**Somerset GP Board**

**Transformation of General Practice in Somerset: A proposal**

**Summary**

This paper discusses the possible allocation of the approximately £1.68m available in Somerset from the notional national GP Transformation Fund.

**Background**

The General Practice Forward View (GPFV) was published in 2016 and proposed investing in general practices to improve their sustainability and resilience as they cope with rising demand and a falling GP workforce. It also encourages practices to manage their services in more efficient ways, including the exploration of new ways of working.

*Ten High Impact Actions (HIA)* were identified to be used as the basis from which practices could improve the way they worked and improve their sustainability. These are:

1. Active signposting
2. New consultation types
3. Reducing DNA’s
4. Developing the team
5. Productive workflows
6. Personal productivity
7. Partnership working
8. Social prescribing
9. Support self-care
10. Develop QI expertise.

SGPB believes that by taking on new ways of working and the pursuing workforce initiatives, practices can reduce their costs, improve services and build on locality working while maintaining their independent GMS/PMS contracts. This should make the vision of resilient general practices firmly embedded in their communities a reality.

However, some partnerships have already decided to give up their contracts, and others are likely to follow the same path. In Somerset all of these non-partner practices are operated by a local Foundation Trust. At the same time, the national expectation is increasingly that services should be delivered in localities of 30-50,000 people, a pragmatic position that seems sensible although lacking in really convincing evidence.

**Developments to date**

Somerset CCG has already indicated that it wishes to allocate its Transformation Fund monies to activity directly related to supporting the implementation of the HIA and the development of locality working. In preliminary conversations between the CCG and GP Board participating organisations it has been agreed that both are important.

**GP Board Position on Investment in HIA**

Generally the Board believes that the HIA should be used to sustain existing practices rather than directly to drive large scale working. We suggest the following principles should apply:

*HIA point 1*

*Active signposting and Productive workflows*

* *A coherent approach to same day demand* exploring urgent care demand and providing

a seamless pathway for the patient to access the right care at the right time.

* *Building on work such as respiratory specialist nurse clinics* which offer training to practice nurses in managing non-communicable diseases such as COPD/asthma and improving outcomes in the long term for patients (similarly to virtual clinics previously piloted for diabetes)

*HIA points 4, 6 and 7*

*Developing the team, personal productivity and partnership working by:*

* *Promoting primary care provision at* *scale*, where appropriate, while preserving individuality in each locality and preserving the partnership model. Recognising

different footprints for different functions and services, exploring options available

to practices to achieve, this including using Somerset Primary Healthcare Limited

(SPH) together with the LMC and CCG. Functional localities already exist with practices working collaboratively in informal networks and more formal associations such as federations...

* *Understanding work force preferences.* Establishing the “how” and “why” of GPs, paramedics, nurses and nurse practitioners wish to work in Somerset. Building on workforce initiatives such as GP in Somerset and the GP plus career schemes. Establishing why GPs are retiring early and what would encourage them to stay

by offering exit interviews

* *Encourage and support each practice* to provide an environment in which all of the primary care team feel valued and supported, and where personal resilience would naturally flourish. Use of streamlined services with partnership working will help

towards this.

* *Developing GPs as healthcare team managers,* including risk management and decision making skills.

*HIA point 2*

* *New Consultation Types* Working with the CCG, and through SPH, expanding on work done thus far regionally in implementing new consultation types that are appropriate given the rurality of Somerset and the limitations posed by infrastructure issues such access to superfast broadband.

*HIA point 3*

* *Reducing DNAs.* Exploring ways to improve hospital processes as, for example, delays in hospitals updating patient contact details are a major contributing factor to patients not receiving appointment details. Developing a safe and simple system of communicating any change of patient contact details with hospital colleagues should improve patient attendances and lessen the administrative burden on practices having to re-refer or contact patients.

*HIA point 5*

*Productive workflows.*

Building on work such as respiratory specialist nurse clinics which offer training to practice nurses in managing long term conditions such as COPD/asthma and improving outcomes in the long term (similar to the virtual clinics previously piloted for diabetes)

Also, exploring and developing a trial programme that uses primary care colleagues to help identify patients still in hospital who could safely be discharged into the community with the right support, liaising more closely with that patient’s GP and facilitating the discharge. The cost effectiveness of this will need to be assessed at the end of a specified period and, if successful, adopted by localities.

*HIA points 4, 6 and 7*

*Developing the team, personal productivity and partnership working by:*

* *Promoting primary care provision at* *scale*, where appropriate, while preserving individuality in each locality and preserving the benefits of the partnership model. Recognising different footprints for different functions and services, exploring options available to practices to achieve this, including using Somerset Primary Healthcare Limited (SPH) together with the LMC and CCG.

Functional localities already exist with practices working collaboratively in informal networks and more formal associations such as federations and these should be retained where possible.

* *Understanding work force preferences.* Establishing the “how” and “why” of GPs, paramedics, nurses and nurse practitioners wish to work in Somerset. Building on workforce initiatives such as GP in Somerset and the GP plus career schemes. Establishing why GPs are retiring early and what would encourage them to stay by offering exit interviews
* *Encourage and support each practice* to provide an environment in which all of the primary care team feel valued and supported, and where personal resilience would naturally flourish. Using streamlined services based on collaborative working will help towards this.

*HIA point 8*

* *Social prescribing* Rapid assessment of all the different schemes for village agents/health coaches/care navigators, leading to a rapid decision as to how this role is best deployed and a planned and costed scheme for introducing more staff to it..

*HIA point 9*

* *Supporting self-care* While much has been done to reduce demand on secondary care through initiatives such as GPED and Consultant Connect, little has been done on a significant level to develop pathways aimed at actively supporting patient self-care. Improving access to dieticians possibly linked via health coaches/Care Navigators/Village agents. The aim would not be to duplicate but enhance existing services and involving practices’ PPGs in the process further linking with the voluntary sector, e.g. Somerset Activity and Sports Partnership (SASP), to encourage exercise and activity in all age groups. Exploring the use of services such as virtual DESMOND, Pre-diabetes clinics which aim at promoting lifestyle changes to improve outcomes for patients.

*HIA point 10*

* *Practices engaging in QI schemes* with SPH providing facilitation and expert resources. Supporting the CCG in interpretation of figures from primary care as quality is often complex and multidimensional.

**Developing the local model & Practice at Scale**

The Board believes that there should be different footprints for different functions and services. For the most part direct patient care is best managed at practice level, high level primary care in practice clusters, and intermediate level care to a larger population again. The definition of a “locality” needs to be agreed. The Board is not yet convinced that a large care hub is necessarily the best or most cost effective way of providing urgent care services and believes this provision needs some formal modelling, despite national pressure for it to be adopted throughout England.

Whilst practices remain under continuous demand, workforce and resource pressure they do not have the capacity to release key personnel to discuss and negotiate necessary change. That means not only is progress towards effective locality working stalled, but also that a growing number of practices may seek sanctuary with a Foundation Trust, feel forced into an unsatisfactory merger, or even close.

We therefore need to make urgent progress on the preferred configuration of localities and then to adopt a tried and tested model for implementing them (such as the Primary Care Home). This will need investment in expert advisers and employed staff who can guide practices through the complexities.

**The Role of SPH**

SPH is limited company wholly owned by the practices of Somerset and as such is able to hold contracts and better manage risk, enabling practices to create economies of scale and to work more collaboratively.

In the context of this paper SPH could offer many functions including:

* Provision of the team of facilitators to support service redesign and continuous quality improvement working with LMC and CCG
* Negotiation and management of existing and proposed locality based contracts
* Developing consistent practice protocols throughout a locality, including CQC, to ensuring consistency and efficiency.
* Holding contracts for shared staff
* Appointing a shared Data Protection Officer for GDPR purposes
* Developing shared EMIS templates for clinical and reporting purposes.

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