NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Primary Care Network Development

Primary Care Commissioning Committee

29th January 2019

NHS Long Term Plan

- Expanded community multidisciplinary teams aligned with new Primary Care Networks based on neighbouring GP practices
- Individual practices in a local area will enter into a network contract, as an extension of their current contract, and have a designated single fund through which all network resources will flow.
- Most CCGs have local contracts for enhanced services and these will normally be added to the network contract.
- Expanded neighbourhood teams will comprise a range of staff such as GPs, pharmacists, district nurses, community geriatricians, dementia workers and AHPs such as physiotherapists and podiatrists/chiropodists, joined by social care and the voluntary sector.

Aspirant ICS – PCN Development

- In recognition of the importance of strong primary care at the heart of integrated care systems within the community
- Funding allocation of £473,000 (non-recurrent 18/19) to support the development of primary care networks using the primary care maturity matrix
- Assessment of localities against the maturity matrix was undertaken by the CCG in partnership with Locality Board Members; Locality Provider Forums and One Care
- Helpful process to identify steps to development of networks
- Most localities are demonstrating successful delivery of elements within step 1, and several also have identified what they would need to build the capacity and maturity required to move to step 2.

	Foundations for transformation	*Step 1*	*Step 2*	*Step 3*
Right scale	**Plan:** Plan in place articulating clear vision and steps to getting there, including actions at network, place and system level.	**Practices identify PCN partners** and develop shared plan for realisation.	PCNs have **defined future business model** and have early components in place.	**PCN business model** fully operational.
Integrated working	**Engagement:** GPs, local primary care leaders and other stakeholders believe in the vision and the plan to get there.	**Analysis on variation** in outcomes and resource use between practices is readily available and acted upon.	Functioning **interoperability within networks,** including read/write access to records, sharing of some staff and estate.	**Fully interoperable IT, workforce and estates** across networks, with sharing between networks as needed.
Targeting Care	**Time:** Primary care, in particular general practice, has the headroom to make change.	**Basic population segmentation** is in place, with understanding of needs of key groups and their resource use.	All primary care clinicians can access **information to guide decision making**, including risk stratification to identify patients for proactive interventions, IT-enabled access to shared protocols, and real-time information on patient interactions with the system.	**Systematic population health analysis** allowing PCNs to understand in depth their populations' needs and design interventions to meet them, acting as early as possible to keep people well.
Managing resources	**Transformation resource:** There are people available with the right skills to make change happen, and a clear financial commitment to primary care transformation.	**Integrated teams**, which may not yet include social care and voluntary sector, are working in parts of the system.	Early elements of **new models of care** in place for most population segments, with **integrated teams** throughout system, including social care, the voluntary sector and easy access to secondary care expertise. Routine peer review.	**New models of care** in place for all population segments, across system. Evaluation of impact of early-implementers used to guide roll out.
Empowered Primary Care		Standardised end state **models of care** defined for all population groups, with clear gap analysis to achieve them.	**Networks have sight of resource use and impact on system performance**, and can pilot new incentive schemes.	PCNs take **collective responsibility for available funding.** Data being used in clinical interactions to make best use of resources.
		Steps taken to ensure **operational efficiency** of primary care delivery and support struggling practices.	Primary care plays an **active role in system tactical and operational decision-making,** for example on UEC	**Primary care providers** full decision making member of ICS leadership, working in tandem with other partners to allocate resources and deliver care.
		Primary care has a **seat at the table** for system strategic decision-making.		

Areas Identified for Accelerated Support

1. Organisational and leadership development within localities (£230,000)

- Discussions have begun with Locality Provider Boards as to how we might develop alliance arrangements between providers to begin to deliver integrated services at a locality level.
- This will require significant organisational development support and a consideration of future business models.
- The intention is to use this funding to enable localities to access accelerated support for this work.
- A key element of this programme will be focused on working with the leadership and practices to enable them to develop their capability to work together as part of such an alliance.
- Bring practices together in clusters and localities to develop a shared vision and common purpose, and in turn to enable localities to work with maturity as part of a provider alliance
- NHS England support to developing business models
- Locality Provider input sort into specification of Organisational Support required
- Specification to be completed – 31/01/19

Areas Identified for Accelerated Support

2. Defined models of care with integrated teams (£140,000)

- Building on programme of work as part of Healthy Weston, extend the innovative work on the frailty model of care across BNSSG.

- Facilitate the accelerated development of a detailed business case for an integrated frailty model for Weston.
- The funding and programme will then be utilised to expand the work completed into a BNSSG wide specific service delivery, taking account of the individual nuances and population requirements of each of the remaining localities

  - Locality specific data and anticipated service demand review

  - Locality specific model of integrated frailty pathway delivery aligned to the BNSSG model with appropriate locality specific design.

  - Indicative design and implementation time line including resource requirements.

  - Document setting out the lessons learnt and best practice examples regarding both model of service delivery and how to achieve a successful implementation.

- Procurement for support commenced

Areas Identified for Accelerated Support

3. Development of Population Health Management in Primary Care (£100,000)

Significant opportunities in BNSSG with a single instance of EMIS across BNSSG supported by One Care, enabling a consistent approach to the developing use of primary care data.

- Currently, five practices have provided data for linking to other datasets in a pilot. The ambition is for all practices to share data routinely to enable linking with other provider datasets and enabling longitudinal views of population health.
- The Aspirant ICS Programme is enabling us to develop a Population Health Management tool – linking primary care data with other datasets is the critical starting point.
- To accelerate progress funding would provide additional capacity to:

  -Accelerate use of data already linked with EMIS to demonstrate the value of linking data working with One Care

  -Developing risk stratification/segmentation algorithms

  -Engaging with other practices and providers to build linked dataset further
- Embedded in BNSSG HT led PHM programme

Outline Delivery Plan

	Nov	Dec	Jan	Feb	Mar	Apr
OD and Future Business Models						
Specification Developed						
Support procured						
Support in place and working with localities						
Leadership Development for localities						
Population Health Management						
PHM workshop	23rd					
Engagement with practices on data sharing						
Models of Care Development						
Develop faculty transformational approach						
Phase 3 models of care first workshop (frailty)		**6th**				
Integrated models of care programme: Phase 3 LTS						

Impact on Maturity Matrix

- January – March 19
  - 100% Step 1
  - Development towards Step 2
- Localities may progress differently to Step 2
- Step 3 achieved by March 2020