained – patients will be made aware of this when they are referred to the service.

Authors:BICS.

Appendix 1


EPiC Plan - High level milestones May 2014 – March 2015
May
June
July
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar
Service Redesign work streams
21/7
Complete
1/9
Go Live – Fast Starters
Action Learning Sets – Fast Starters
Action Learning sets – Early Adopters
27/10
Go Live – Early Adopters
Project Board
27/5
26/6
31/7
28/8
25/9
30/10
27/11
TBC
29/1
26/2
Citizens Board
TBC
TBC
TBC
TBC
TBC
TBC
TBC
TBC
TBC

Appendix 2


Primary Care Citizen's Board Representatives from PPGs and Healthwatch
EPiC Project Board
Chair: Jonathan Serjeant
Members: Jessica Sumner (Age UK), Sarah Bartholomew, Lindsay Coleman, Pharmacy, 3 GP practices, Co- chair PC Citizens Board, CCG clinical lead
Action learning sets responsible for 5 service re-design areas. Each of the 5 redesign areas will have as a minimum:
Named GP lead
Named Practice Manager lead
Citizen
Representatives from other service re-design workstreams as required
Project coordinator support
ALS's are made up of Practice leads and pharmacy leads. They are responsible for clinical areas of quality and safety.
Action learning sets
(Fast Starters Module 1)
Action learning sets
(Fast Starters Module 2)
2 More CQG's will be introduced for early adapters after 6 months
1. Care Navigators Lead: Jessica Sumner
2. Pharmacy Lead: Ramiz Banham
3. Extended hours and skill-mix Lead: Dr Alex Morton
4. GP Triage Lead: Dr Peter Devlin
5. Redirecting workflow – delivery of central Back office functions Lead: Dr Reggie Sangha
Cross cutting areas span all 5 service redesign areas and include IM&T, engagement, co-production, training and continuous learning and finance.
Project Director
Project Manager
Project Coordinator
IM+T Manager
IM+T Analyst
Operational Implementation & Sustainability Group.
Chair: Sarah Bartholomew
This group will be responsible for the implementation of the project and supporting the 5 service redesign areas.

**HWOSC 11 June 2014** **Agenda Item 6**
**GP Challenge Fund**