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WORKING TOGETHER TO IMPROVE HEALTH AND CARE

Update on GP Access

Health Scrutiny Sub-Committee

21 November 2023

GP Access: a local priority

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Improving access to general practice is a Bromley priority.

Initiatives were reinvigorated as the pandemic eased to modernise general practice operations and maximise use of new ways to access primary care in order that those patients who most needed it could continue to use the more traditional forms of access.

GP Access has also become a national priority.

NHS England published a Recovery Plan for Delivering GP Access in May 2023, and expanded the initiatives and schemes in support of realising that plan in September.

The NHS England framework was accompanied by a national campaign launched in October 2023 which contains similar themes and messaging to the Bromley campaign from 2022.

This report seeks to update on progress with GP access improvements against the four priority areas in the national Delivery Plan, and introduce the broader programme of innovation to improve GP access in Bromley.

Delivery Plan ambitions

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The plan has two central ambitions:

1. **To tackle the 8am rush and reduce the number of people struggling to contact their practice.**

Patients should no longer be asked to call back another day to book an appointment, and there will be investment in general practice to enable this.

2. For patients to know on the day they contact their practice how their request will be managed.

a) If their need is clinically urgent it should be assessed on the same day by a telephone or face-to-face appointment. If the patient contacts their practice in the afternoon they may be assessed on the next day, where clinically appropriate.

b) If their need is not urgent, but it requires a telephone or face-to-face appointment, this should be scheduled within two weeks.

c) Where appropriate, patients will be signposted to self-care or other local services (eg community pharmacy or self-referral services).

Many of these initiatives are in train across Bromley, and the focus now is on establishing this in a consistent manner across all GP practices, taking up the opportunities newly available and targeting additional support.

Four priority areas in the Delivery Plan

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The Delivery Plan makes a clear acknowledgement of the unprecedented demand for general practice appointments in challenging circumstances.

It sets out the national approach to respond to this demand and best meet the needs of local communities, with programmes designed to expand capacity and transform the way primary care services are delivered.

1	**Empower patients**	• Improving NHS App functionality	• Increasing self-referral pathways	• Expanding community pharmacy	
2	**Implement new Modern General Practice Access approach**	• Roll-out of digital telephony	• Easier digital access to help tackle 8am rush	• Care navigation and continuity	• Rapid assessment and response
3	**Build capacity**	• Growing multi-disciplinary teams	• More new doctors	• Retention and return of experienced GPs	• Priority of primary care in new housing developments
4	**Cut bureaucracy**	• Improving the primary-secondary care interface	• Building on the 'Bureaucracy Busting Concordat'	• Reducing IIF indicators and freeing up resources	

The work underway to deliver improvements to GP access in Bromley have been aligned to these national priority areas. The following slides indicate progress and just some of the ways we are tracking the impact of these initiatives to achieve improvement in Bromley.

Empower patients

Empower patients: progress

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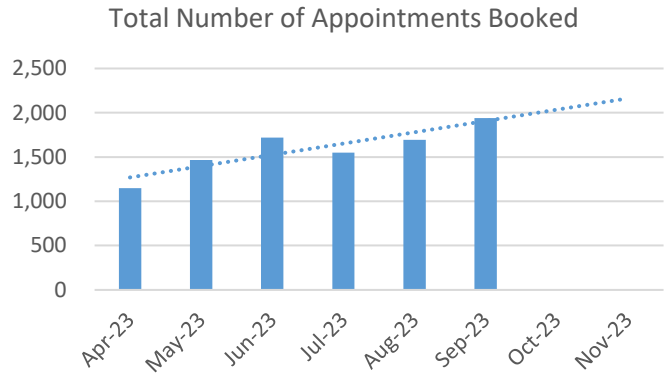
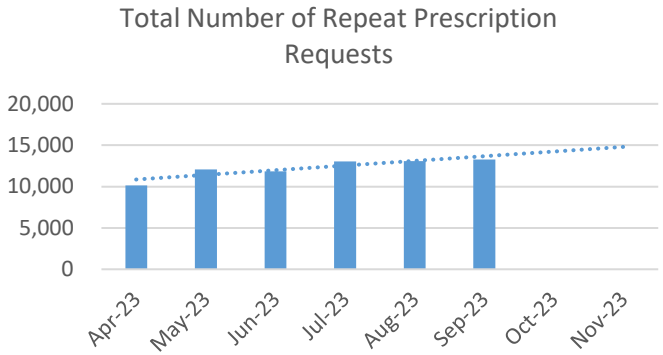
• Improving NHS App functionality

Enable patients to see their records and practice messages, book appointments and order repeat prescriptions using the NHS App.





• Increasing self-referral pathways

Expand (community) self-referral pathways, as set out in the 2023/24 Operational Planning Guidance.

Self-Referral Pathway	Bromley status with offering self-referral access
Musculoskeletal	
Audiology (for older people)	
Weight Management Services (Tier 2)	
Community Podiatry	
Wheelchair Services	
Fall Services	Bromley provision is designed as a specialist service requiring MDT assessment prior to referral and therefore exception to this requirement.
Community Equipment Services	

• Expanding community pharmacy

Preparing for Spring implementation (pending national announcement) of new **Community Pharmacy** initiatives:

- Expand pharmacy oral contraception (OC) and blood pressure (BP) services this year, to increase access and convenience for millions of patients, subject to consultation.
- Launch Pharmacy First so that by end of 2023 community pharmacies can supply prescription-only medicines for seven common conditions, subject to consultation, to save appointments in general practice.

Implement new Modern General Practice Access approach

Modern GP Access: progress

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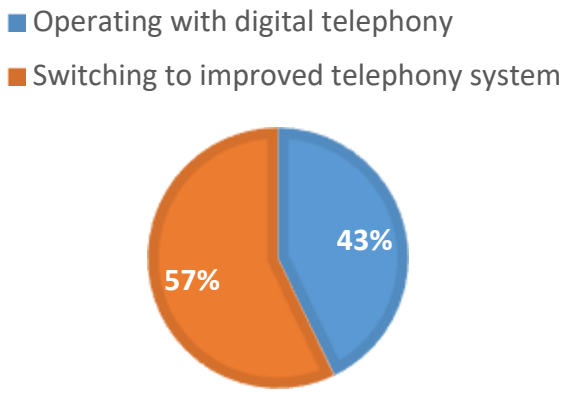
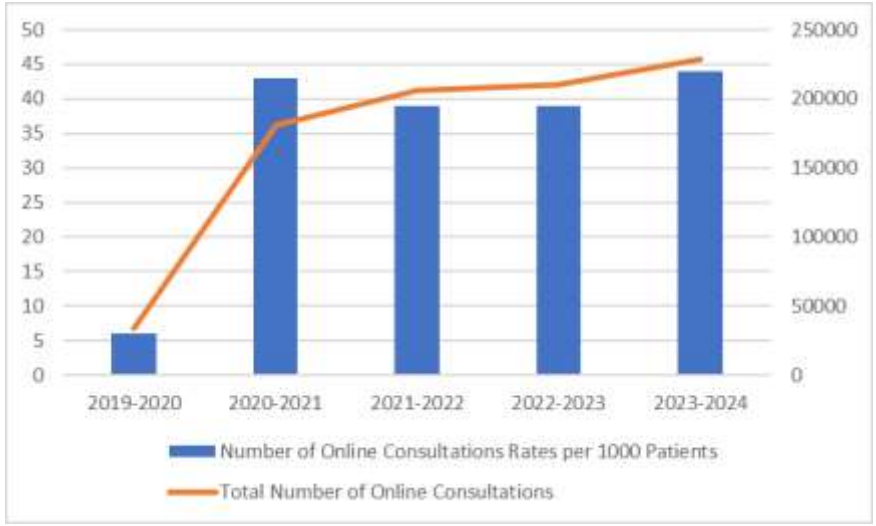
- Roll-out of digital telephony

Support all practices on analogue lines to move to digital telephony.



- Easier digital access to help tackle 8am rush

Provide practices with the digital tools for Modern General Practice Access.



- Rapid assessment and response

Training and transformation support to handle demand and deliver care efficiently.

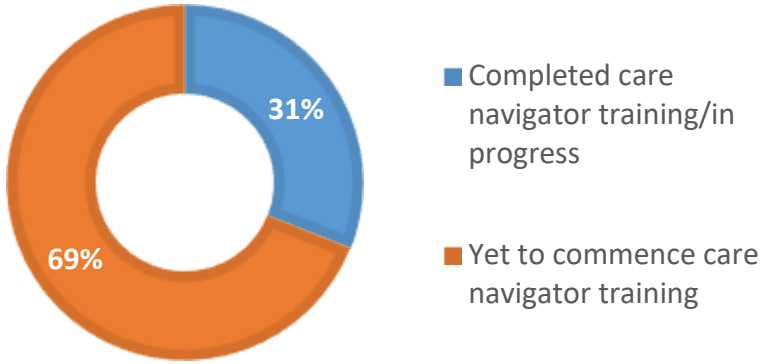
14% already undertaking quality improvement (QI) programme

Further 28% being nominated for next wave QI support

Transforming GP services to be fit for the future requires investment in technology and quality improvement capacity to support changes in ways of working.

- Care navigation and continuity

Provide practices with care navigation training to conduct triage at point of contact and direct requests



Build capacity

Build capacity: progress

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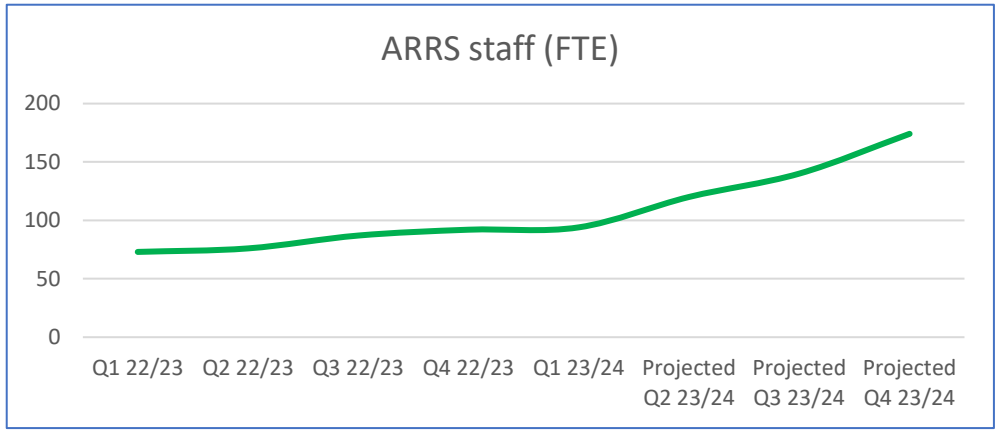
- Growing multi-disciplinary teams

Employ more direct patient care staff to deliver more appointments in primary care.

- Rapid rise in ARRS staff planned over next six months

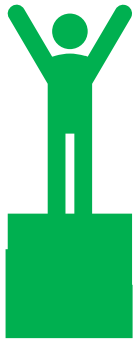


Primary Care has joined the One Bromley recruitment campaign to promote health and care roles within the borough and encourage people to take up careers in Bromley.

- More new doctors
- Retention and return of experienced GPs

In Bromley we have established:

- Proactive Training Hub also delivering Primary Care Recruitment and Retention initiatives to support practices
- Investment in new GP trainers and GP trainer champion to help further expand GP training places in the borough
- Expanded non-traditional entry routes, including fellowships and apprenticeships



Predominantly driven as national initiatives:

Further expand GP specialty training and make it easier for newly trained GPs who require a visa to remain in England.

Encourage experienced GPs to stay in practice through pension reforms and create simpler routes back to practice for the recently retired.

- Priority of primary care in new housing developments

Through local authority planning guidance amendments, raise the priority of primary care facilities when considering how funds from new housing developments are allocated.

Awaiting developments following recent Royal Assent for the Levelling-up and Regeneration Act 2023

Cut bureaucracy

Cut bureaucracy: progress

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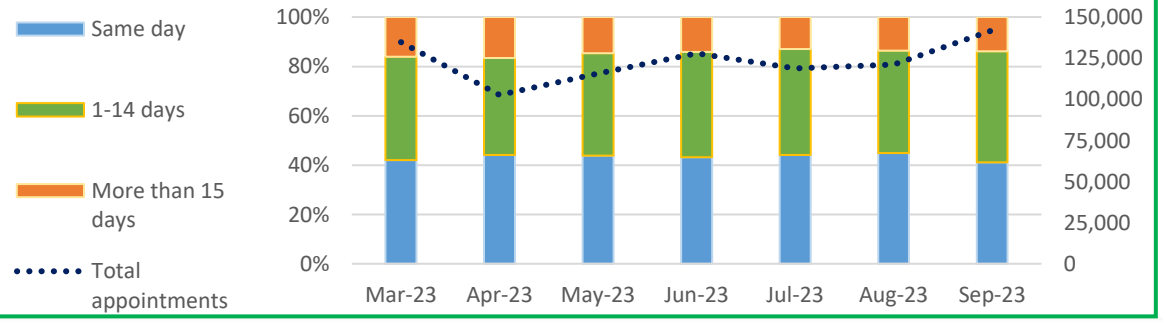
- Improving the primary-secondary care interface

Reduce GP time spent liaising with hospitals by improving working together relating to patient-focussed, operational, design-related and cultural domains.

- Meetings in train between primary care clinical directors and PRUH executive and clinical leadership
- Due to feed into a SEL-level forum expected in Spring (ie for common/cross-trust issues)

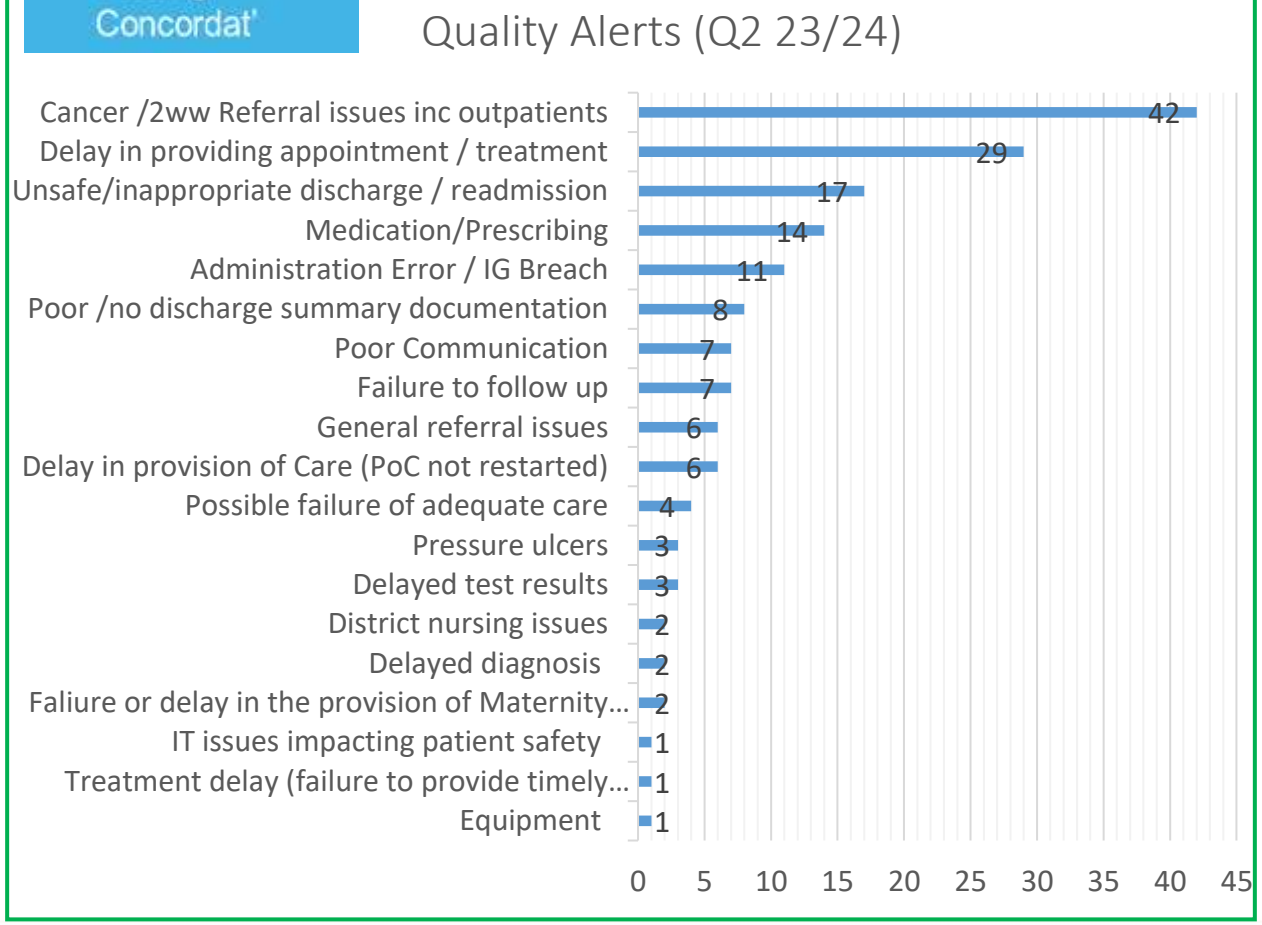
- Reducing IIF indicators and freeing up resources

Indicators reduced from 36 to five, focused on four clinical priorities and one on timely access to appointments.



- Building on the 'Bureaucracy Busting Concordat'

Reduce requests to GPs for actions more suitable elsewhere (eg acute, other Government departments).



Leading transformation – role of PCNs

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- Neighbourhood projects transforming access have been operating at PCN-level or multi-PCN level
- Development has initially targeted ways to minimise health inequalities, focusing on local needs, for example isolated people over-65s, young mums, people with serious mental health illnesses. Several case studies are provided in the appendix.
- Can be grouped around the core services in primary care:

Same day care	Complex/Long Term Condition Management	Preventative care
Primary Care Networks with ARRS roles supporting core primary care offer in eight groups across Bromley.	Integrated well-being service: proactive identification and interventions with over-65s in Core20PLUS5.	Bromley Children's Integrated Partnership, to cover all PCNs by April 24
Winter illness hubs – four locations across Bromley, same day face-to-face appointments bookable via practice, 111 and potentially other partners	Young Mums Hub to improve health outcomes and offer advice.	Pharmacy Hub focussed on DMARs for rheumatology patients
Same day community discharge from hospital – linking with community locality teams	Wellbeing Café – over 65s health checks and service talks	Renal-cardiometabolic multi-morbidity approach for CKD patients with diabetes and/or CVD, screening / community optimisation / case management with consultant.
Virtual wards – enabling care at home rather than in hospital setting	Integrated Care Networks – Proactive Care for people with long term conditions / at risk of hospital admission. 3 covering borough	Increasing co-working between practices and partners on geographic footprints for end of life care patients, underpinned by Gold Standard Framework
	Integrated diabetes service providing holistic model of care to improve outcomes.	

Enhanced access weekday evenings and Saturdays on PCN footprints

Future of general practice access

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The current model of general practice is changing.

At its heart should remain responsibility for same day/urgent, complex/long-term condition management and preventative care.

These will require integrated neighbourhood teams in the future.

Providing a strong platform for delivering and improving primary care services, PCNs are being asked to work in partnerships, bringing together a wide range of services involved in managing the health of local communities to form integrated neighbourhood teams. These teams and their services should be planned and organised around their local population needs.

Engaging patients is critical for the immediate and longer-term changes in GP access.

To monitor effectiveness of the Delivery Plan, PCNs are required to engage patients through surveys, Patient Participation Groups (PPGs) and other feedback channels.

The patient experience of local trials to modernise GP access will be tracked to refine systems, evaluate effectiveness and inform any wider adoption across Bromley.

To invite patient support and involve local people in the journey, the local ICB team recently held a One Bromley Patient Network event on GP Access, involving local leaders from across primary care. PPGs exchanged ideas and shared examples of work done to support their GP practices. Continued joint working with PPGs will be essential for introducing the broader changes in GP access.

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Appendix:

Bromley Primary Care Networks taking a neighbourhood approach to improving access

Bromley PCNs' approach to neighbourhood working

- Delivering joint services that make sense geographically
- Addressing specific healthcare needs across multiple PCNs
- Bringing services closer to the home of patients
- Connecting and sharing learning across PCNs
- Maximising shared workforce and resources

Case Study 1:

Orpington PCN and Crays PCN Frailty Hub in partnership with Bromley Healthcare

Case study 1: Orpington PCN and Crays PCN Frailty Hub

Before officially working as a neighbourhood team with Bromley Healthcare and Crays PCN, Orpington PCN had started a collaborative approach to open the Wellbeing Café.

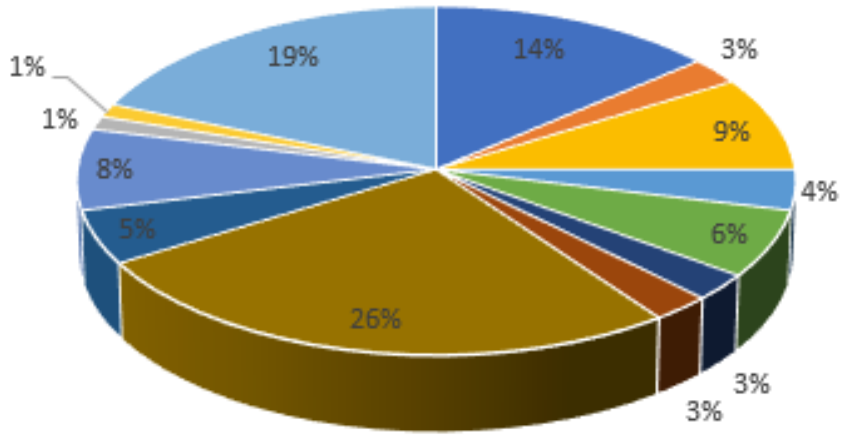
How did it come about?

Initiated in July 2022 by Orpington PCN, supported by Bromley Healthcare based on a review of local people who hadn't contacted their GPs in over 2 years.

Café Attendance Data

From 3rd August 2023

- Collecting data every session on attendance and onward referrals as well as activity from the café
- Using a Snomed code to keep an EMIS register of attendees
- The patients attending were noted to be not only from Orpington PCN practices but other PCNs too



- Ballater
- Bank
- Broomwood
- Chelsfield
- Derry Downs
- Family
- Gilmans
- GSGreen
- Highlands
- Knoll/OHW
- Poverest
- St Mary Cray
- Summercroft
- The Crescent
- Tudor Way
- Whitehouse
- Other Practices/unknown

Case study 1: Orpington PCN and Crays PCN Frailty Hub

What we've learnt

- Social element with over 75 attendees at each cafe
- It has become a happy, comfortable, safe space to engage with healthcare professionals
- Sessions are based on feedback and requests
  - Talk Together Bromley
  - fit-to-move sessions,
  - mindfulness,
  - art classes
- Social prescribers attend and this helps residents understand their role
- Digital inclusion support will be next with training for residents on how to use NHS digital tools such as eConsult
- Guidance and signposting is also given to residents by care co-ordinators as to how to access healthcare, ie the role of the ARRS staff

"I came to the OWC and they were doing a talk on blood pressure which come with a chance to have ours taken. I am so happy I had my blood pressure taken. My blood pressure was really high and it was decided to see my GP. I am now on medication which I am still trialling but I am hoping it will help improve my tiredness and ultimately my blood pressure. I am so grateful for the OWC for identifying this for me. It truly is a great space and initiative"
Pearl

Case study 1: Orpington PCN and Crays PCN Frailty Hub

What is it?

Orpington PCN is working with Bromley Healthcare and Crays PCN to design a new service to improve anticipatory care for people aged 65+ and reduce health inequalities within the local population.

Who is it for?

Local people in Orpington and Crays PCNs aged 65+ with complex needs and long-term health conditions, including those from marginalized, seldom-heard and underserved communities.

How we are developing the service?

- Understand local needs and what matters to communities of interest
- Tackle potential complexities that certain communities may face
- Aid inclusivity by allowing service design leads to hear the voices and perspectives of those who may traditionally be excluded

Case study 1: Orpington PCN and Crays PCN Frailty Hub

Who is the service for and how will it reduce population health inequality?

The focus for this service will be patients aged >65 with rising frailty, multi-morbidity and other inequalities. Case Management approach care

All over 65s in the Orpington/Crays population will be invited to the Hub to access support with:

- Undiagnosed or poorly controlled long-term conditions with a particular focus on hypertension and COPD
- Mental Wellbeing Issues
- Keeping warm, reducing isolation and tackling social issues, including the cost of living issues facing our population

There will be targeted invitations (via care coordinator outreach) for:

- Health Checks – SMI and Learning Disability
- Core20PLUS5 cohort and investigate how differently we could provide service

What can local people influence in co design?

What's in scope

- How people get access to professionals such as nurses and care coordinators
- Patient need – wellbeing, checks and screening
- Patient experience – identifying gaps in skills and upskilling our workforce

What could change as a result of this?

- Care Co-Ordinator performing blood pressure and pulse checks which used to need nursing staff.
- Training of residents in the use of eConsults and also knowledge of services to which residents can self-refer.
- Long term health condition checks.
- Learning disability health checks
- Timing of clinics
- Locations – ease of access

Case study 1: Orpington PCN and Crays PCN Frailty Hub

Recruitment – Resources to put co-design into action

Recruitment Update:

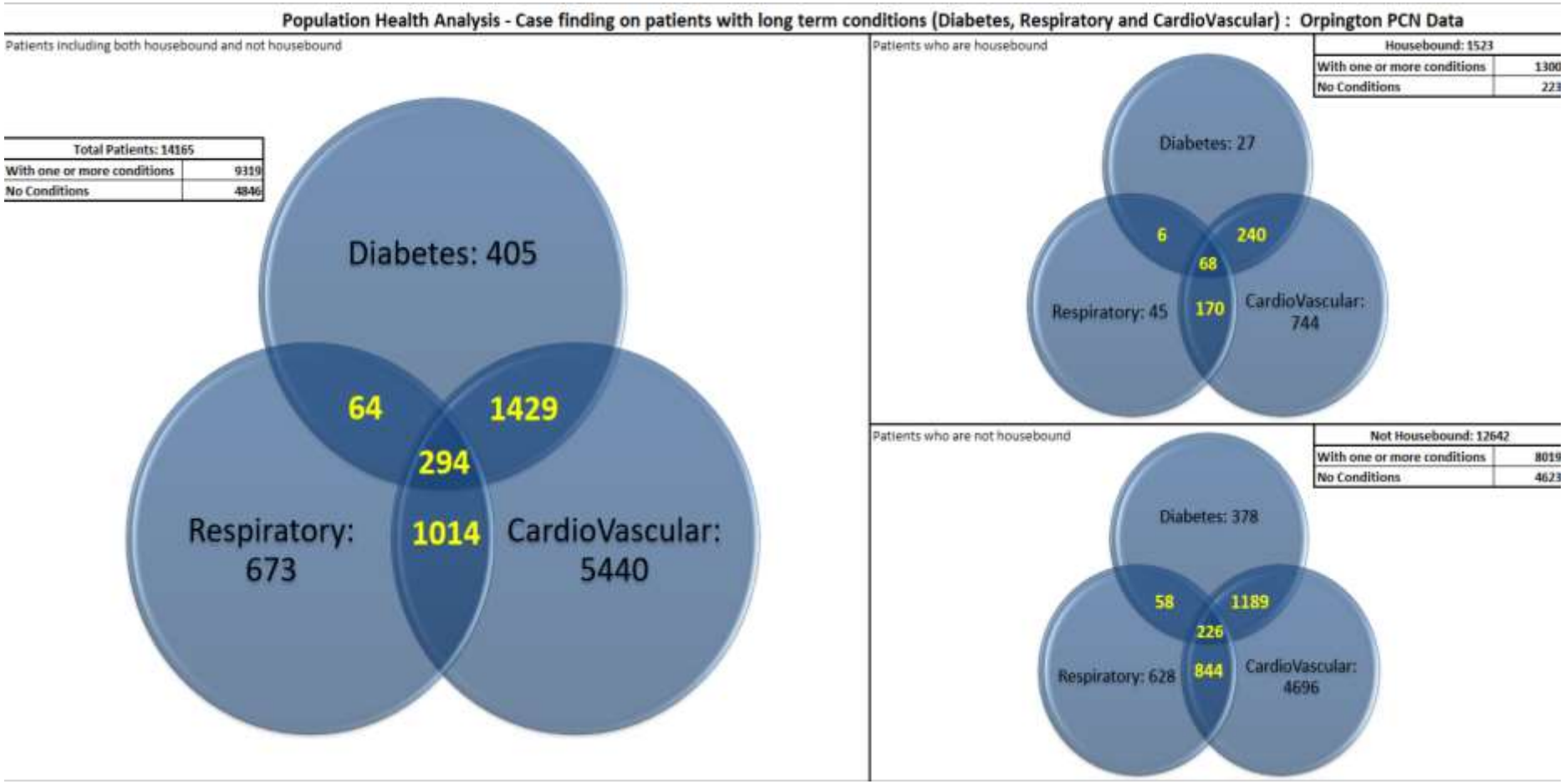
- Band 7 Clinical lead appointed and clinics have been set up
- Band 3 HCA appointed and started housebound visits based on our proactive case finding.
- A Nursing Associate has been recruited, planning induction now

Challenges:

- No model joint contract
- Line management
- Record keeping
- Estates survey

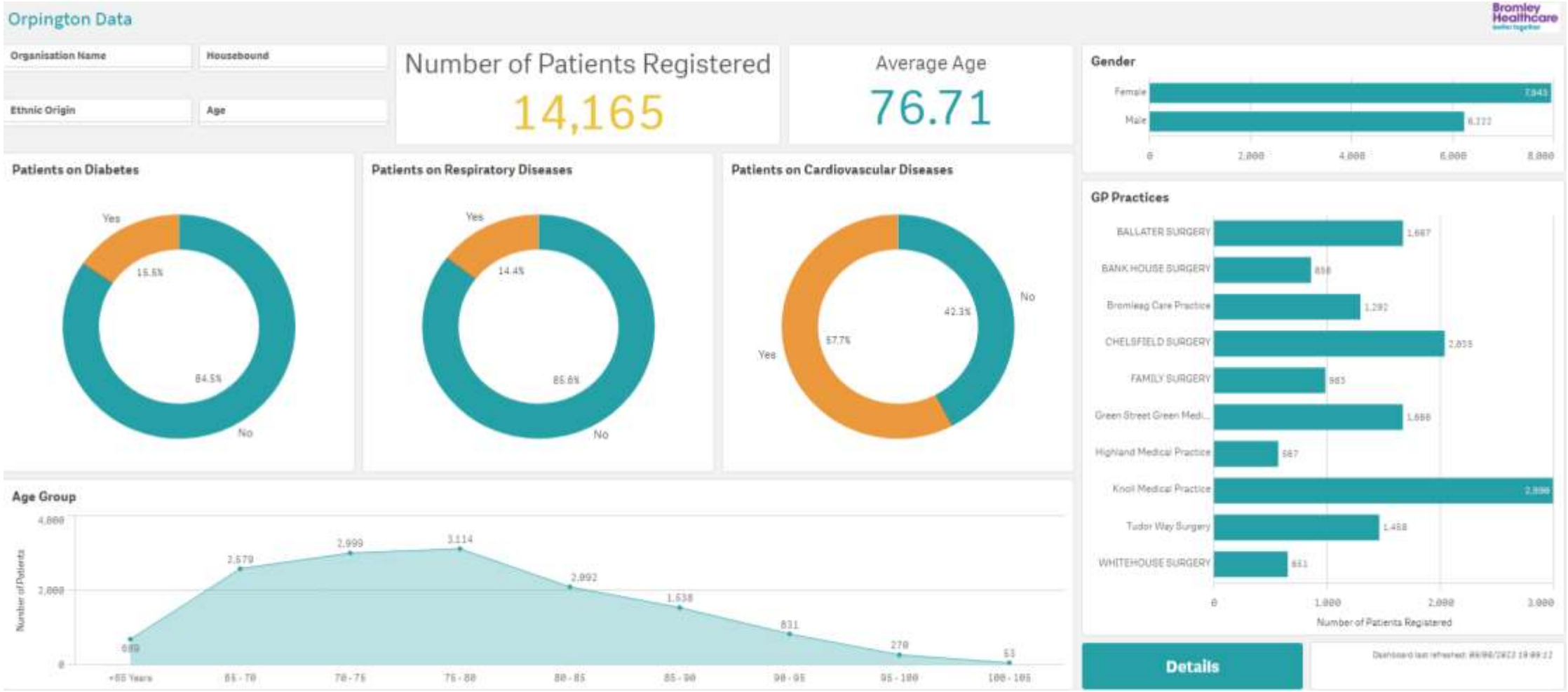
Case study 1: Orpington PCN and Crays PCN Frailty Hub

Fuller Pilot Data – Starting to proactively case find LTC patients



Case study 1: Orpington PCN and Crays PCN Frailty Hub

Fuller Pilot Data – Dashboard



Next Steps

Opened a clinic and began appointments in October 2023

Develop proactive case finding and a dashboard to show pilot outcomes

Complete co-design with the Band 7 clinical lead involvement

Upskill ARRS staff

Case Study 2:
Beckenham PCN B-CHIP

Case study 2: Beckenham B-CHIP

Each local Primary Care Network or Neighbourhood has:

A PCN or Neighbourhood Child Health team, which includes:

- An identified GP CYP lead
- A dedicated Patch Paediatrician
- A patch Children's Community Nurse

Holds a **weekly** triage meeting of CYP referred in from across the PCN / neighbourhood

1 Child Health Team: Triage meeting

2 In-reach clinic

In-reach clinic on a **4-6 weekly basis**

- Led by patch paediatrician
- Attendance by GPs is encouraged for training and education purposes

CYPHP specialist nursing service **4**

- Specialist children's nurses
- Look after the child's physical and medicine management issues
- Work in conjunction with primary care providers
- Treat diagnosed conditions (asthma, eczema and constipation)
- Active case finding using EMIS call/recall for early intervention of patients can self-refer

Multi-disciplinary Team meeting (MDT) **3**

Monthly MDT meeting, for all interested GPs and partners in the PCN / neighbourhood who care for CYP, such as:

- Child Health Team
- Any interested GP or nurse in primary care
- Health Visitors
- School Nurses
- Mental Health professionals

Case study 2: Beckenham B-CHIP

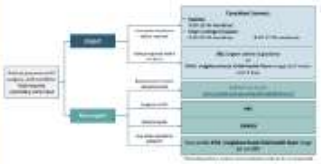
1. Child Health Team: Triage meeting

CHILDREN & YOUNG PEOPLE'S HEALTH PARTNERSHIP

ATTENDANCE

Patient visits a primary care provider to understand more about their health issue.

See Paediatric Referring Guide for more detail:



REFERRAL

GP refers patient to PCN or Neighbourhood Child Health Team via email and/ or puts patient straight onto the triage list on EMIS

CHILD HEALTH TEAM TRIAGE MEETING

PCN or Neighbourhood Child Health Team discusses in detail all clinical queries and referrals, either virtually or in person.
This happens on a weekly basis.

RECOMMENDED TREATMENT

The Child Health Team recommend the best treatment for the patient:

Advice and guidance : The triage team make a recommendation to the referring clinician on further management or investigation. This is provided through 'tasks' within EMIS.

Specialist community nursing service: the child is reviewed by a CYPHP specialist nurse

In-reach Clinic: a paediatric specialist and GP work together at a local GP practice, age-appropriate site (e.g. school) or virtually to look after children's health and wellbeing

A specialist team: where specialist input is deemed appropriate, the GP is asked to refer on to a specialist team. If possible, the paediatrician will refer on behalf of the GP.

Multi-disciplinary Team meeting (MDT): Complex cases may be reviewed during a monthly MDT discussion and a recommendation provided

Bromley Primary Care Networks

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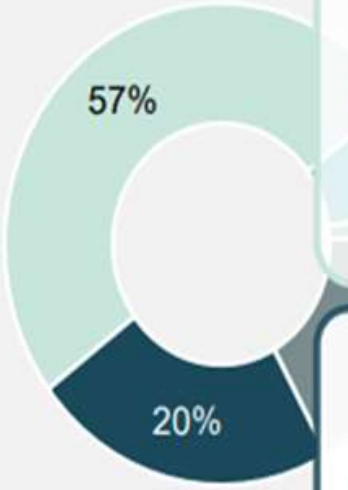
Case study 2: Beckenham B-CHIP

BENEFIT OF THE MODEL ON PATIENT CARE



For over half of triaged patients, **advice and guidance is provided back to the referring GP**, thus avoiding outpatient referrals.

57%

What this means:
- GPs receive better training and guidance

A fifth of triaged patients are seen within **local child health clinics**, led by local paediatricians.

20%

What this means:
- Children receive the most appropriate care close to home
- Unnecessary hospital referrals are reduced

REDUCTION IN PRIMARY CARE APPOINTMENTS

Primary care appointments before and after local child health clinic

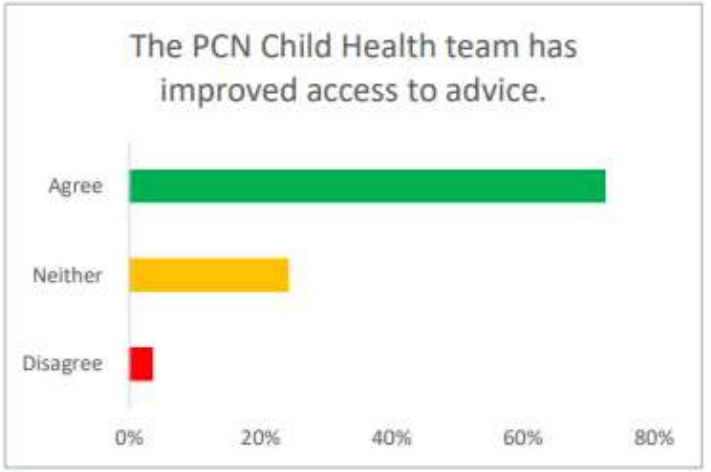
40% reduction in the number of primary care appointments for patients in the 6 months following the local child health clinic.

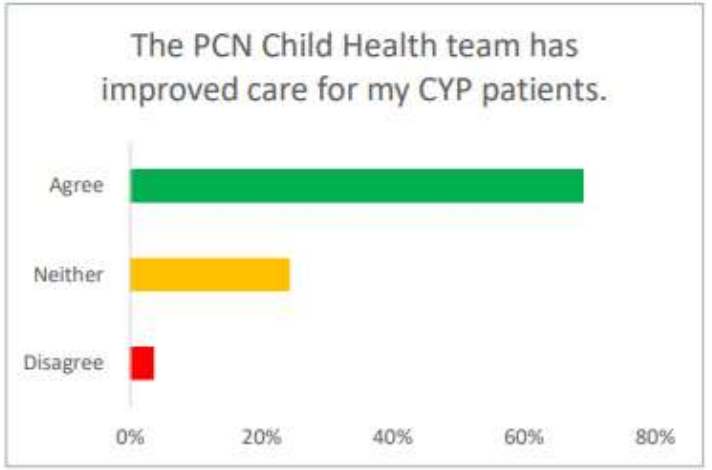
Case study 2: Beckenham B-CHIP

Clinician Feedback

GP FEEDBACK IS VERY POSITIVE…

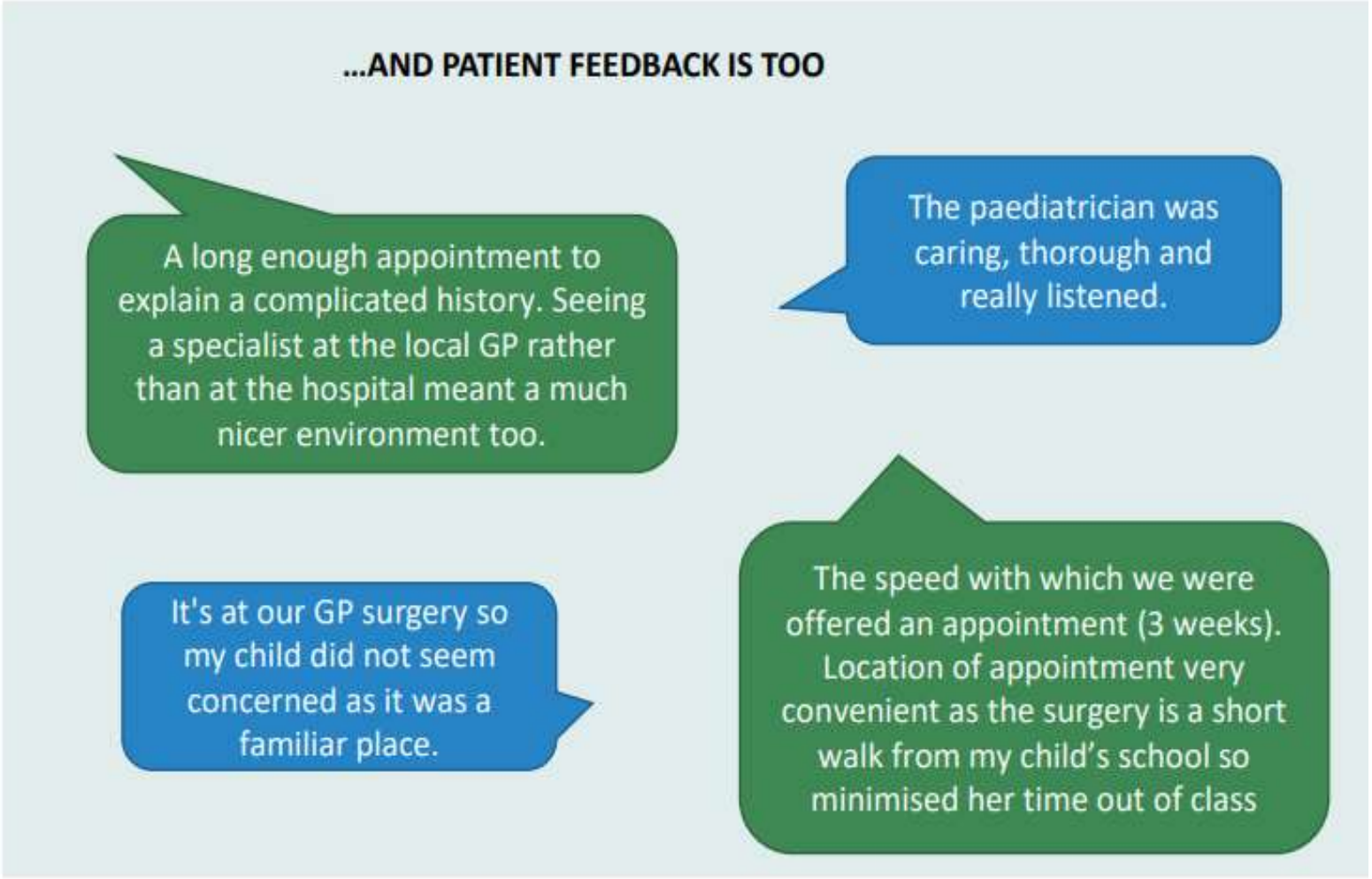
- Having a named consultant for queries and questions. Teaching sessions tailored around our learning needs
- The ability to triage quickly, get good feedback and the monthly meetings are excellent as we get to know the consultants and the educational aspect relevant and clear
- Quick reply to my advice request – really like the weekly review.
- Weekly access, easier to have dialogue and learning opportunity.
- Educational presentations useful and relevant
- Booking appointments easy and helpful. Comments received back via task easy to use
- On-site local child health [in-reach] clinics work really well, especially the clinical team de-brief post-clinic.
- I like that the notes get into EMIS quickly when they are seen in a local clinic.





Case study 2: Beckenham B-CHIP

Patient feedback



Why do this in Bromley?

The need for change and to implement the model is evidenced by large waiting times for children to be seen, with potential to support children better & more effectively through optimised capabilities in the local system

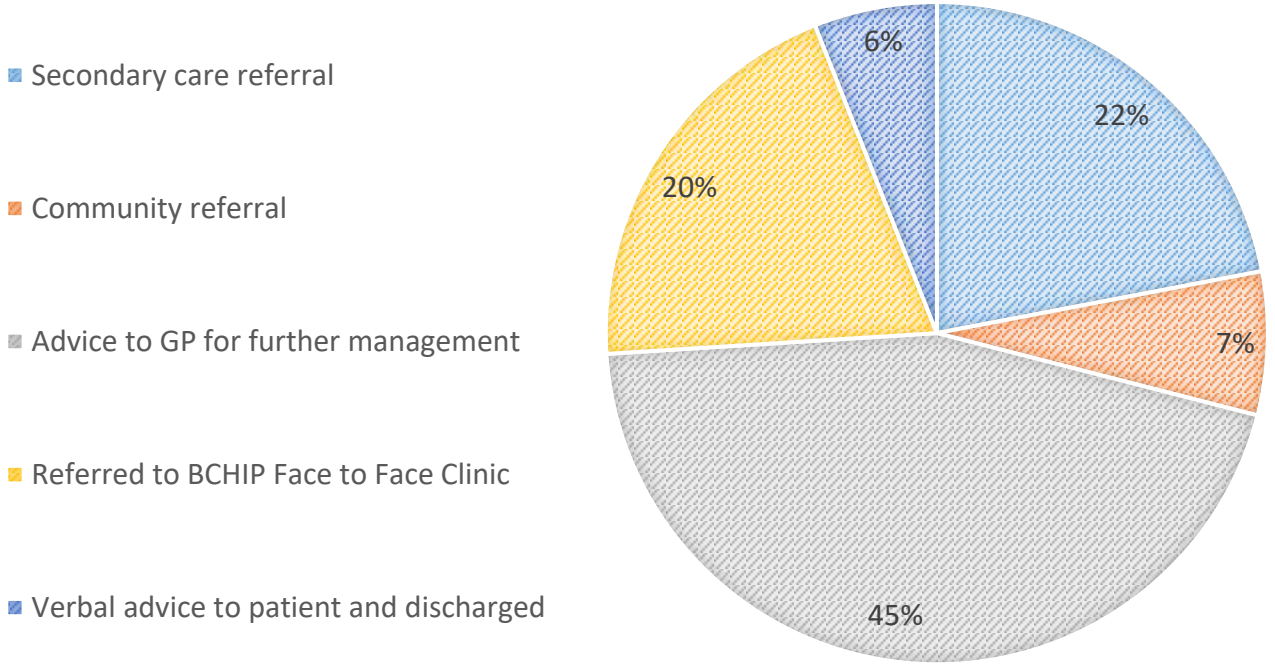
There has been a 50% to 60% increase in the number of General Paediatric referrals to hospital since the COVID-19 pandemic.

2017/18: 2,813 referrals
2018/19: 2,597 referrals
2019/20: 2,615 referrals
2020/21: 3,294 referral
2021/22: first 15 weeks – 1,125 referrals
(extrapolated – 4,000/yr)

Despite an increase in supply of appointments (300 additional appointments this year, from a baseline of 1400 new patient consultations per year), there is currently a >23 week wait for a Paediatric outpatient appointment at the PRUH

Case study 2: Beckenham B-CHIP

Beckenham PCN - number of referrals into the BCHIP triage service received to date: 82



Case study 2: Beckenham B-CHIP

B-CHIP face to face clinic outcomes