HEALTH SCRUTINY SUB-COMMITTEE

Minutes of the meeting held at 4.00 pm on 6 March 2019

Present:

Councillor Mary Cooke (Chairman)
Councillor Robert Mcilveen (Vice-Chairman)
Councillors Gareth Allatt, Ian Dunn, Judi Ellis, David Jefferys, Keith Onslow and Angela Page

Roger Chant and Mina Kakaiya

Also Present:

Councillor Diane Smith, Portfolio Holder for Adult Care and Health

31 APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTE MEMBERS

Apologies for absence were received from Councillor Evans, Justine Jones and Lynn Sellwood. Apologies for absence were also received from Councillor Cuthbert and Tim Spilsbury, and Councillor Onslow and Mina Kakaiya attended as their respective substitutes.

Apologies for lateness were received from Councillor David Jefferys.

32 DECLARATIONS OF INTEREST

There were no declarations of interest.

33 QUESTIONS FROM COUNCILLORS AND MEMBERS OF THE PUBLIC ATTENDING THE MEETING

One oral question and two written questions were received from Councillors and members of the public and these are attached at Appendix A.

There was no supplementary oral question.

34 MINUTES OF THE MEETING OF HEALTH SCRUTINY SUB-COMMITTEE HELD ON 17TH OCTOBER 2018 AND MATTERS ARISING

RESOLVED that the minutes of the meeting held on 17th October 2018 be agreed.

35 PRESENTATION ON PRIMARY CARE WORK (CCG)

Dr Agnes Marossy, Consultant in Public Health, Bromley Clinical Commissioning Group, attended to present the findings of the Bromley Primary Care Needs Assessment. Dr Marossy had been seconded to the CCG to carry out a Primary Care Needs Assessment.

The aim of the Primary Care Needs Assessment was to describe both the need for primary care, and the needs of those delivering primary care, in order to inform the development of a sustainable model of primary care in Bromley. The Primary Care Needs Assessment had been informed by a Steering Group and a Clinical Reference Group. The Steering Group had consisted of GP Clinical Directors, the Bromley GP Alliance, the CCG Primary Care Team, the CCG Nurse Lead and the Director of Organisational Development, and the Clinical Reference Group had included GP's (Partners, Salaried, Locums and Trainees), Practice Nurses and Practice Managers.

The Consultant in Public Health had undertaken a number of tasks, including workforce analysis and workforce surveys which identified trends, but the bulk of her time had been spent carrying out public engagement. This had included attending the Practice Nurse Forum, which was attended by around fifty Practice Nurses, and visiting and spending time at forty two of the forty five Practices in the Borough, to get an understanding of how they operated. The work also included engagement with patients and public, including vulnerable groups, and some of this was commissioned out to Healthwatch Bromley.

The results of the public engagement had found that patients were now more accustomed to not seeing the same person each time they visited their Practice. Patients did not feel this was an issue, acknowledging the positive impact of being 'known' at the Practice by clinical and non-clinical members of the team, and that a person's job title was not important as long as they sorted out the patient's problem. However, certain vulnerable groups, such as those with mental health issues and those with learning difficulties, benefitted from having continuity with one GP. A fundamental issue raised was the length of consultations, as neither doctors nor patients were happy about the ten-minute consultation time. Ten minutes was perceived to be too short. It was highlighted that an older patient may take longer to reach the consultation room, and then may need time to sit and compose themselves before speaking to the GP, would find most of the appointment time had already been used up. Patients also particularly objected to the 'one appointment, one problem' policy where it was being implemented.

There had been a number of questions asked when visiting Practices, and one key area of focus had been resilience and how they would continue to manage to provide care if a Partner went on long-term sick leave or retired; if a neighbouring Practice closed; or a new housing development was built close by. Other issues regarding how the Practices recruited and retained their workforce had been highlighted. There had been a number of key outputs, but the main ones to be addressed had been 'workforce' and 'workload'. With regards to workforce, it was stated that in order for Bromley to reach the same ratio as London, an additional 2.7 whole time equivalent GP's

were needed in Bromley, and to reach the same ratio as England, an additional 13.4 whole time equivalent GP's were needed. Bromley had a higher nurse to patient ratio than London, but an additional 18 whole time equivalent nurses, of all types, were needed to reach the same ratio as England. In order to keep up with population growth, an additional 1.5 GP's per year were needed in Bromley. The annual workforce survey had shown that Bromley had lost 1.85 whole time equivalent GP's the previous year, which highlighted that the gap was getting wider.

Views had been gathered on recruiting to Partnerships, and the responses received had included "as a Partner it was not possible to control your workload", and that "there was a feeling of uncertainty about the future of General Practice as a whole which discouraged commitment to Partnerships". It was also considered that it was "not clear what incentive there was in 'slaving to death' and not being adequately remunerated". Recruiting salaried GP's took on average six months, from the post being advertised to being filled, and there were too few applicants. This was due to a combination of Practices not knowing how to access the trainee cohort, there being high indemnity fees and competition from higher paid posts at access hubs and Urgent Care Centres. There were also difficulties in retaining salaried GP's once they were recruited, due to excessive workloads which caused them to resign. Views had also been gathered on the recruitment of Locums, a number of which the Consultant had found worrying. The feedback received included statements that Locums did not do any admin; did not deal with difficult issues; did not follow up results; were unwilling to do home visits; and referred excessively because they were risk adverse. This indicated that the work life balance and caring responsibilities or life choices had created a shift in thinking about how doctors wanted to work. The evidence suggested that the negotiation of contracts between Locums and Practices was not always done well; and that there was imperfect understanding between the three distinct groups of GP's (Partners, Salaried and Locums). It was also evident that young doctors were making very different career choices.

With regards to the recruitment of Nurses, the annual workforce survey had shown that in the previous year, Bromley had lost 1.13 whole time equivalent Adult Nurse Practitioners, whilst gaining 2.95 whole time equivalent Practice nurses, which related to an overall increase of 1.83 whole time equivalent Nurses. Alongside this, there was a loss of 1.37 whole time equivalent Health Care Assistants. When the Consultant in Public Health had met with around fifty Nurses and Nurse Practitioners, they had highlighted that they felt they were not valued enough, and that they were tired, so a number of longstanding experienced nurses would choose to retire on a full pension at the age of 55. Newly recruited Nurses would not gain experience instantly - it took ten to fifteen years to 'grow' a good Nurse, and it was highlighted that there were a lack of training courses available, which needed to be addressed. Key issues that this underlined for the workforce were: that there was an insufficient number of GPs and Nurses; a lack of skill mix; competition between local services for GPs and Nurses; and an undesirable workload and work life balance.

With regards to workload, it was noted that under the GP Contract, GPs must provide a service to manage a registered list of patients. This included consultation, treatment, onward referral for investigation and extended primary care services such as prevention, screening, immunisations and some diagnostic services. GPs also helped to ensure effective coordination of care for their patients with other NHS services, social care and health services outside the NHS. Analysis had been undertaken to quantify the workload of GP's in Bromley. On average, they had 103 face to face appointments with patients, issued 513 prescriptions, provided 97 sets of results to patients, dealt with 107 items of incoming correspondence and made 27 referrals, per week. There had also been an increase of 55.7% in the number of home visits made in Bromley (from 11,596 in 2015 to 18,052 in 2017), which was in contrast to the national trend which had seen a decrease. Nearly 28% of these visits were to patients living in care homes, and it was noted that for some Practices, this represented 80% of their total home visits. An analysis of administrative workload filtering, looking at how non clinical staff could help filter the administrative workload of the GPs, had found that 28 Practices diverted a proportion of the GP's administrative workload, but it was largely ineffective. The findings of the assessment were that they were at the point where the issues of insufficient capacity and overwhelming workload were creating an unsustainable future for Primary Care in Bromley, and therefore something transformational was needed.

The traditional model of a Practice had five elements - GP Partner, Salaried and Locum GPs, Practice Manager, Practice Nurse and Receptionist / other admin roles, to which new roles of Physician Associate, Clinical Pharmacist, Medical Assistant and Health Care Assistant had been added. A 'first draft' of a new model had been provided, however it was noted that this may cover more than one Practice, and that the new roles would need to be wrapped around with training and support. Following further refining, a new conceptual model for Bromley had been created, based on five to six Practices working with a population of between 30,000 to 50,000 patients. The principles of the model were that it included sustainable ways of working; utilised a wider skill mix, including new roles; ensured all staff worked to the top of their skill set; refocused the role of the GP as an expert medical generalist; improved the quality of care; maintained continuity of care; and met the needs of the population.

On 31st January 2019, the NHS Long Term Plan and GP Contract Reforms had been published, which agreed with the findings of the Bromley Primary Care Needs Assessment, and also included Network Directed Enhanced Service (DES) and the expansion of digital access for patients. NHS England and committed to the implementation of a number of additional new roles over the next two years, with a 70% reimbursement for five years, and 100% for social prescribing link workers. Digital improvements included access to online and video consultation for all patients by April 2021; online access to full medical records by April 2020; electronic ordering of repeat prescriptions and electronic repeat dispensing from April 2019; 25% of appointments to be bookable online by July 2019; and up to date and informative online presence

for Practices by April 2020, although it was hoped that this would happen sooner.

In response to a question from a Co-opted Member, the Consultant in Public Health said that as Practices adopted the new way of working they would be encouraged to strategically engage with Patient Participation Groups (PPG), to involve PPGs in the plans for new ways of working, e.g. active signposting, and consideration was being given to the PPGs also joining in networks.

The Portfolio Holder for Adult Care and Health highlighted the Borough's older people demographic, and enquired if Occupational Therapists and Physiotherapists would be included in Practices to reduce the workload of GPs as part of a preventative agenda. The Consultant in Public Health responded that patients could self-refer to the Crystal Palace Physio Group, and that this would form part of the signposting role of Practice Receptionists. It was hoped that this would deliver faster treatment of common conditions. It was noted that preventative services were likely to be around cardiac rehabilitation and other chronic conditions, not just bones and joints.

In response to a question, the Consultant in Public Health said that the enhanced Care Home Service was intended to be a virtual Practice for around 1,800 patients. It was considered that the service would be more proactive if dedicated to them. It was noted that the home visits in general were largely reactive, and that pro-active care for the housebound was a matter of concern.

The Chairman queried if the proposal of 25% of appointments being bookable online by July 2019 was feasible. The Consultant in Public Health responded that most patients in the Borough should already be able to book appointments online, and that Practices had targets for signing patients up to use this service. There were two main apps that patients could use, Patient Access and My GP, and an NHS app would also be launching shortly. Online consultations were quicker than face to face consultations, and took place via eConsult, which allowed patients to describe their symptoms and navigate through a questionnaire. A report of the results was then created and provided to the patient's GP, and a response would be received in 24 to 48 hours. The response could be for the Practice to call the patient advising them to book a face to face or a telephone consultation, or to provide them with a prescription of further information. Video consultations were aimed at improving access for certain groups or patients, such as those with a disability or mental health issue, and were not intended to save time.

A Member considered what could be done in terms of attracting entry level practitioners to the Borough and suggested that a recruitment campaign could be helpful to sell the benefits of locating to Bromley. The Consultant in Public Health agreed, and said that this was something that would be discussed at the steering group and could be fed back to Members.

The Chairman led Members in thanking Dr Agnes Marossy for her excellent presentation which was attached to the minutes at Appendix B.

RESOLVED that the presentation be noted.

36 VERBAL UPDATE ON DIABETES: FLASH GLUCOSE MONITORING (CCG)

Dr Angela Bhan, Managing Director, Bromley Clinical Commissioning Group provided a verbal update on Diabetes Flash Glucose Monitoring. These were devices for Diabetics to self-monitor their glucose levels, without the need for a pin-prick test. The devices were placed under the skin, and monitored the levels of glucose in the fluid found between cells in the body. This was intended to develop a better understanding of each patient, and was a new way of continuously recording the glucose found in their bloodstream.

Despite there being only a very limited amount of evidence as to the outcomes of their use, these devices were taking off by popular demand. However, there was a cost to the CCG associated with their use, and for the patients in Bromley that were eligible, and most severely affected by Diabetes, this would be at least an additional £250k per year. It was recognised nationally that to provide the devices, the CCG's funding would be top-sliced and that the devices would be rolled-out gradually.

The Chairman said that a constituent had spoken with her, and questioned why they had not been able to obtain a Flash Glucose Monitoring device, and asked for further information on their availability. The Managing Director, Bromley Clinical Commissioning Group said that information regarding eligibility had not been distributed effectively. This had led to the demand for the devices growing within patient groups that were not eligible to receive them, and also a number of patients obtaining devices when they were not necessarily the most appropriate solution for the individual patient. It was acknowledged that there had not been a cohesive approach, and that there was a need for a patient education programme. It was noted that there was still a need for evidence to gauge the long-term impact of the devices, such as whether they made patients more anxious, and resulted in them constantly checking their glucose levels.

A Member expressed that they felt this was a major step forward, however there were concerns as to what would be done with the data gained from the device, and the implications as to how Diabetes was managed. Some Flash Glucose Monitoring devices could be bought 'off the shelf' and the extra demand could lead to patients modifying their own treatment, which could be counter-productive.

Another Member said that she was aware of the devices through a Child Looked After (CLA), and that the definition as to who could, and could not, receive the devices was unclear. It was felt that children were a relevant group of patients to be receiving these devices, especially those that had hospital admissions as a result of their Diabetes, and it could be considered a safeguarding issue if the devices were not provided to them. It was noted that the devices could be particularly helpful for parents dealing with their children 'midnight eating', as it would allow them to monitor the child's glucose levels

on their phone. It was requested that Members be provided with a copy of the patient criteria to receive a Flash Glucose Monitoring device, and the questions asked to consider eligibility. The Managing Director, Bromley Clinical Commissioning Group agreed to provide Members with a copy of the patient criteria, and noted that alongside a patient education programme, GP's also needed to be further educated about the devices. It was noted that patients who had received the devices would have their use reviewed every three to six months by a specialist Diabetes team.

37 Work Programme 2018/19

Report CSD19029

Members considered the forward rolling work programme for the Health Scrutiny Sub-Committee.

The Chairman invited Members of the Sub-Committee to provide details of any other items they wished to discuss at future meetings to the Clerk to the Committee.

RESOLVED that the work programme be noted.

38 ANY OTHER BUSINESS

Moorfield's Eye Hospital

Dr Angela Bhan, informed Members that Moorfield's Eye Hospital planned to move to new premises at King's Cross, for which a consultation had been launched. Members agreed that this was felt to be advantageous for the residents of Bromley as they would benefit from a new and improved building, and a much easier journey by public transport to get to King's Cross than Old Street. In response to a question, the Managing Director, Bromley Clinical Commissioning Group said that between 700 and 750 patients were referred by Bromley CCG to Moorfield's Eye Hospital each year.

Treatment Access Policy

The Managing Director, Bromley Clinical Commissioning Group advised Members that there was a revised Treatment Access Policy, which had been produced jointly by the six South East London CCG's. It was proposed that there would not be a formal consultation on these changes, but instead a period of engagement. A few local changes had been made to the policy to reflect national evidence based interventions and NICE guidance, which included:

- Stating that micro-suction is suitable for earwax removal
- Not removing bunions for cosmetic purposes
- Adhering to the national 'pause' on using vaginal mesh surgery for urogenital prolapse
- Shoulder arthroscopy replaced by decompression

- Bariatric surgery was now a CCG responsibility, which was a move from being commissioned by NHS England

Meeting with King's / PRUH

Councillor Jefferys informed members that he had attended the King's College Hospital NHS Foundation Trust Council of Governors meeting that afternoon. There had been a change in personnel, with Ian Smith's role as Interim Chair of King's College Hospital NHS Foundation Trust having ended on 1st March 2019, and Sir Hugh Taylor being appointed to the post for the next two years. Simon Stevens, Chief Executive Officer (CEO) of NHS England had also taken over responsibility for NHS Improvement, resulting in the body that oversaw finances being under one person.

Sir Hugh Taylor had taken on the position of Interim Chair of King's College Hospital NHS Foundation Trust alongside his existing role as Chair of Guy's and St Thomas' NHS Foundation Trust, but he had been clear that they were two separate hats, and it was not a takeover. He was aware that there were a number of issues at the PRUH, which he was keen to progress forward, and expressed the need for the closest cooperation with Bromley. With regards to the financial situation, it would be a difficult period with challenging budgets, as there was already an in-year deficit of £145m.

The Chairman noted that the PRUH needed to look at the service being provided to residents, as it was felt that changes were needed. Councillor Jefferys responded that staff surveys had highlighted that staff were feeling down beaten and dealing with incidents of bullying and harassment, which meant that morale was not good. A Member said that when talking to people about the PRUH, perception and reality were very far apart. Some services were considered to offer fantastic levels of treatment and care, but only the negative reports were heard. The Chairman agreed that the clinical care the PRUH provided was, on the whole, very good, but many felt that the people care needed to be improved.

RESOLVED that the issues raised be noted.

39 FUTURE MEETING DATES

4.00pm, Wednesday 3rd April 2019
4.00pm, Tuesday 2nd July 2019
4.00pm, Tuesday 8th October 2019
4.00pm, Tuesday 28th January 2020
4.00pm, Thursday 23rd April 2020

The Meeting ended at 5.50 pm

Chairman

HEALTH SCRUTINY SUB-COMMITTEE
6th March 2019

ITEM 3 – QUESTIONS FROM COUNCILLORS AND MEMBERS OF THE PUBLIC ATTENDING THE MEETING

Oral Questions to the Chairman of the Health Scrutiny Sub-Committee received from Councillor Ian Dunn

1. **Why is there no update from Kings on this agenda as there was on the agenda of the postponed meeting on 29 Jan? Can Kings please provide a representative to provide the sub-committee with an update?**

Reply:

I share the disappointment that Kings are not at the meeting. Both the Portfolio Holder and I have made our views clear to Kings at the highest level. However there are mitigating circumstances.

Firstly King's had agreed to attend Health Scrutiny Sub Committee originally scheduled to take place in January 2019. It was necessary to postpone, at relatively short notice, the January meeting to 6th March 2019 to accommodate a Special Executive and Council. In response to the reschedule Kings advised on 4th February that it would not be possible to send a representative on 6th March 2019. This was accepted as the change of date had been instigated by the Council, and therefore out of King's control.

Secondly you will be aware that there have been management changes at the highest level in Kings with a new Chairman, Chief Executive and Chief Operating Officer plus, recently, a new acting MD at the PRUH. Not all of these new people have yet started.

We have advised Kings of all the dates for the next Council year and I'm confident they will do their best to attend.

Fiona Wheeler, the new Acting Executive Managing Director of the PRUH, has met with the Adult Care Portfolio Holder and agreed that regular attendance from Kings to the Health Scrutiny Sub committee should be a priority and has committed to attending future meetings.

HEALTH SCRUTINY SUB-COMMITTEE
6th March 2019

Written Questions to the Health Scrutiny Sub-Committee received from Mrs Susan Sulis, Secretary, Community Care Protection Group

1. **Scrutiny of plans for maintaining uninterrupted provision of medical supplies from E.U. countries, including essential medication, in the event of a 'No Deal Brexit':**

   a) **Patients with life-threatening conditions rely on continuous supplies of drugs, eg Insulin and anti-coagulants, and medical supplies. What action has the Subcommittee taken to scrutinise plans by the Government and relevant bodies to ensure these supplies are maintained?**

   Reply:

   Items for inclusion on the agenda for the Health Scrutiny Subcommittee are requested and set at the discretion of the Chairman of the Adult Care and Health PDS in conjunction with advice from Council Officers. To date Senior Officers at the Council have not raised any concerns.

   The attached information however has been provided by the CCG.

   b) **What information has been made available to patients?**

   Reply:

   Please see attached response from the CCG.

2. **Minute Item C, Orpington Hospital Update (Kings) 17 October 2018 Health Scrutiny Sub-Committee:**

   a) **What action is taken to provide care in "settings appropriate to their needs" of "stranded" and "super stranded" patients (including those with no fixed abode, and with no recourse to public funds)?**

   b) **Who has a responsibility of care, and how are they funded?**

   Reply:

   Please see attached response provided by the CCG and Bromley Council.

1. **Scrutiny of plans for maintaining uninterrupted provision of medical supplies from E.U. countries, including essential medication, in the event of a 'No Deal Brexit':**

   a) **Patients with life-threatening conditions rely on continuous supplies of drugs, eg Insulin and anti-coagulants, and medical supplies. What action has the Subcommittee taken to scrutinise plans by the Government and relevant bodies to ensure these supplies are maintained?**

1(a).

The government is working with pharmaceutical companies, suppliers, and the NHS to make sure patients continue to receive the medication they need if the UK leaves the EU without a deal.

The government has analysed the supply chain, made plans to reduce the risk of disruption, and given instructions to pharmaceutical companies to ensure that they have adequate stocks to cope with any potential delays at the border

We are working together across the NHS in South East London, to make the necessary plans and taking the precautions required to prevent any adverse impact on prescribed medication and other key areas. Risk assessments have been undertaken by commissioners and providers on the seven key areas identified in the national guidance.

Bromley CCG has set up a CCG EU Exit group through our senior management team which meets bi-monthly and feeds into the South East London STP (Sustainability and Transformation Partnership) EU Exit oversight group which meets monthly in preparation for a no deal EU Exit.

Our advice and indeed the national advice, is for patients not to stockpile but to ensure you get prescriptions to your pharmacist in good time.

   b) **What information has been made available to patients?**

1(b).

NHS England is working closely with the Department for Health and Social Care, patient groups and others to provide relevant information to patients and the public. For the moment all public communication is led at national level and the CCG is promoting national messages through our providers. The CCG will provide a link to the national messages from its website.

Further information can also be found on the Government website
https://www.gov.uk/government/collections/planning-for-a-possible-no-deal-eu-exit-information-for-the-health-and-care-sector

2. **Minute Item C, Orpington Hospital Update (Kings) 17 October 2018 Health Scrutiny Sub-Committee:**

   a) **What action is taken to provide care in "settings appropriate to their needs" of "stranded" and "super stranded" patients (including those with no fixed abode, and with no recourse to public funds)?**

2(a).

King's College Hospital, PRUH site, along with local partners, have initiated weekly Long Length of Stay Patient Reviews for those patients who have become 'stranded' or 'super stranded'. A team of Senior Clinicians, Managers, Discharge Coordinators, Social Workers and Community providers, go directly to the wards to discuss each patient with a stay longer than 21 days. The team discusses the patient with relevant clinicians and helps the ward multidisciplinary teams tackle obstacles that are delaying the treatment and discharge of patients.

If a person who attends the hospital has no fixed abode and needs an element of care and support, the person will be referred to social services in the hospital. A member of the social care management team will meet with the person to obtain further information and agree a discharge plan and what further support may be needed. After this information has been obtained, contact is made with the London Borough of Bromley's Housing team, even where the individual may have no recourse to public funds or may not be eligible or in priority need for housing assistance. In such cases, London Borough of Bromley has a role in providing information and advice about homelessness prevention and alternative support options.

   b) **Who has a responsibility of care, and how are they funded?**

2(b).

The responsibility of care lies with the hospital trusts, emergency departments and urgent treatment centres to refer people with no fixed abode to the local authority. Any care and support required would be funded by the local authority. If the person has no recourse to public funds, Bromley Council has a role to provide assistance as mentioned above.

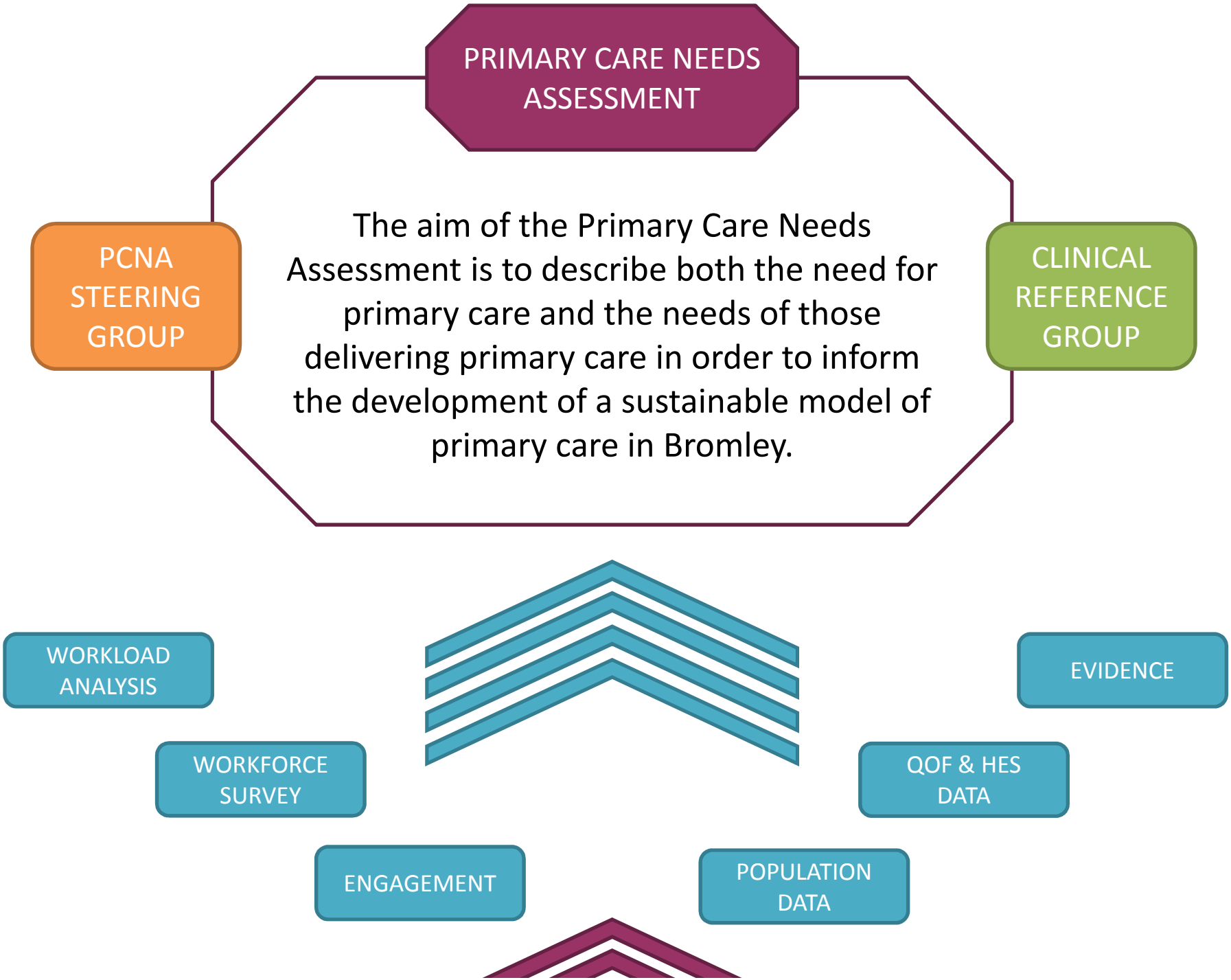
helping the people of Bromley live longer, healthier, happier lives

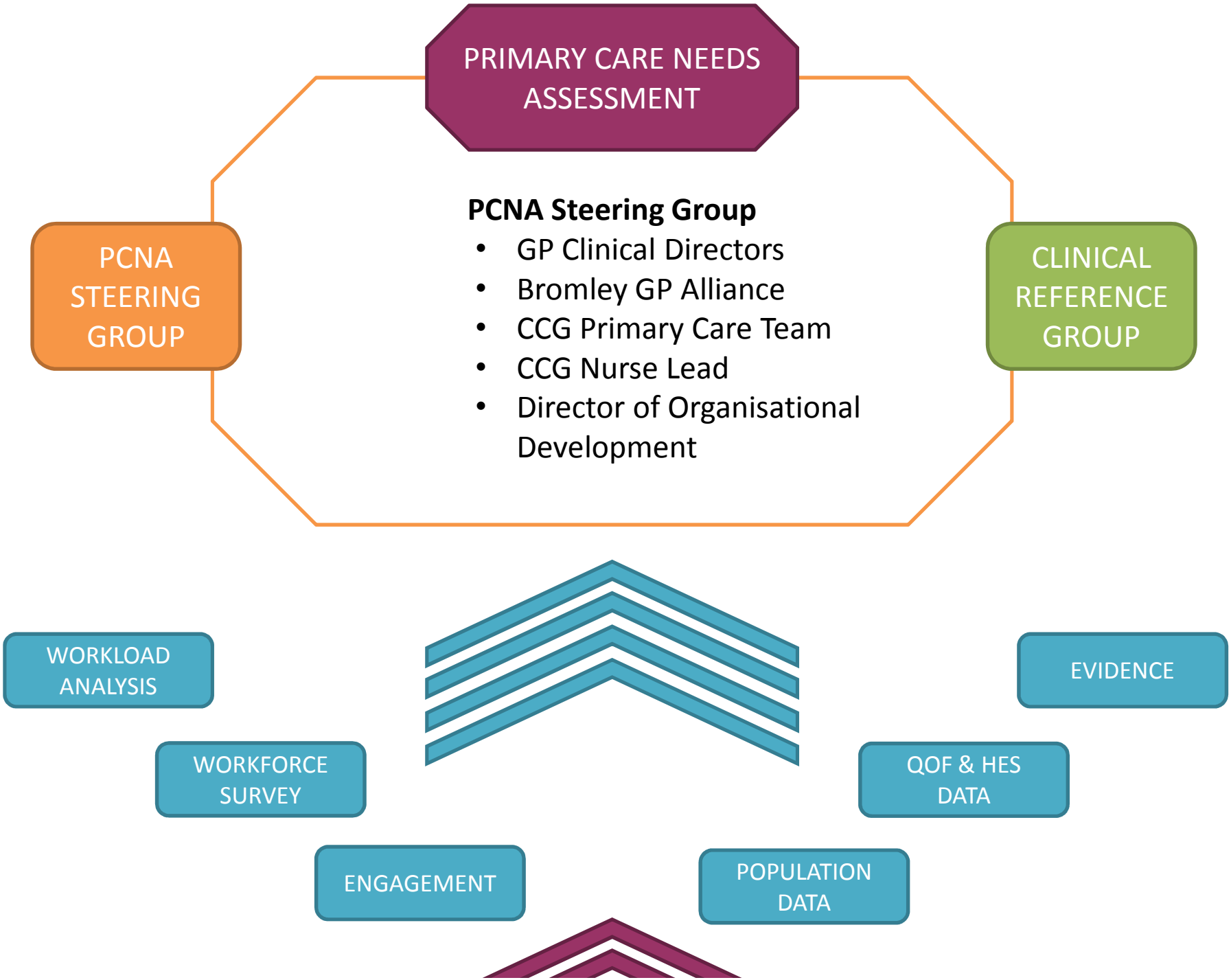
NHS
Bromley
Clinical Commissioning Group

Bromley Primary Care Needs Assessment – Findings

Dr Agnes Marossy

Consultant in Public Health


PRIMARY CARE NEEDS ASSESSMENT
The aim of the Primary Care Needs Assessment is to describe both the need for primary care and the needs of those delivering primary care in order to inform the development of a sustainable model of primary care in Bromley.
PCNA STEERING GROUP
CLINICAL REFERENCE GROUP
WORKLOAD ANALYSIS
EVIDENCE
WORKFORCE SURVEY
QOF & HES DATA
ENGAGEMENT
POPULATION DATA


PRIMARY CARE NEEDS ASSESSMENT
PCNA STEERING GROUP
CLINICAL REFERENCE GROUP
PCNA Steering Group
GP Clinical Directors
Bromley GP Alliance
CCG Primary Care Team
CCG Nurse Lead
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WORKLOAD ANALYSIS
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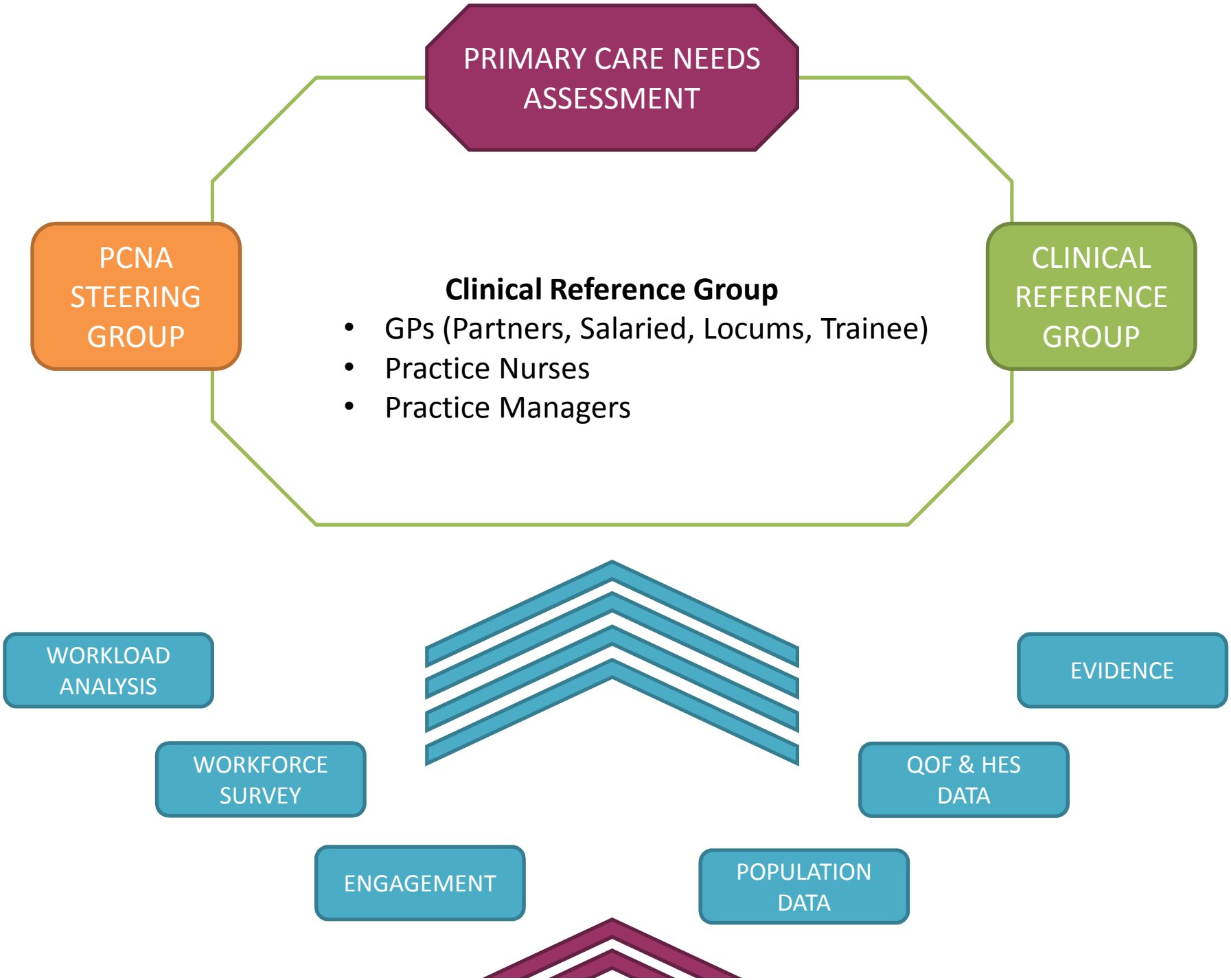
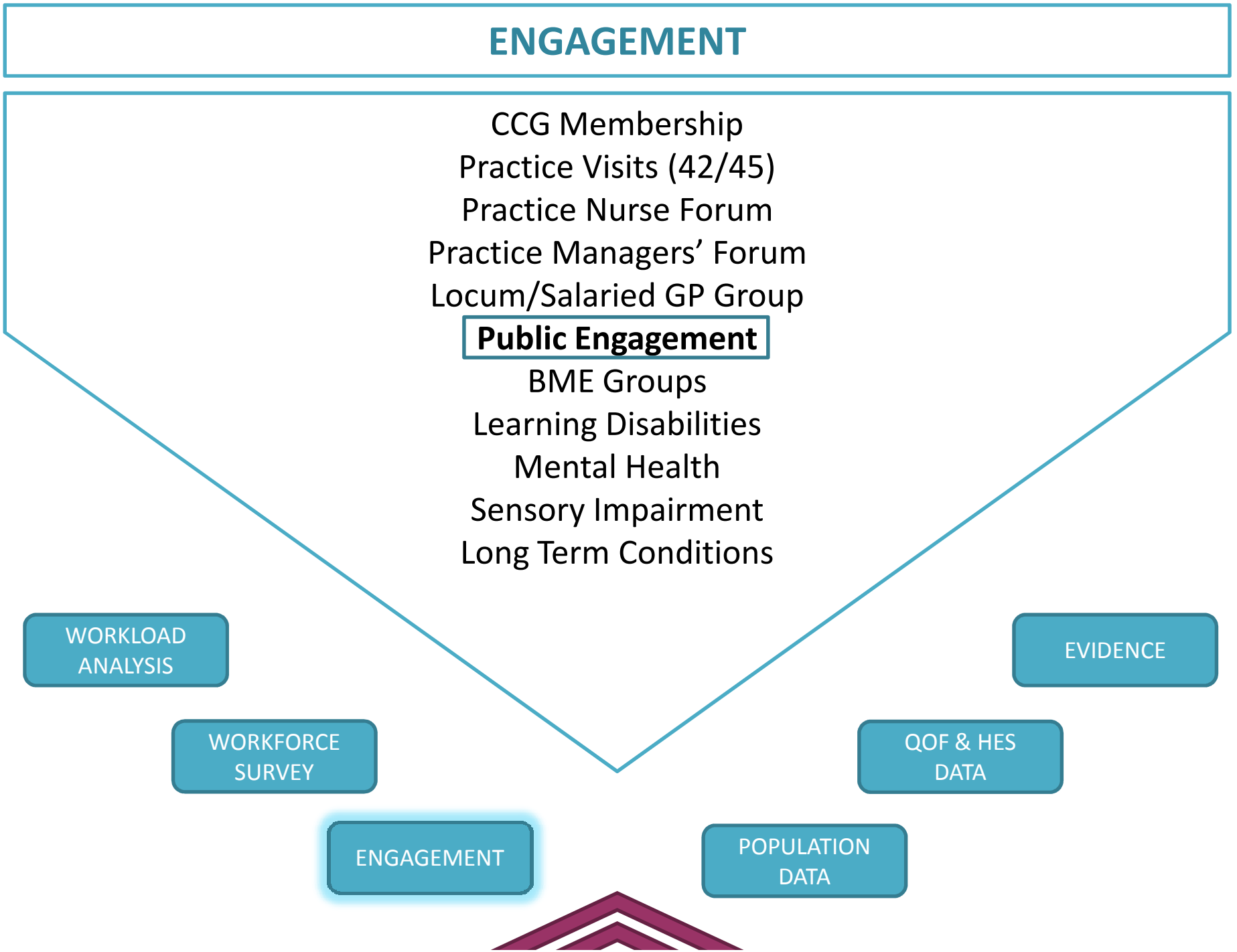
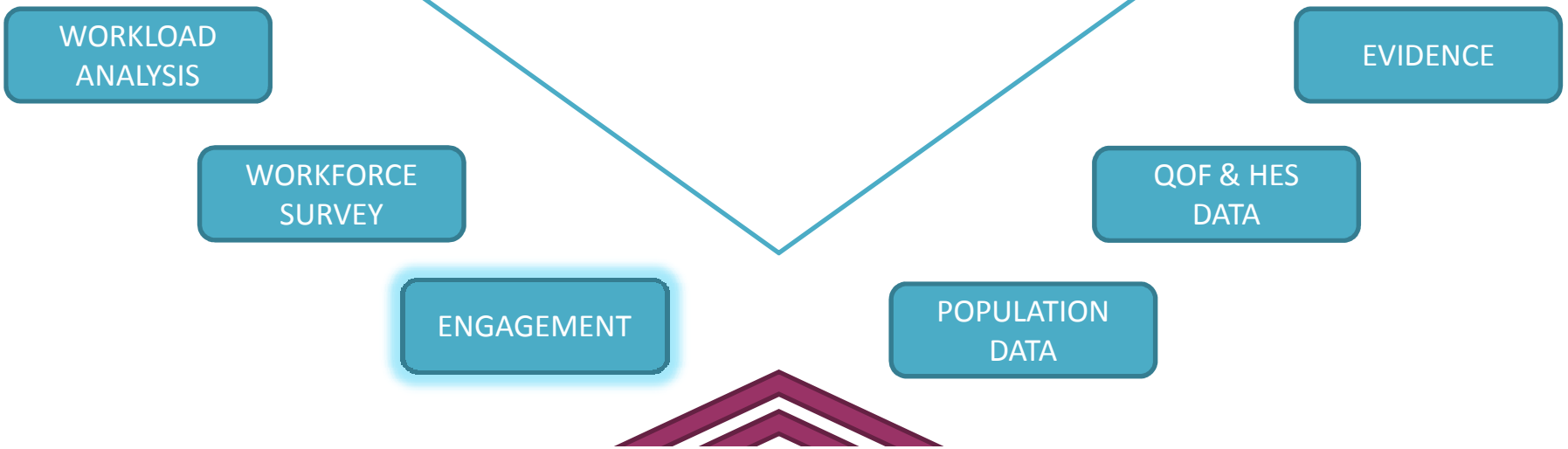
POPULATION DATA


PRIMARY CARE NEEDS ASSESSMENT
PCNA STEERING GROUP
CLINICAL REFERENCE GROUP
Clinical Reference Group
GPs (Partners, Salaried, Locums, Trainee)
Practice Nurses
Practice Managers
WORKLOAD ANALYSIS
EVIDENCE
WORKFORCE SURVEY
QOF & HES DATA
ENGAGEMENT
POPULATION DATA


ENGAGEMENT
CCG Membership
Practice Visits (42/45)
Practice Nurse Forum
Practice Managers' Forum
Locum/Salaried GP Group
Public Engagement
BME Groups
Learning Disabilities
Mental Health
Sensory Impairment
Long Term Conditions
WORKLOAD ANALYSIS
EVIDENCE
WORKFORCE SURVEY
QOF & HES DATA
ENGAGEMENT
POPULATION DATA

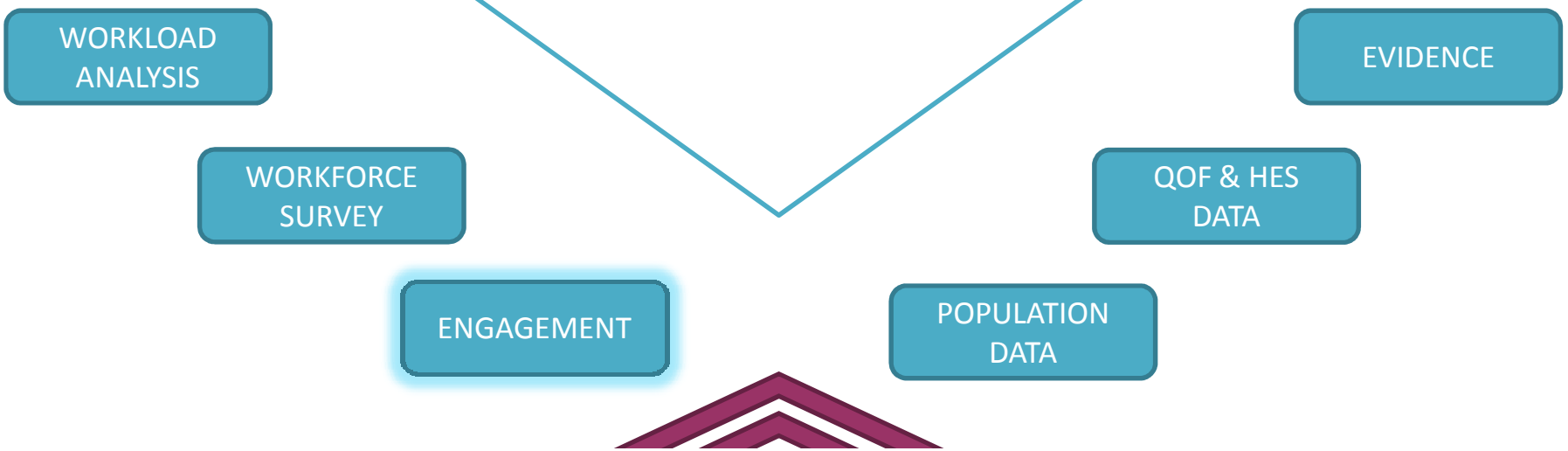
PUBLIC ENGAGEMENT

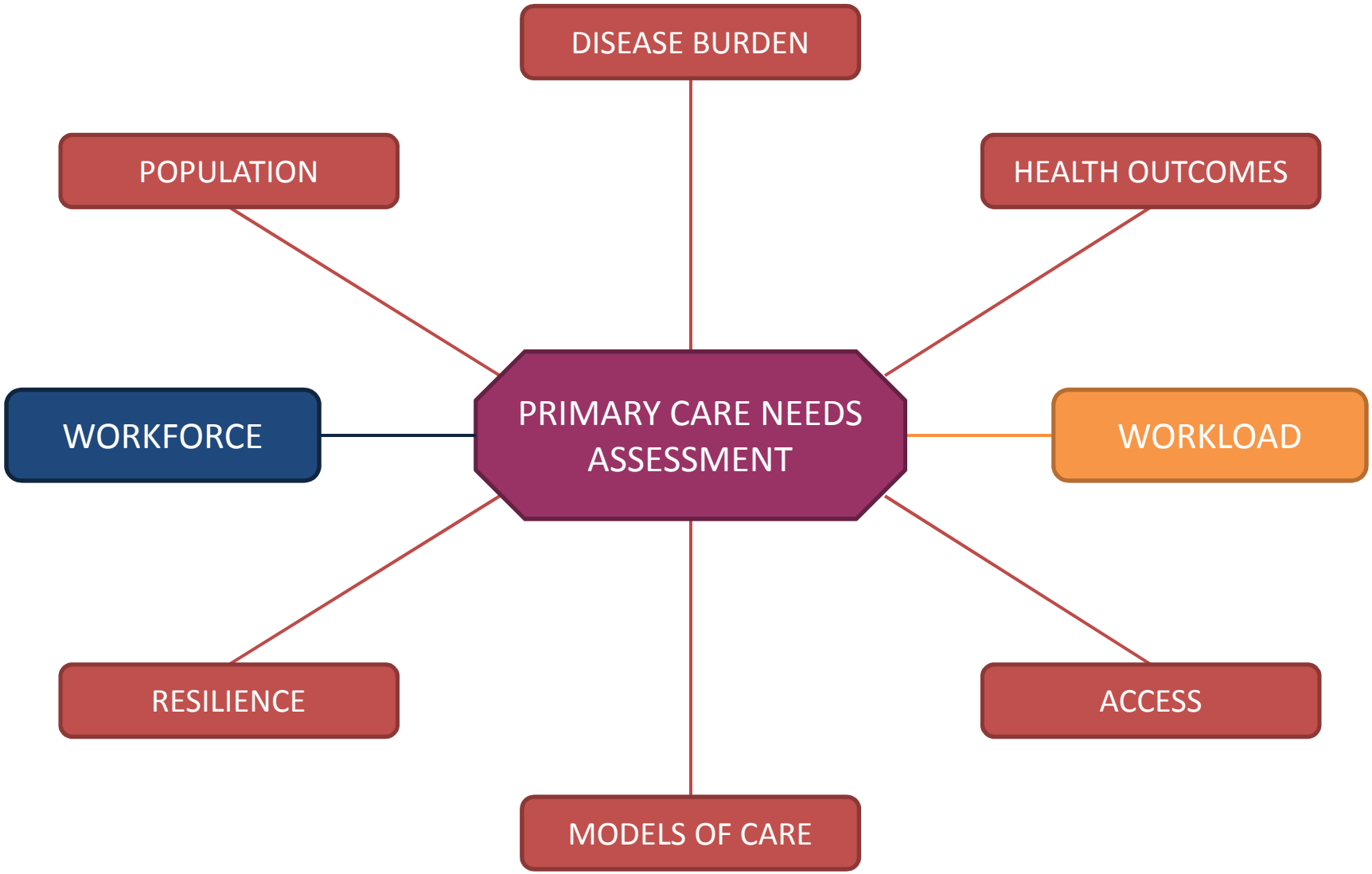
- Continuity
- Skill Mix
- Vulnerable Groups
- Consultation Length



PRACTICE VISIT QUESTIONS

Population
Access
Workforce
Integration & Coordination
Complex Multimorbid Patients
Shift of Care Closer to Home
Resilience
Models of Care
Integrated Care Networks




DISEASE BURDEN
POPULATION
HEALTH OUTCOMES
WORKFORCE
PRIMARY CARE NEEDS ASSESSMENT
WORKLOAD
RESILIENCE
ACCESS
MODELS OF CARE

HOME

WORKFORCE

"In order for Bromley to reach the same ratio as London, an additional 2.7 WTE GPs are needed in Bromley, and to reach the same ratio as England, an additional 13.4 WTE GPs are needed."

GPs

"Bromley has a higher nurse to patient ratio than London, but an additional 18 WTE nurses (of all types) are needed to reach the same ratio as England."

PNs

In order to keep up with population growth, we need 1.5 additional GPs per year in Bromley.

NEW ROLES

NON CLINICAL STAFF

CAPACITY

VIEWS ON PARTNERSHIP

VIEWS ON LOCUMS

The annual workforce survey in Bromley shows that we lost 1.85 WTE GPs last year.

BACK

CAPACITY

VIEWS ON PARTNERSHIP

VIEWS ON LOCUMS

BACK

Salaried GPs

Too Few Applicants

- Practices don't know how to access the trainee cohort
- Competition from posts at access hubs and UCC
- High indemnity fees

Difficulty in retention

- Excessive workload
  Causes GPs to resign
  Practices protect salaried GPs from workload to retain them.

- Salaried GPs not willing to be on call
- Only want to work 4 to 6 sessions per week
- Want a mentor

Don't develop the full range of GP skills

CAPACITY

VIEWS ON PARTNERSHIP

VIEWS ON LOCUMS

Recruiting Locums

Locums don't do any admin.

Poor response to recruitment requests

Locums don't follow up results

Pay is an issue. More financially attractive to work as a locum.

Locums want flexibility

Locums are unwilling to do home visits

Locums don't deal with difficult issues

Childcare stops at 6 pm

Locums are unwilling to take clinical leadership roles

Locums refer excessively because risk averse

The practice also has to pay into the pension scheme for the locum.

The new HMRC IR 35 regulations pose a problem for practices employing regular locums.

Retired locum GPs struggle with IT.

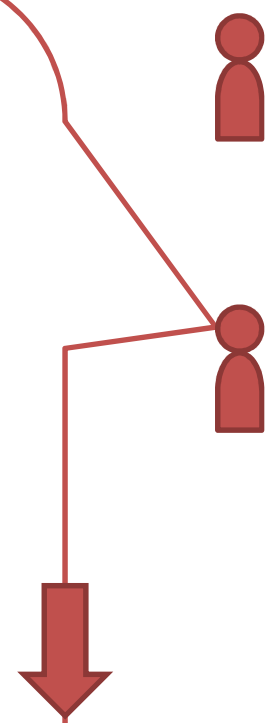
BACK

CAPACITY

NURSE RECRUITMENT

The annual workforce survey in Bromley shows that we lost 1.13 WTE ANPs whilst gaining 2.95 WTE PNs relating to an overall increase of 1.83 WTE Nurses last year.

Alongside that there was a loss of 1.37 WTE HCAs



BACK

CAPACITY

NURSE RECRUITMENT

ISSUES	INNOVATIONS
Retirement of longstanding experienced nurses	Nurses as mentors
Small pool of practice nurses	In house training of nurses
Hospital nurses not aware of practice nursing	Student nurse placements in practices
Terms & Conditions not standardised and less attractive than in secondary care.	Use of a training contract with commitment for nurse to stay in practice
Lack of training courses	Higher rates of pay

BACK

WORKFORCE

Key Issues:

- Insufficient number of GPs and nurses
- Lack of skill mix
- Competition between local services for GPs and nurses
- Undesirable workload and work life balance

OVERWHELMING WORKLOAD

WORKLOAD

Much is spoken about General Practice workload, chiefly about it increasing and becoming unmanageable, but what exactly are we talking about?

Under the GP Contract, GPs must provide a service to manage a registered list of patients. This includes consultation, treatment, onward referral for investigation and extended primary care services such as prevention, screening, immunisations and some diagnostic services. GPs also help to ensure effective coordination of care for their patients with other NHS services, social care and health services outside the NHS.

WORKLOAD

Quantifying Workload in Bromley

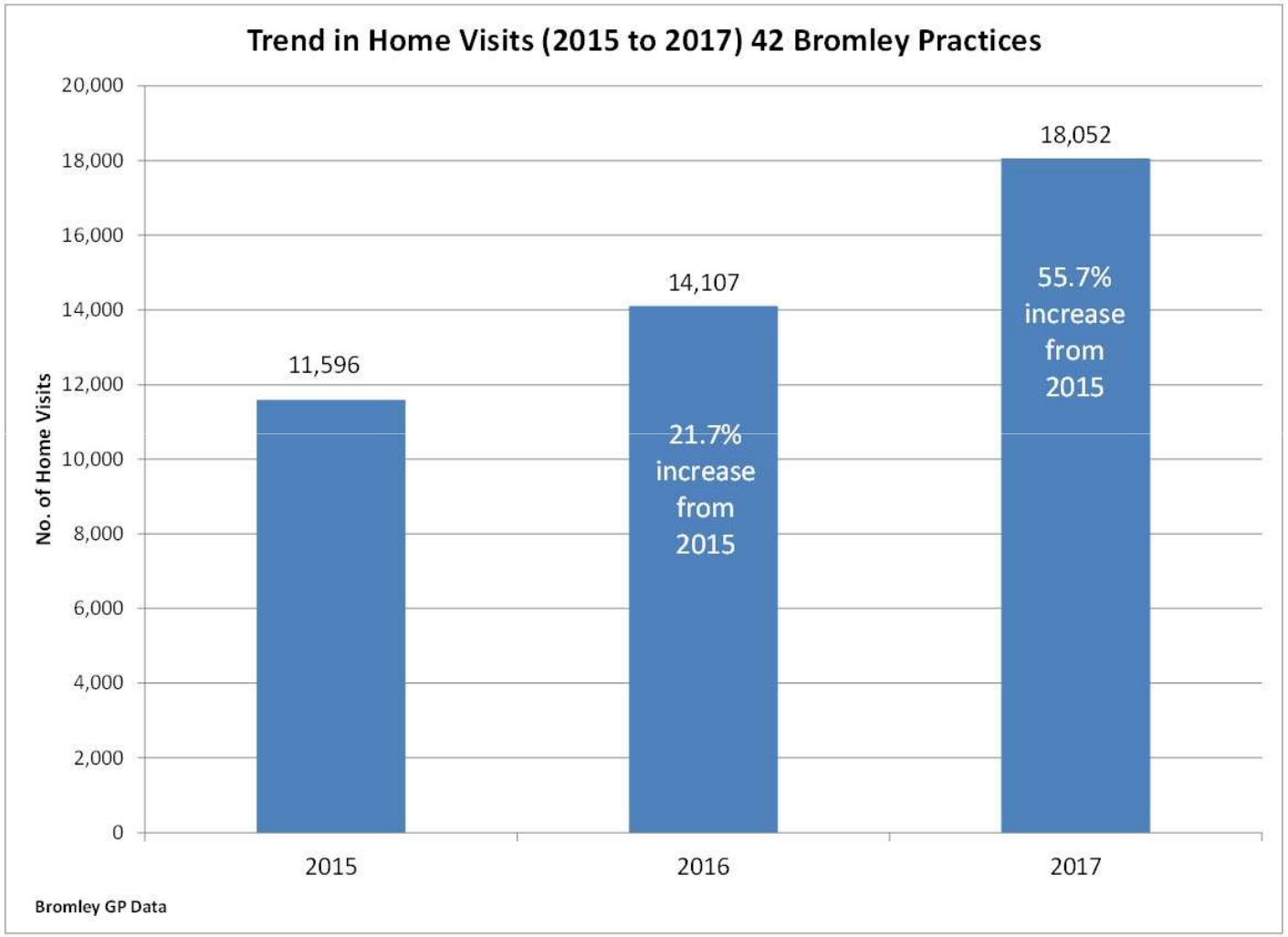
	Number per GP/week				
	GP Appointments	Prescriptions	Results	Incoming Correspondence	Referrals
Average	103	513	97	107	27
Minimum	47	243	45	2	10
Maximum	185	1231	166	201	49
Median	98	506	90	114	25

WORKLOAD

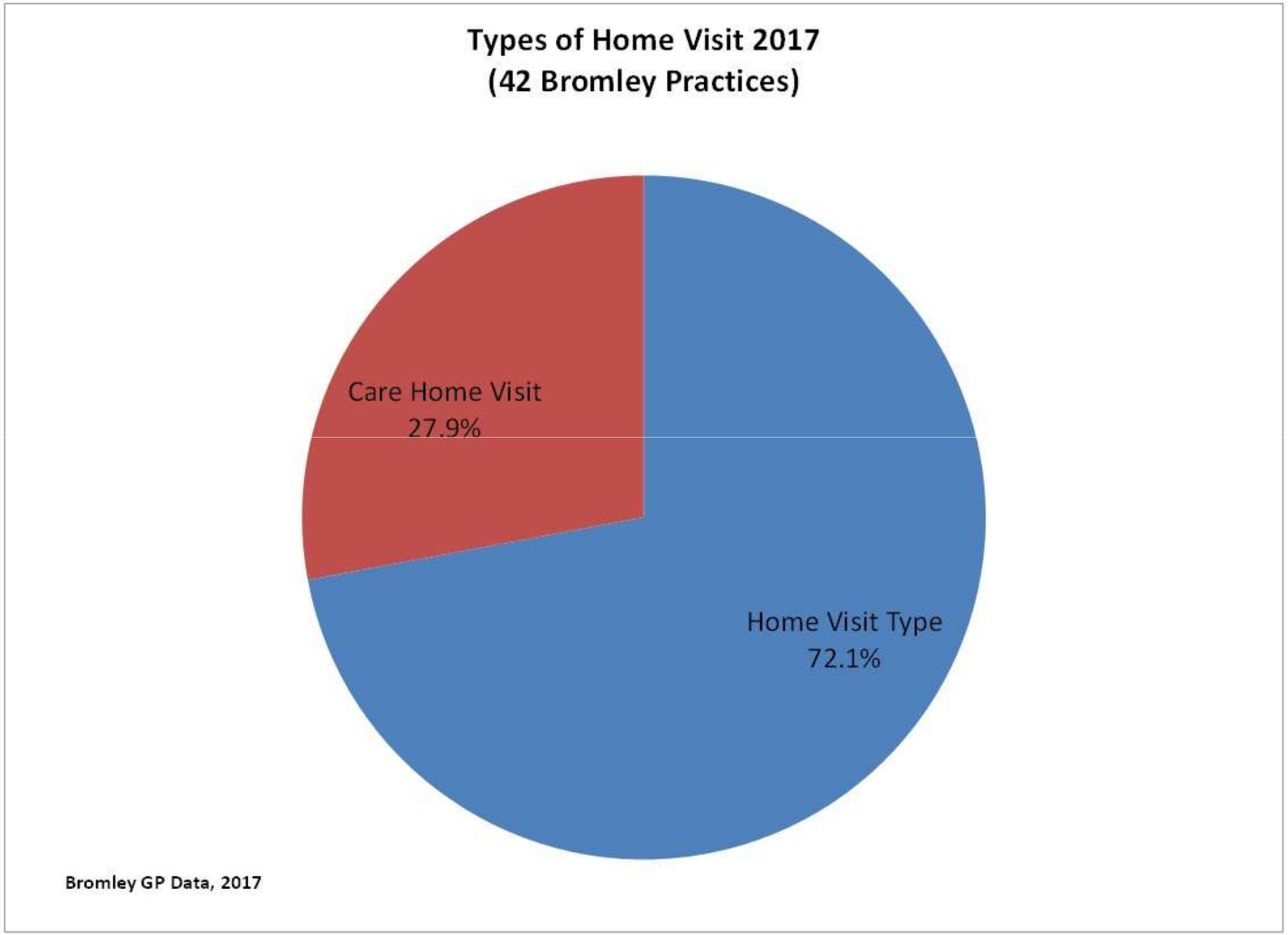
Quantifying Workload in Bromley

	Distribution of Appointments by Session Holder				
	GP %	Practice Nurse %	ANP % (n=12)	HCA% (n=24)	Access Hub %
Average	72.7	16.3	9.4	9.5	2.2
Minimum	54.7	1.4	2.0	1.4	0.0
Maximum	83.9	37.0	20.1	31.6	13.2
Median	72.9	16.0	7.1	7.9	1.5

WORKLOAD


Trend in Home Visits (2015 to 2017) 42 Bromley Practices
No. of Home Visits
20,000
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
11,596
14,107
18,052
21.7% increase from 2015
55.7% increase from 2015
2015
2016
2017
Bromley GP Data

WORKLOAD


Types of Home Visit 2017
(42 Bromley Practices)
Care Home Visit
27.9%
Home Visit Type
72.1%
Bromley GP Data, 2017

WORKLOAD

Administrative Workload Filtering

Proportion of Administrative Work Diverted from the GP	No. of Practices (n=28)
<10%	4
10 to 20%	4
20 to 50%	3
50 to 75%	4
>75%	4
Unknown	9

WORKFORCE

We are at the point where the issues of

INSUFFICENT CAPACITY

AND

OVERWHELMING WORKLOAD

are creating an unsustainable future for Primary Care in Bromley and we therefore need to do something transformational…

OPTIONS

STATUS QUO

Who will be

LAST MAN STANDING?

OPERATING AT SCALE

MERGERS/TAKEOVERS

- Take a long time
- Often fail on premises issues

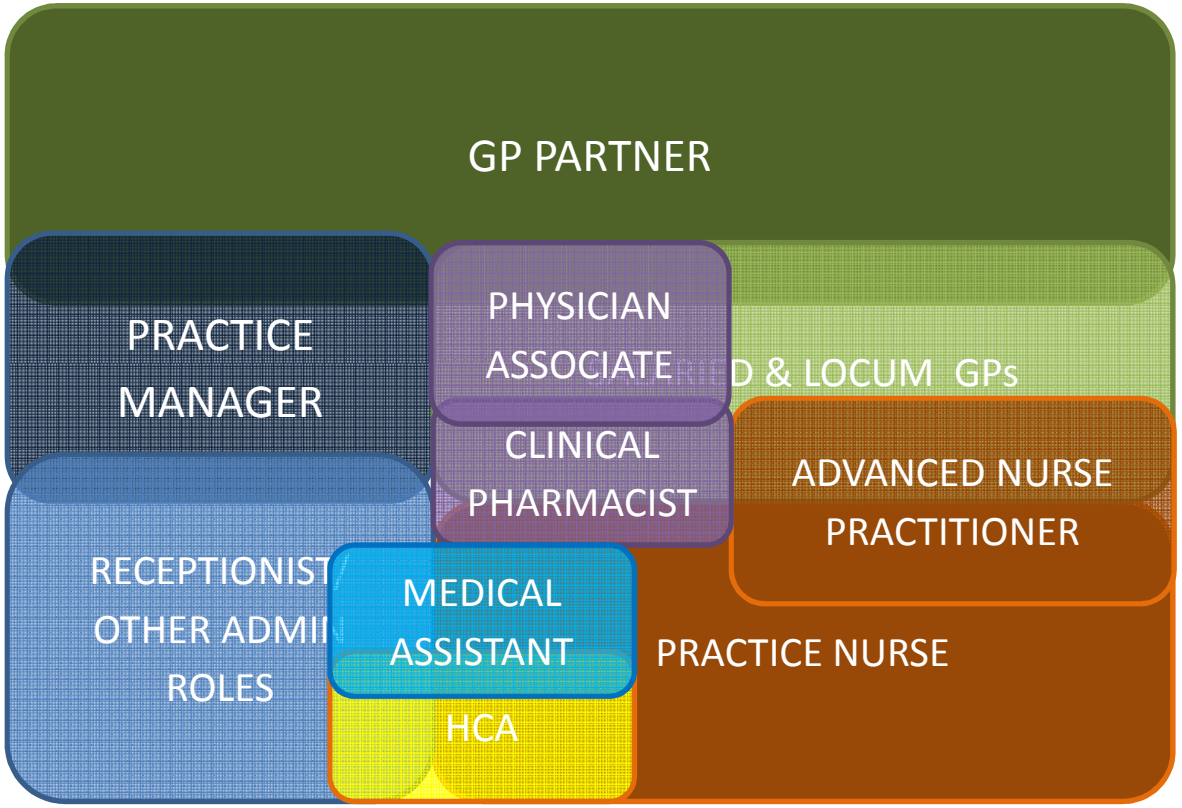
COLLABORATION

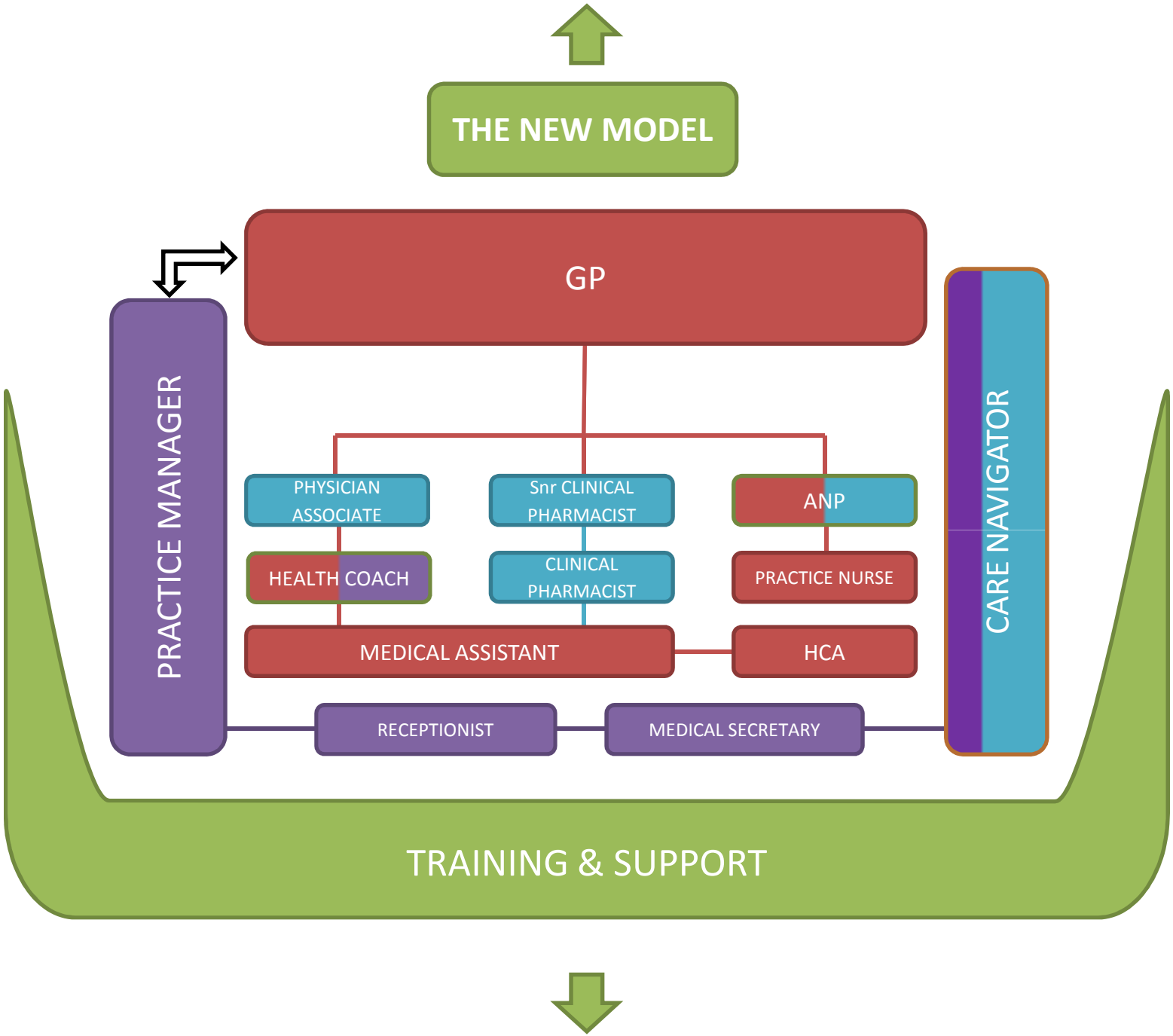
- Retain Partnerships
- Retain Premises *(at least in the short term)*

PREMISES

- Financial Considerations/ Ownership
- Exit Strategy
- ?Attractiveness to new partners
- Current state/capacity

THE TRADITIONAL MODEL…



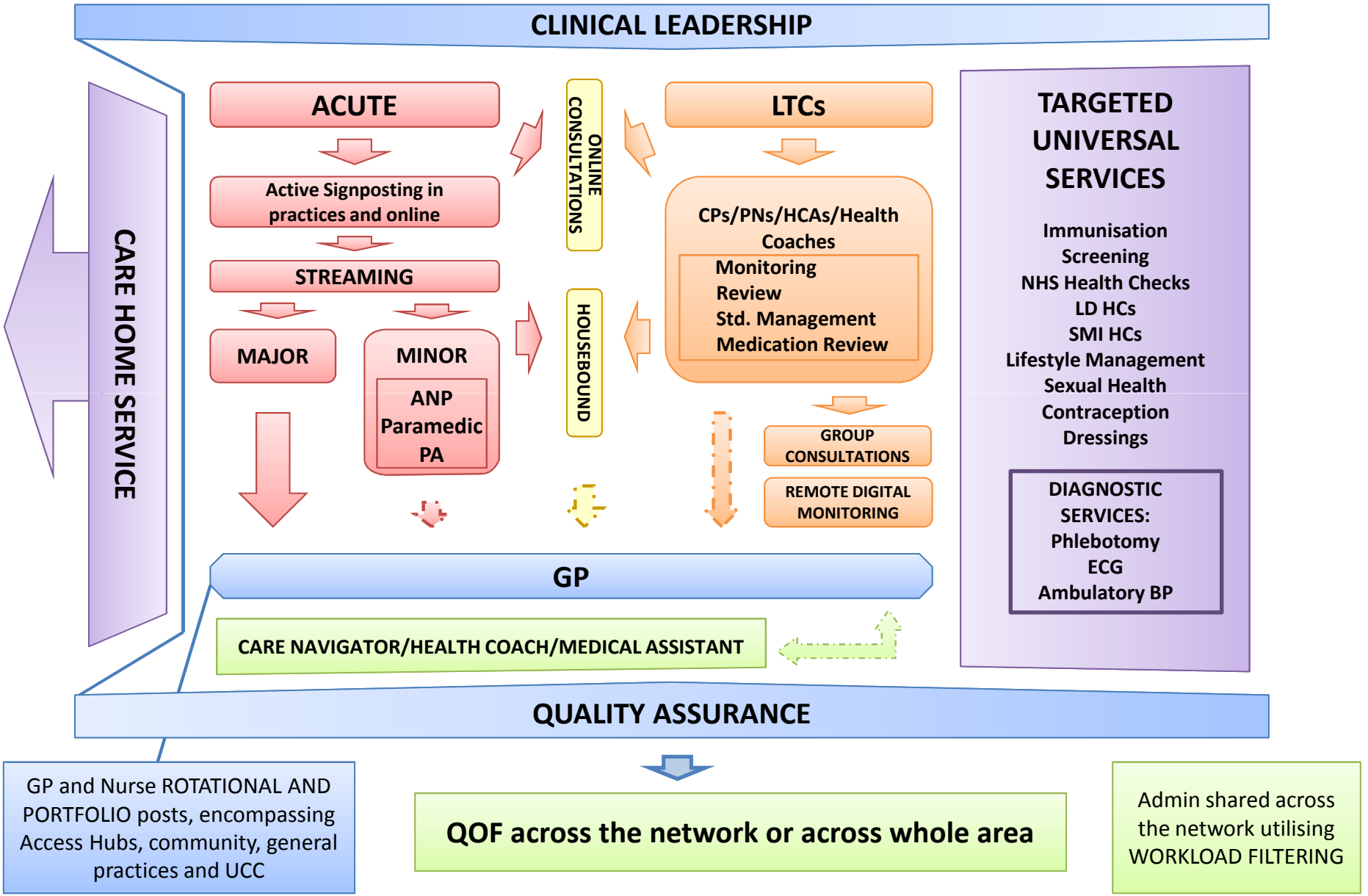

THE NEW MODEL
GP
PRACTICE MANAGER
CARE NAVIGATOR
PHYSICIAN ASSOCIATE
Snr CLINICAL PHARMACIST
ANP
HEALTH COACH
CLINICAL PHARMACIST
PRACTICE NURSE
MEDICAL ASSISTANT
HCA
RECEPTIONIST
MEDICAL SECRETARY
TRAINING & SUPPORT

RESOURCES:
£££ and people

BROMLEY NEW MODEL

Based on 30-50,000 patients

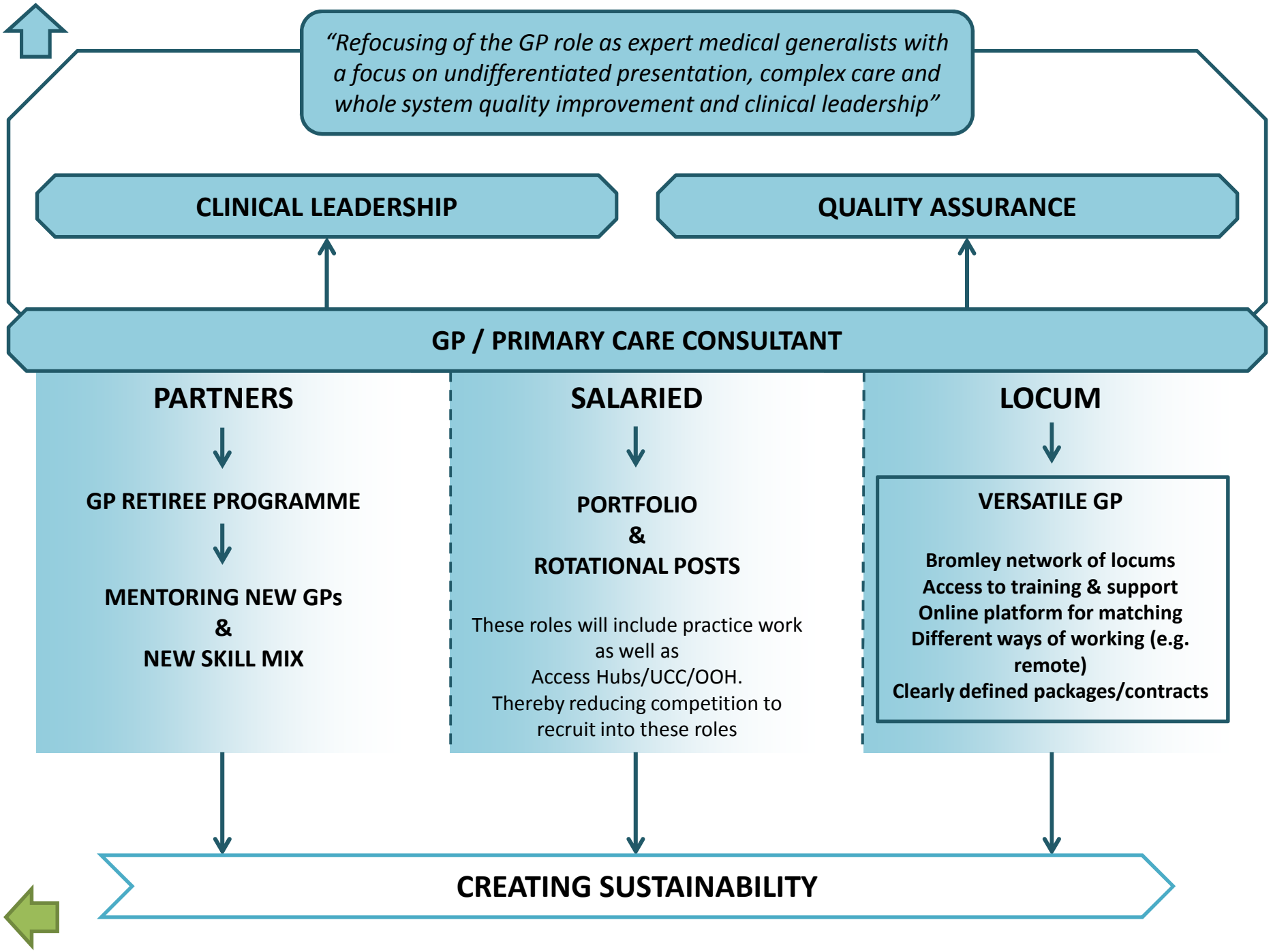
NHS Bromley Clinical Commissioning Group



GP and Nurse ROTATIONAL AND PORTFOLIO posts, encompassing Access Hubs, community, general practices and UCC

QOF across the network or across whole area

Admin shared across the network utilising WORKLOAD FILTERING


"Refocusing of the GP role as expert medical generalists with a focus on undifferentiated presentation, complex care and whole system quality improvement and clinical leadership"
CLINICAL LEADERSHIP
QUALITY ASSURANCE
GP / PRIMARY CARE CONSULTANT
PARTNERS
GP RETIREE PROGRAMME
MENTORING NEW GPs
&
NEW SKILL MIX
SALARIED
PORTFOLIO
&
ROTATIONAL POSTS
These roles will include practice work as well as Access Hubs/UCC/OOH. Thereby reducing competition to recruit into these roles
LOCUM
VERSATILE GP
Bromley network of locums
Access to training & support
Online platform for matching
Different ways of working (e.g. remote)
Clearly defined packages/contracts
CREATING SUSTAINABILITY

- [redacted] working [redacted] with a population of 30 to 50,000
- [redacted] of new ways of working
- Utilising a wider [redacted], (incl. new roles)
- Ensuring all staff are working to the [redacted]
- Refocusing the role of the GP as an [redacted]
- Improving the [redacted]
- Maintaining [redacted]
- [redacted]

NHS Long Term Plan and GP Contract Reforms

- Primary Care Networks (30 to 50,000 population)
- Additional Roles
- Network DES
- Expanding digital access for patients

Additional Roles

- Clinical Pharmacists (2019)
- Social Prescribing Link Workers (2019)
- Physician Associates(2020)
- First Contact Physiotherapists (2020)
- First Contact Community Paramedics (2021)

- 70% reimbursement for five years, 100% for social prescribing link workers

Digital Improvements

- Access to online and video consultation for all patients by April 2021
- Online access to full medical record by April 2020
- Electronic ordering of repeat prescriptions and electronic repeat dispensing from April 2019
- 25% of appointments bookable online by July 2019
- Up to date and informative online presence for practices by April 2020

Network Specification

1. Structured medications review and optimisation
2. Enhanced health in care homes
3. Anticipatory care
4. Personalised care
5. Supporting early cancer diagnosis
6. CVD prevention and diagnosis
7. Tackling neighbourhood inequalities

Primary Care Transformation Programme