NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

7. Primary Care COVID-19 Response and Recovery Update

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Overview

1. Oximetry at Home
2. Community Phlebotomy LES
3. Covid Mass Vaccination
4. Operational Plan 2021/2022 draft narrative

1. Oximetry at Home

- Ongoing work to evaluate the O@H project
- Project groups established
  - integrate this with STP respiratory board
  - bring both O@H and Virtual Ward together
  - address health inequalities

2. Community Phlebotomy – LES

- Q1 21/22 funded on block payment
- Intention is to proceed on cost and volume basis from Q2
- Commitment from whole system that this would be priority going forwards and find financial solution
- Final detail and specification to be confirmed

3. Covid Vaccination Programme

- 620,575 vaccinations delivered in BNSSG of which 148,275 are second doses as at 18th April recorded in NHSE Foundry
- 64% vaccines delivered by PCNs and a further 12% by community pharmacies
- National ambition is to complete first dose vaccination programme by end July
- National Booking Service open to people aged 45-49 and PCNs can invite people in this cohort if supply allows
- Extension of PCN mass vaccination national enhanced service made to support PCNs who wish to continue the vaccination programme for the next cohorts. All 19 PCNs have opted to continue in BNSSG. National guidance now received on confirming PCN continuation in the programme and the contracts team will be formally writing to PCNs
- Support meetings with PCNs where PCNs have indicated a request for support as part of the opt-in process
- Moderna vaccine now in the system at Ashton Gate
- Clinical guidance to PCNs around Astra Zeneca to support informed decision making with patients
- Actively searching for those patients who have missed their second dose

Covid Vaccination Programme

- Trial of Vaccination Coaches to support PCNs by calling people who have concerns about having vaccine
- Initiating activity for younger people:
  - 16-25 year olds: partnerships with youth organisations
  - 25-50 year olds: webinar to inform ‘influencers’
- Addressing areas of low uptake
  - Pharmacies
  - Mobile unit
  - Community clinics
- Specific clinics at Ashton Gate
  - Health and social care workers
  - Under 30s in cohorts 4 and 6
  - Pregnancy
  - Those at risk of missing second Pfizer doses due to delivery schedules
  - Eligible 16-17 year olds
- On track to complete first doses by national schedule subject to vaccine supply

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4. Operational Plan 2021/2022 draft narrative

Supporting the health and wellbeing of staff and taking action on recruitment and retention

Please set out the specific actions that, as a system, you will prioritise over the next 6 months to address the objectives below:

A3 Embed new ways of working and delivering care

- Implement staff passporting across general practice
- Providing shared decision making and virtual group consultation training
- Supporting digital nurse ambassadors to increase use of virtual ways of working
- Creation of staff bank for community and primary care, supported by an e-rostering system
- Expanding undergraduate student placements, utilising technological solutions where practicable
- Developing and embedding virtual consultations

Please set out the specific actions that, as a system, you will prioritise over the next 6 months to address the objectives below:

A4 Grow for the future

- Supporting staff and employers with new ways of working for those employed through the Additional Roles Reimbursement scheme by:
- Providing education and training in supervision arrangements for the multi disciplinary team in primary care (HEE roadmaps)
- Providing dedicated professional resources to create communities of practice for First Contact Physiotherapists, Paramedics, Physician Associates, Pharmacists, Therapies (OT, Dietician and Podiatrists), Personalised Care Roles (Social Prescribing, Care Navigation and Health Coaching), supporting the integration of new roles with primary care
- Dedicated nursing resource working between primary and social care to develop working relationships, understand the training needs for nurses in social care (prevent skill decay) and development of undergraduate placement opportunities in social care (rotating between health and social care)
- Identifying training needs to provide targeted CPD support

A4 Grow for the future – continuation

- Promoted mental wellbeing resources
- Promoting the people pulse survey in primary care
- Newly Qualified GP and Nurse Fellowships
- GP Mentoring Scheme for newly qualified GPs and General Practice Nurses (GPNs), plus extended BNSSG scheme for mid career GPs
- Supporting International GP recruits through preceptorships
- New into Practice scheme for nurses new to primary care
- Motivational Interviewing and Facilitation training for GPNs
- Expanding the number of undergraduate student placements in Primary Care for adult nursing students and AHP's
- Supporting leadership development training for GPN's (Aspiring Leaders) and CARE programme
- Develop Preparing for Partnership programme for people aspiring to move into primary care partnership roles (GP and non GP)
- Working with Learning Academy Group and University of West of England 'Futurequest' project to improve outreach to students in schools and colleges to make health and social care a career of choice
- Working with Primary Care Networks to develop workforce planning skills

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Restoring and increasing access to primary care services

Shaping better health

Please set out the specific actions that, as a system, you will prioritise over the next 6 months to address the LTP objectives below:

Getting Practice appointment levels to appropriate pre-pandemic levels

Summary of H1 Deliverables

0-3 months:

- Implementation of General Practice Activity Data Guidance by end of Q1
- Continued delivery of the Covid Vaccination Programme
- Implementation of IUC Direct Booking by end of Q1
- 100% of practices signed up to Community Pharmacy Consultation Service

3-6 months

- Restoring practice appointment levels to pre-pandemic levels
- PCNs continue to be supported to recruit maximally to ARRS
- Locality and PCN estates review complete
- Implementation of Cinapsis by end of July to support advice and guidance for Dermatology and Mental Health pathways

6-12 months

- Implementation of new improved access specification
- Achievement of targets for vaccs/imms; LD and SMI health checks and early diagnosis of cancer
- Action plan embedded following Phase 3 response to 8 Urgent Health Inequalities actions

Getting Practice appointment levels to appropriate pre-pandemic levels

General Practice Appointment Data (GPAD)
Implementation of GPAD guidance to improve data quality and accurate recording and reporting of appointments by the end of Q1.

PCN Dashboard
Effective use of new PCN dashboard to support PCNs to understand their local population health priorities and the benefits that they are delivering to their patients – including use of indicative data on performance and achievement for the Investment and Impact Fund indicators, as well as PCN service delivery and progress with recruitment.

Covid Mass Vaccination Programme
All 19 PCNs have signed up to Phase 2 of the Covid Vaccination programme. Continued system support to PCNs to participate in the vaccination programme whilst supporting recovery – access to staff bank and volunteers to support with workforce, continued support for ARRS to support vaccination programme, developing health coach offer to support PCNs with encouraging uptake, virtual system hub to support vaccination allocation in the system, maximising uptake work stream with system partners developing offers for population cohorts, 2 x weekly Q&A sessions with PCN leads to share best practice, disseminate communication and provide regular mutual aid support. *We are currently validating the inclusion of mass vaccination data within the GPAD*

Getting Practice appointment levels to appropriate pre-pandemic levels

Covid Expansion Fund and local commissioner support for capacity
Covid Expansion Fund to support key recovery outcomes and the 7 national goals
CCG has confirmed continued income protection arrangements for Local Enhanced Services in Q1 in line with other providers
System prioritisation tool and guidance developed for general practice in line with BMA guidance which will continue to be reviewed as we progressively recover from Covid

Covid pandemic
Our activity assumptions assume continued steady state of low Covid rates in the first 6 months of the year

QOF 2021/2022
Provide practice stability and support recovery.
Four indicators have been agreed to comprise the new vaccination and immunisation domain, transferring almost £60m from DES to QOF in 2021/22.

Investment and Impact Fund
IIF funding in 21/22 will incentivise improvements in access for patients, new indicators to be phased
Indicators for flu, LD health checks and social prescribing referrals continue for 21/22

Getting Practice appointment levels to appropriate pre-pandemic levels

Continuing to support clinically vulnerable patients

- Restore service levels and face to face appointments
- Protect the most vulnerable
- Better engage those who need most support
- Ensure datasets are complete to understand and address inequalities
- An inclusive communication and engagement plan for co-design
- Having clear definitions and aligning vulnerable, health inequalities, medical vs non-medical and social determinants of health
- Building on the integrated ways of working and scaling up as part of a preventative, proactive, personalised approach to integrated care

Ethnicity Coding

Continue work to further improve completeness and accuracy of ethnicity data recording achieved during Covid vaccination clinics and flu clinics.

Getting Practice appointment levels to appropriate pre-pandemic levels

Learning Disabilities (LD)

Embed and build on the targeted interventions from 2020/21:

- Embed work for improved coding to address incorrect coding errors and assist with accurate identification and reporting
- From the success of the pilot rollout the LD champions programme to all GP practices across BNSSG supported by Community Learning Disabilities Team staff
- Develop further specific training sessions for practice nurses & other practice staff involved in LD Annual Health Check (AHC) completion
- Ensuring Health Action Plans are produced as a result of the AHC
- Targeted support for practices with high numbers of patients with LD
- Targeted support for practices with low AHC compliance
- Engage GP LD Leads and PCN Clinical Directors to support delivery - work with PCNs to set up local LD forums and 'buddy' practices with high compliance with those who are struggling
- Regular prompts and support calls to practices about progress with annual health checks.
- Provide pertinent information on reasonable adjustments, coronavirus issues, vaccine, mental capacity act, best interests decision making and consent etc.
- Linking AHC to various quality improvement projects e.g. STOMP and improving uptake of cancer screening (particularly bowel cancer)
- BNSSG will develop one agreed easy read AHC template on EMIS
- Develop AHC audit tool with LD GPs – auditing 5 AHC per practice
- Quality Audit of AHC planned for April 2021 - Ensuring that health checks are comprehensive and actions following the health check are identified and followed up.

Getting Practice appointment levels to appropriate pre-pandemic levels

Severe Mental Illness (SMI) Physical Health Checks

NHSE will invest a further £24m into QOF from April in order to strengthen the indicator set and support uptake.

Addressing health inequalities and improving the physical health of those people with severe mental illness is a priority for our system.

- Dedicated steering group in place sitting under the Community Mental Health Programme Board driving this work forward.
- Continue to work with practices to ensure the data can be extracted and support offered where needed to improve uptake for the physical health checks and outcomes for our population

Supporting Earlier Cancer Diagnosis

Continue messaging to encourage and provide assurance for our patients to come forward and therefore restoring 2 week wait referral levels. Focus planned on Lung Cancer pathways as this is the area which is slowest to recover.

Obesity and Weight Management

Introduction of an enhanced service on obesity and weight management as early as circumstances allow during 2021.

Getting Practice appointment levels to appropriate pre-pandemic levels

Capacity Planning

- Capacity modelling tool for primary care in place to feed into wider system planning and understanding
- Roll out of Primary Care escalation plan and OPEL status reporting for practices to support system-wide approach to escalation reporting and action planning
- Continuation of Improved Access (IA) to support focus on recovery, provide services for vulnerable groups and catch up opportunities.
- Implementation of Integrated Urgent Care (IUC) Direct Booking in addition to continuation of 111 Direct Booking, capacity based on 1 per 500 practice population
- Implement system plans to support the flu programme and to identify opportunities for partnership working to support delivery
- Modelling of capacity impact from recruitment to PCN Additional Roles Reimbursement Scheme

Managing demand

- Continue to monitor, review and further update activity prioritisation guidance developed to support general practice as part of restoration
- Communications team continue to publicise access to primary care to support public understanding that primary care is open and appointments may be delivered in new ways
- Embed the use of new models of access including telephone triage, video and online consultation tools
- Increase awareness and signposting to self-care options
- Implementation of Cinapsis in Q1 to improve access to advice and guidance – initially for Dermatology and Mental Health Services

Getting Practice appointment levels to appropriate pre-pandemic levels

Digital Enablers

- Roll out of N365 to support MDT working
- Roll out of improved WiFi in practices
- Sign up to ORCHA for Clinical App safety monitoring
- Implementation and roll out of improved advice and guidance capability through Cinapsis
- Implementation of Elemental to support Social Prescribers
- Remote monitoring for Long Term Condition management

Quality and Resilience

- Quality and Resilience dashboards in place to support identification of practices which would benefit from quality and resilience programme support. Quality and resilience team have toolkit and processes in place to support practices which may benefit from targeted support and this is supported by LTP transformation funds. Regular review of dashboards at monthly Quality, resilience and contracting sub-group of PCOG and progress tracking reported at PCCC. Packages of intensive support for practices developed with system partners – One Care and the LMC.

Estates

- CCG has commissioned a locality and PCN estates review to take place during H1. This will include a number of key outputs:
  - Locality workbook with baseline of current community estate
  - Development of PCN estate strategies
  - Development of locality (place) estate strategies
  - BNSSG outputs document summarising the work across the 6 localities and developing prioritisation for future capital development

Next steps

- Healthier Together Executive review and feedback
- Draft plan submission (narrative, activity and workforce) to NHSE 6th May 2021
- NHSE feedback and local plan iteration
- Final plan submission to NHSE 3rd June 2021