City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Bradford District and Craven Health and Care Partnership to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 6 October 2022 H

Subject: Update on Primary Care - General Practice

Summary statement:

This report and appendices provide HOSC members with an update on Primary Care – General Practice since the last report provided to this committee in September 2021.

The report contains an update on the following key areas:

- Summary
- Background
- Core local systems and nation planning priorities
- National Primary Care Review (The Fuller Report)
- Covid 19 update
- Primary Care Enhanced Access
- General Practice Primary Care Core Access
- Primary Care General Practice Workforce
- Workforce Development and Care Navigation
- Primary Care Workforce Health and Wellbeing
- Community Partnerships
- Addressing Health Inequalities

We would also like to acknowledge the tremendous efforts our General Practice and system partners are making to continue to deliver primary care services, including moving back to business as usual, whilst delivering the Covid-19 autumn booster programme, within the current workforce challenges and increase in patient needs for access to primary care.

Portfolio:

Healthy People and Places

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1. Summary

This report and appendices provide HOSC members with an update on Primary Care – General Practice since the last update provided to this committee in September 2021.

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2. Background

2.1. Since the last primary care update to HOSC, under the new Health and Care Act 2022, CCGs were abolished, and Integrated Care Systems (ICS) became live from the 1st of July 2022. Under these new arrangements Bradford District and Craven Health and Care Partnership has been established and is delegated by our West Yorkshire ICS to lead at Place level. Both systems have an explicit purpose to improve health outcomes for their whole populations. The new legislative framework is designed to enable decisions to be taken as close as possible to their local populations for maximum benefits and outcomes delivered by working through multi-partnership arrangements.

Previously primary care – general practice was delegated by NHSE to the CCGs, under the new arrangements these primary care – general practice delegations have been assigned to the West Yorkshire ICS (WYICS) who in turn have delegated this responsibility to Bradford and Craven Health and Care Partnership.

The Health and Care Act 2022 has also directed that Pharmacy, Optometry and Dentistry (POD) should also be delegated to the ICS from 1st April 2023. Work is on going via design workshops on how and what functions of the PODs will be delegated from NHSE to WYICS and then down to Place.
(This report does not detail in full the WYICS arrangements as these have been presented to the committee in previous reports.)

3. Core local systems and national planning priorities

3.1. National

The NHSE Planning Guidance published for 2022-23 identified the following 10 key priorities:

1. Workforce investment, including “strengthening the compassionate and inclusive culture needed to deliver outstanding care”.
2. Responding to covid-19.
3. Delivering “significantly more elective care to tackle the elective backlog”.
4. Improving “the responsiveness of urgent and emergency care and community care capacity.”
5. Increasing timely access to primary care, “maximising the impact of the investment in primary medical care and primary care networks”.
6. Maintaining “continued growth in mental health investment to transform and expand community health services and improve access”.
7. Using data and analytics to “redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities”.
8. Achieving “a core level of digitisation in every service across systems”.
9. Returning to and better “pre-pandemic levels of productivity”.
10. Establishing integrated care boards and collaborative system working, and “working together with local authorities and other partners across their ICS to develop a five-year strategic plan for their system and places”.

These priorities have been embedded into the CCGs and now the ICSs delivery plans. All these priorities link back into primary care, but key focus will be on numbers 5 and 10.

3.2. Local

Bradford District and Craven, Health and Care Partnership have set with partners 5 key strategic priorities for 2022 – 2024.

Based around the following:

- Purpose - Inverting the Power to Act
- Population – Recovery from Covid
- Place – Prevention of ill health

- Partnership – Workforce and Organisational Development
- Spotlight – Children and Young People

These strategic priorities will support us and our system partners to focus on local areas to improve health outcomes. By working in partnership, we can share a common purpose and get greater value through the best use of resources and reduce duplication. Therefore, the health and care partnership have ambitions to an agreed 1% shift of funding to invest towards early intervention and prevention.

Review all our programmes including Act as One programmes, such as, Aging well, diabetes, better births, children and young people's wellbeing, healthy hearts, Access to health and care. We will be reviewing these programmes to ensure that they are still aligned with our key strategic priorities and that they do not overlap or duplicate other work programmes.

4. National Primary Care Review (The Fuller Report)

Amanda Pritchard – Chief Executive of the NHS commissioned Professor Claire Fuller to lead on the review of primary care and how it could be supported within the Integrated Care Systems (ICS).

Following the review, a report was published titled "Next steps for integrating primary care: Fuller Stocktake report in May 2022.

An overview of the report findings is detailed below:

Dr Fuller has set out a vision for the future of primary care, with practical actions that ICS and national leaders can take to work with primary care to make the changes needed to deliver this vision. The vision focuses on four main areas:

- neighbourhood teams aligned to local communities.
- streamlined and flexible access for people who require same-day urgent access.
- proactive, personalised care with support from a multi-disciplinary team in neighbourhoods for people with more complex needs, and more ambitious and joined-up approach to prevention at all levels.

Informed by wide-reaching engagement, the vision builds on what is already working in primary care, while recognising work is needed to create stability within general practice to deliver change. It outlines the need for a system-wide approach to workforce, data, and estates to make more effective use of capacity and capability.

<u>The vision for the future of primary care:</u>

Integrated neighbourhood teams

Systems should support primary care to build on the primary care network (PCN) structure by coming together with other health and care providers within a local community to develop integrated neighbourhood teams at the 30,000-50,000 population level. This will help to realign services and workforce to communities and drive a shift to a more holistic approach to care.

This means putting in place the appropriate infrastructure and support needed to build these multi-disciplinary teams, so they can proactively tailor care to meet the needs of particular communities and individuals in their local population, with a particular focus on the most deprived 20 per cent of their population (Core20PLUS5).

Streamlined access

To improve access, primary care should be supported to offer streamlined access to urgent, same-day care and advice from an expanded multi-disciplinary team and given the flexibility to adapt their service to local need. Data and digital technology should be optimised by systems to connect existing fragmented and siloed urgent same-day services, empowering primary care to build an access model for their community that gives patients with different needs access to the service that is right for them. This will also create resilience around GP practices by connecting patients to the practitioner who meets their need, rather than increasing GP referrals to additional services, increasing practices' capacity to deliver continuity of care.
Personalised care for those who need it, people should be able to access more proactive, personalised support from a named clinician working as part of a multi-professional team. To achieve this, development of neighbourhood teams providing joined-up holistic care to people who would most benefit from continuity of care in general practice (such as those with long-term conditions) should be supported and delivered in partnership with system partners and primary care.
This model of care should offer greater shared decision-making with patients and carers and maximise the role of non-medical care staff, such as social prescribers, so people get the care they need as close to home as possible.

Helping people to stay well for longer

There should be a more ambitious and joined-up approach to prevention for the whole of health and care with a focus on the communities that need it most. System partners should work collectively across neighbourhood and place to share expertise to understand what factors lead to poor health and wellbeing and agree how to work together proactively to tackle these.

This means building on what primary care is already doing well to improve local community health: working with communities, effective use of data, and relationships with local authorities while harnessing the wider primary care team including community pharmacy, dentistry, optometry, and audiology, as well as non-clinical roles.

Creating the environment for change

The report also includes steps that can be taken to create the right environment for change:

Locally driven change

- Local decision-making should be maximised to enable the delivery of improved support at a local level. NHS England and NHS Improvement (NHSEI) should consider what investment could be devolved to ICSs as part of the implementation of the wider recommendations.

- NHSEI should also consider combining and simplifying central programme and transformation budgets for primary care.
- Creating the capacity

Workforce

- Workforce capacity remains a huge pressure on primary care. There must be a continued focus on recruiting and retaining GPs and the wider primary care workforce, alongside optimising current capacity with a long-term, system-wide workforce strategy that includes primary care.
- The report welcomed progress made in recruitment through the Additional Roles Reimbursement Scheme (ARRS). However, it recognised there needs to be improvements in supervision, development, and career progression. Systems and national leaders also need to support PCNs to deliver the ARRS offer post-2024.
- More work is also required to make primary care more attractive to staff by addressing work-life balance, parity with other NHS career paths, and making a portfolio career more accessible. Training and education to encourage career development should be rolled out across primary care, from clinical to managerial and reception roles.

Estates

- Estates that are not fit for purpose can impact how well providers can collaborate. Therefore, there needs to be greater weighting of capital investment to primary care estates, informed by a detailed review of physical space within systems to build a one public estate approach.
- NHSEI and the Department of Health and Social Care should consider what flexibilities and permissions should be afforded to systems to build estates capability.

Data and digital

- Shared data and digital capabilities can play a big part in joining up services and help the whole health and care system to deliver care informed by local knowledge.
- A shared patient record, interoperability and system-level data analysis capabilities are essential to planning and delivering service in a coherent way.
- ICSs should develop coherent plans to data sharing and cross-system IT infrastructure, supported by NHSEI.
- Building sustainability

Infrastructure

- To ensure the right environment for improvement, there needs to be stability in general practice across all parts of the country. This can be achieved by:
    - utilising at-scale providers, such as GP federations, to enable general practice to work with other providers
    - providing support where there are gaps in provision or services which are deemed inadequate by the Care Quality Commission.

- back-office support such as HR, finance and organisation development to be delivered by at-scale providers such as GP federations or NHS trusts.

- At a national level, there should be consideration of the contractual and funding levers needed to create the right environment for integration and improving local health outcomes.
- At a system level, there needs to be accountability for delivery of integrated primary care reflected in the ICS accountability framework. This should include tailored support to practices to improve and, where appropriate, actively commission new providers of integrated list-based primary care that includes a focus on quality improvement.

Leadership and representation

- The report outlines the importance of primary care leadership and representation across the whole system. It states that investing in
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- leadership at PCN, place and system level will be the difference between success and failure in integrating primary care.

The report finishes with a framework for shared actions focusing on 15 areas that holds both NHS England and ICSs to account for delivery. These are detailed in **Appendix K** - (The Fuller Review of Primary Care and framework for actions)

5. Covid 19 - Update

5.1. Phase 3 Covid -19 update- Bradford District and Craven Strategic Approach:

5.2. As reported in previous reports primary care – general practice and our 12 PCNs have played an integral part in supporting the Covid-19 vaccination and booster programmes. Though Covid-19 infections are down nationally to combat the risk of another widespread epidemic it is important that we continue to deliver the autumn Covid-19 booster programme, *3rd covid -19 vaccinations along with the winter flu vaccinations.
**3rd covid vaccination is for those aged 5 and over who had a severely weakened immune system when they had their first 2 doses, will be offered a 3rd dose before any booster doses.*

The JCVI has identified the following priority groups for the Covid-19 booster:

- Residents in a care home for older adults and staff working in care homes for older adults.

- Frontline health and social care workers

- All adults over 50 years of age

- Persons aged 5 to 49 years in a clinical risk group

- Persons aged 5 to 49 years who are household contacts of people with immunosuppression

- Persons aged 16 to 49 years who are carers

All our PCNs have either opted in or are working in collaboration with another PCN to deliver this year's booster programme.

Appendix A – Outlines our PCNs arrangements and location of the sites for the delivery of the booster programme.

Appendix B – Shows that as a system we have administered a total of 284,353 covid-19 boosters or 3rd vaccinations indicating 73.2% of our eligible population, with approximately 97% representing all patient cohorts that have received a vaccination.

5.3. **Long Covid:**

Long Covid continues to have an impact on our population. As per NICE/SIGN/RCGP guidance, 'Long COVID' is a commonly used term to describe:

- ongoing symptomatic Covid-19: signs and symptoms of Covid-19 from 4 to 12 weeks
- post-Covid-19 syndrome: signs and symptoms that develop during or after Covid-19 and continue for more than 12 weeks and are not explained by an alternative diagnosis

NHSE in July 2021 up to March 2022, introduced to primary care – general practice an Enhanced Service with financial support to manage patients presenting with Long Covid symptoms, including developing pathways and learning from these complex conditions. NHSE have renewed the Long Covid Enhanced Service from the 1st April 2022 for 12 months and all our practices have signed up to deliver this service.

Currently, our data systems have identified 88 patients with a diagnosis of Long Covid, however we are aware from local conversations that the patient numbers are likely to be higher than reported and data will improve as practices get used to the new clinical coding.

5.4. **Practice Closures during Covid-19**

We previously reported that 4 of our practices (branch sites) were still unable to open due to either workforce capacity or operating under safe covid conditions. We are pleased to report that all our practices and branch sites are now open and accessible to patients.

5.5. **Support to care home residents**

We know that older residents are more vulnerable and at risk of covid-19 and breakouts in care homes can have a devastating affect not only on individuals, their families but also place urgent care and hospital admissions under strain. This year

NHSE have asked PCNs to prioritise care home residents for the booster programme and complete by the 29th of November 2022 to reduce the risk of a Covid-19 breakout in our care homes, keep residents safe as well as supporting the winter impact and pressures on urgent care.

6. Primary Care – Enhanced Access

6.1. In March 2022 NHS England and Improvement (NHSEI) published requirements for the contractual arrangements providing access to primary medical care services outside of core hours (8:00am to 6:30pm) to transition to Primary Care Networks (PCNs) from 1 October 2022.

This requires a transition from previous commissioning arrangements for equivalent services. In Bradford District and Craven, the existing contractual arrangements for appointments outside of core hours consist of:

a) CCG Commissioned Extended Access Service (defined as 7 days a week before 8.00am and between 6.30pm to 8.00pm)

b) PCN Funded Extended Hours Access Service (defined as working week before 8.00am and between 6.30pm to 8.00pm)

Locally these two services have been merged and delivered as a single access scheme providing a 7-day GP appointments service. This includes appointments offered before 8am or from 6:30pm to 8pm on weekdays and is inclusive of service provision on weekends and Bank Holidays.

The new national requirements formally merge these arrangements into the single Enhanced Access service to be delivered by PCN's in Network Standard Hours i.e., 6.30pm to 8pm Mondays to Fridays and 9am to 5pm on Saturdays, from the 1st October 2022.

6.2. **New PCN Enhanced Access Requirements**

Enhanced Access has been introduced to the PCN DES from October 2022. Requirements for the PCNs from 1st October 2022 can be summarised as:

a) 6.30pm and 8pm Mondays to Fridays and between 9am and 5pm on Saturdays (network standard hours).
b) A minimum of 60 minutes of appointments per 1,000 PCN adjusted populations per week.
c) GP cover during the network standard hours.
d) Appointments must be bookable in advance and same day.
e) Must deliver a mixture of in person face to face and remote.
f) PCNs must deliver general practice services, including appointments for planned care like screening, vaccinations (including COVID-19 vaccinations and boosters) and immunisations, health checks and PCN services.

g) Appointments must be delivered by a multi-disciplinary team of healthcare professionals.
h) Must make available to NHS 111 any unused on the day slots during the Network Standard Hours.
i) PCNs must actively communicate availability of Enhanced Access appointments to patients.
j) Sites at which face-to-face services are to be provided must be at locations convenient to access for patients.

These criteria are important to note again now as some of the new requirements will see a change to access, particularly on Sundays and Bank Holidays that no longer form part of the PCN Network Standard Hours. Nationally feedback has been DNA rates are high during these periods leading to the change in national policy.

Appendix C – Details new Enhanced Access arrangements from the 1st October 2022.

7. General Practice - Primary Car Access during core hours

7.1. General practices are contractually required to deliver core primary care services and makes these accessible to their patients from the hours 8.00am to 6.30pm Monday to Friday.

7.2. This includes same day urgent and pre-bookable appointments. Since the pandemic primary care -general practice has seen a significant increase in demand. However, following a return to pre-pandemic appointment levels for 2021 / 2022, the number of GP appointments delivered shows a moderate increase into 2022 / 2023.

As of June 2022 (359,297) appointments were delivered in Bradford District and Craven an increase of (14,767) on the previous year and an increase of almost 60,000 appointments in comparison to pre-pandemic levels

The mode of delivery for appointments also shows an increase in Face-to-Face appointments. 231,057 appointments have been delivered Face-to-Face an increase of 10,338 appointments, approximately 60% of total appointments are currently delivered Face-to-Face.

Practices are currently transitioning from NHSE's directive of 'Total Triage' as established in the Covid response, i.e., remote appointments as a precursor to Face-to-Face appointments, to models of service delivery that accommodate increased patient preference for direct in person appointments, whilst still maintaining covid safe environments.

Workforce pressures to meet service demand remains a pressure point for Primary Care. Though appointment levels have increased by approximately 60,000 appointments in comparison to pre-pandemic the Full Time Equivalent GP staffing rates have remained at 0.6 per 1,000 patients for the same period.

E-consults continue to be used more so by the younger cohort of patients and have achieved a steady state since first introduced during the beginning of the Covid pandemic. ICS is looking to procure a new e-consult software model later in the year.

The following **Appendices D to I** and **Appendix J** gives a further breakdown of the various types of access data:

- **Appendix D** GP appointment

Appendix D – shows total appointments delivered within primary care as of June 2022, which is the last published national data set. Though we have seen an overall increase of additional (14,767) appointments compared to last year (7,904) of these appointments delivered from December 2021 to March 2022 were because of additional *****winter access funding being made available centrally, which enabled GP practices to take on additional staff and locum GPs.

*******There is no indication at the time of writing this report that any further winter access funding will be made available to primary care for 2022.*

- **Appendix E** Mode of GP Appointments

Appendix E – shows mode of GP appointment types, over 60% of all appointments were delivered face to face, followed by telephone consultations. As per patient demand and change in national direction of offering all patients a face to face if they so wish we are seeing a steady increase.

- **Appendix F** Time Taken from Booking to Receiving an Appointment

Appendix F - details time taken from patients requesting and booking an GP appointment. A significant number of our patients can book a same day appointment, whilst those waiting over the 2 weeks wait time is below a 1000.

- **Appendix G** GP Online Consultation / e-Consult Data

Appendix G – Shows e-consult usage and rates per 1000 population, there has been some decline compared to last summer, this in part is due to more patients requesting and seen by either face to face or telephone appointment.

- **Appendix H** Consults by age

Appendix H – shows patients using e-consult by age. Those aged between 25 to 64 appear to by the highest users of this method of contacting general practice and receiving information via e-consult. We will be exploring this further, but it could be due to younger age group being more comfortable using technology and working age patients who may find it more convenient to fit around their working hours.

- **Appendix J** – Patient 111 Calls (April 21 to June 22 Data)

Appendix J – Shows call made to the 111 service, 53.2% of these calls are non - urgent and patients referred into primary care.

As part of the new access arrangements, we are working 111 call handlers to be able to directly book patients into general practice appointments slots as well as our enhanced access providers systems.

8. Primary Care general practice workforce

8.1. Primary Care general practice workforce continues to be a challenge. Despite national and regional recruitment campaigns there are not enough GPs coming into the system and those that are do not see our Place as an attractive proposition. **Table 1** below shows the GP to Patient Ratio on the previous CCG footprints.

Compared to the same time last year Bradford District and Craven is down by 2 GPs. However, these figures are taken from a national data set which we are aware has recording issues, as well as including locums into these overall figures.

Table 1

GP to Patient Ratio

Bradford District and Craven Health and Care Partnership ACTasONE

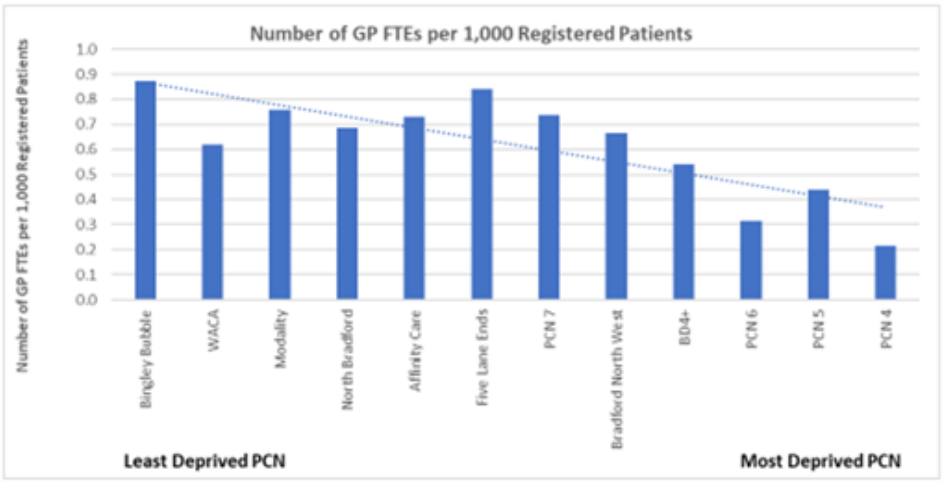
	Total GPs FTEs			Total Registered Patients			Number of GP FTEs per 1,000 Registered Patients		
CCG	Dec-21	May-22	Jul-22	Dec-21	May-22	Jul-22	Dec-21	May-22	Jul-22
Bradford District & Craven CCG	406.6	405.5	404.5	647970	650982	651895	0.6	0.6	0.6
Leeds CCG	557.8	541.7	539.6	908875	909779	908742	0.6	0.6	0.6
Wakefield CCG	244.7	233.7	228.8	383381	389187	389787	0.6	0.6	0.6
Kirklees CCG	233	234.4	232.7	449540	451128	451426	0.5	0.5	0.5
Calderdale CCG	114.9	109.9	109	222299	222705	223027	0.5	0.5	0.5

West Yorkshire Health and Care Partnership

Table 2 below also demonstrates that the more deprived a PCN the less likely it is able to attract and retain full time GPs

Table 2

GPs per PCN



We have commissioned our local Health Education England, Training Hub team over the next 12 months to carry out a review of our current GPs and Practice Managers, modelling how many are likely to leave general practice through retirement or other planned moves. This will then enable us to work with system colleagues and primary care on future workforce capacity and develop future development and recruitment plans.

8.2. **Additional Role Reimbursement Scheme (ARRS)**

Under the Primary Care Network DES, PCNs are able to recruit to additional new roles under the ARRS to further boost and compliment the primary care workforce and free up GP time for those patients that need to be seen by a GP, whilst the wider ARRS workforce can focus on patients with low level needs.

The following ARRS are shared amongst the practices within a PCN and are nationally funded at 100% apart from Mental Health Practioners which are 50% nationally funded via the ARRS scheme and 50% via the Mental Health Foundation Trust.

- Clinical Pharmacist
- Pharmacy Technician
- Social Prescribing Link Worker
- Health and Wellbeing Coach
- Care Co-ordinator
- Physician Associate
- First Contact Physiotherapists
- Dieticians
- Podiatrists
- Occupational therapists
- Mental Health Practitioner
- Paramedic
- Nursing Associate

Our ARRS allocation based upon our PCNs population size is approximately £7.8m, the table 3 below shows current ARRS roles that are employed within our PCNs, with data taken from the national ARRS reporting portal which is usually a few months behind actuals.

Table 3

Role/FTE	Social Prescriber Link Worker	Pharmacist	Physio	Physicians Associate	Paramedic	Pharmacy Technician	Podiatrist	Occupational Therapist	Nursing Associates	Trainee Nurse Associate	Practice Manager	Practice Nurses
Bradford District & Craven	4.0	28.1	2.8	8.3	5.7	2.0	0.0	2.5	1.0	3.0	112.7	136.0

However, despite the additional investment PCNs are struggling to find enough capacity in the labour workforce market to meet demand. Primary care estates are another key issue in being able to accommodate the ARRS roles.

We are working PCNs and at ICS level to develop our future estates strategies that can support a future integrated primary and community care service.

8.3. **Promoting Additional Primary Care Roles and news ways to access**

Making use of Winter Access funding from NHS England, the Access to Primary Care communications campaign is an insight-led campaign across Bradford District and Craven to support colleagues working in primary care by increasing public awareness of the ARRS and range of services at GP practices, and how they can be accessed. The campaign aims to support general practice teams and improve patient care by increasing the public's understanding of the different services offered by healthcare professionals at GP practices and encouraging patients to access these services via the most suitable routes.

The campaign has been developed with colleagues at Magpie, a creative behaviour change agency. Together, we have worked with patient groups and primary care staff across Bradford District and Craven to co-create the most effective campaign approach and messaging.

Patients identified that the campaign needs to;

- Show the different ways in which GP practices can be accessed
- Remove the mysticism around how triaging works
- Frame Primary Care staff as a team of specialists
- Show real routes to care that meant people avoided taking time away from work or children out of school
- Reinforce the expertise of Primary Care staff and raise awareness of some of the common medical problems that they're trained to deal with
- Address our audience in an empathetic tone

Patients participating in the research overwhelmingly used (and preferred) the phrase 'GP Practice'. The resulting campaign, 'It's a GP Practice thing', which

showcases the multi-disciplinary roles within GP practices and how each role can help patients, has been built on behavioural science.

The campaign will launch in early October 2022 and will feature images of local staff to reflect the local communities. Materials which will be made available to practices will include posters and leaflets, as well as digital images and a video how-to guide for accessing practice online services, which will be shared via social media, websites and screens in practice waiting areas. The materials have been carefully designed to ensure accessibility for varying levels of literacy and for those whose first language is not English and will be translated into a number of key local community languages.

9. Workforce Development and Care Navigation

Making use of Winter Access funding from NHS England, Conexus, a GP federation in Wakefield, were commissioned to review Care Navigation across Bradford District and Craven and identify future training needs to ensure a consistent approach across all practices. Since 2016, Conexus has successfully developed a safe, sustainable, and scalable care navigation model that has been rolled out nationwide. Care navigation is a tried and tested model of care that improves access to primary care services for patients whilst also reducing pressure on GPs. It allows frontline staff to provide patients with more information about local health and wellbeing services, both within and outside of primary care, in a safe, effective way. Care navigation offers the patient 'choice, not triage' to access the most appropriate service first, which - as is well evidenced - is not always the GP. Over 30% of practices in England and 27% of practices in Wales have care navigators who have been trained by Conexus Healthcare.

Conexus began with an initial stocktake, using a survey shared with practices and data from the Care Navigation dashboard to understand how Care Navigation was being implemented across Bradford District and Craven Place. Following this, and in consultation with Primary Care colleagues, Conexus has developed a bespoke package of training to refresh and enhance previous Care Navigation training and up-skill frontline General Practice primary care staff.

Conexus are currently working with PCNs to determine a delivery plan with training commencing from October 2022, to suit practice and PCN needs. The training available is designed to empower all staff and practices to deliver care navigation consistently and robustly and will include provision of essential skills training i.e., how to support and advise patients, conflict resolution and management, assertiveness skills, communications skills etc.

Conexus will also work with PCNs to validate and update Care Navigation templates to facilitate Care Navigators in sign-posting and referring patients to the most appropriate service to meet their needs in a timely and efficient manner. Using Care Navigation rather than referring all patients directly to a GP by default improves patient care by making best se of the wider clinical workforce in primary care, ensuring access to the member of staff with the most suitable skills to meet patient

needs and is often quicker than waiting for a GP appointment. It will also support and develop particularly our front-line staff on how to communicate more effectively with patients, being mindful of the patient's circumstances, whilst making best use of available both clinical and other resources.

As part of our PCN and Primary Care Organisational Development Plan we will further build on this work to create a more sustainable and resilient workforce.

10. Primary Care workforce – Health and Wellbeing

Primary Care faces the challenges of staff being absent due to the affects of Covid, as well the stress and pressures of working within primary care general practice. Both locally and nationally incidents of abuse and violence to staff from patients is on the increase and at an WYICS level and national there has been a targeted campaign of "zero tolerance to NHS staff".

We have also worked with YORLMC colleagues to develop health and wellbeing offers for GPs and practice nurses and are exploring other ways of supporting general practice staff.

Nationally the number of referrals to the "Health Practioner Programme" (this is a programme) to support GPs who are struggling to continue to practice has increased by a third over the last 16 months.

We are consistently working with our Local Medical Committee (LMC) colleagues to look at ways we can protect and support our staff.

11. Community Partnerships

Community Partnerships were established across Bradford and Craven in 2017/18, bringing together representatives from statutory health and care providers, voluntary sector organisations, Local Authority neighbourhood teams and others. The intention was to work on prevention, bring focus to the wider determinants of health and adopt an asset-based approach in local communities.

There are 12 Community Partnerships within the Bradford district (plus 1 in Craven). They are based on groups of GP Practice populations of around 50k and are co-terminus with Primary Care Networks (PCN's).

Community Partnerships have a clear potential to address Health Inequalities at the level of local populations and the conclusions of two recently commissioned local reports (Hambleton and Farrer) support this approach. In addition, the Fuller Stocktake into Primary Care advocates the development of neighbourhood approaches by PCN's. At the same time, the Core 20 + 5 framework for tackling health inequalities (which recognises the impact of deprivation on health outcomes alongside the needs of particular groups) together with the redefined 5 Place Based Partnership priorities (including Healthy Communities) provide the overarching context for prioritisation and planning in the coming months.

Whilst this is all consistent with the work undertaken in the past 12/15 months, there is now an opportunity to pick up the pace. The next steps will, therefore, involve the following:

Work to further develop Community Partnerships will be overseen by the new Healthy Communities Board and will sit alongside other community initiatives including those, such as Care Coordination, where PCN's will be key players.

- Close working with enabling programmes, such as Living Well and Reducing Inequalities Alliance, as well as other priority areas such as MHLDN.

- The development of Locality based collaboratives building on existing work to align Community Partnerships with Locality footprints. This will create greater potential for both more integrated service planning and delivery as well as local accountability. It will offer greater opportunities for enhanced partnership working at scale around defined shared priorities and the ability to connect better with the wider determinants of health and wellbeing through Locality Planning arrangements.

- A series of Locality based workshops is being organised, beginning in October. These will follow on from the initial meeting of the new Healthy Communities Board. They will bring together the key health, care and VCS stakeholders in each Locality and will give impetus to joint prioritisation and planning arrangements.

There is additional resource to support this work in the form of Core 20 + 5 implementor posts for the 6 Community Partnerships with the most deprived populations and Community Partnership/Locality development posts for each of the 5 Localities.

12. Addressing Health Inequalities

12.1. Health Inequalities Premium

As part of the 'Fairer Funding' review of all locally commissioned services, the Health Inequalities Premium (HIP) contract and service specification were recently refreshed and renewed with practices. The thirty-five practices which were identified as having the greatest risk of health inequalities were included in the HIP contract to incentivise initiatives to reduce health inequalities. The practices were identified using a calculation based on Index of Multiple Deprivation (IMD) scores, as well as a funding matrix which considers factors not included in the Carr Hill formula (this is the national formula on price per a patient in general practice), such as deprivation, ethnicity, life expectancy, poverty, long term condition prevalence, polypharmacy and Covid 19.

Practices may choose to focus on any of the metrics from the Bradford District and Craven priority list. A mapping exercise has been carried out to identify alignment and overlap between local HIP priorities and other ICS and national primary care metrics. Practices have been encouraged to focus on a HIP initiative which aligns with Core20Plus5 priorities, which is a national NHS England and NHS Improvement approach to support the reduction of health inequalities, focussing on the 20% most deprived population, plus other key minority groups, for example, people with a learning disability and autistic people, people experiencing homelessness. Core20Plus5 identifies 5 areas of clinical focus:

- Maternity
- Severe Mental Illness
- Chronic Respiratory Disease
- Early Cancer Diagnosis
- Hypertension
- and a local priority indicator focused on children and young people.

The aim of the HIP is to improve patient care by encouraging practice to work even more closely with its most vulnerable communities and provide additional support to individuals to improve health outcomes. Some examples of initiatives that have been proposed by practices are:

- Increasing cervical screening rates
- Reducing rates of smoking in pregnancy
- Increasing uptake of flu, pneumococcal and covid-19 vaccines
- Support improvements for patients with diabetes
    - Increasing annual health checks for people with serious mental illness or learning disabilities.

Community Partnerships and PCNs across the patch are at different stages of their development and how they work with each other and localities to reduce health inequalities, improve health outcomes and life expectancy in our most deprived areas.

The PCNs delivery plan up to 2023 in Appendix I lists its 5 overall objectives including its priority is to focus on addressing health inequalities.

Table 4 below details our 12 PCNs and population size covered.

Table 4

Locality (former CCG's)	PCN	Raw List Size	Locality List Size
Airedale, Wharfedale & Craven	Modality	87,232	
	WACA	75329	162,561
Bradford City	PCN 4	46181	
	PCN 5	56079	
	PCN 6	54131	156391
Bradford District	Affinity	59341	
	Bingley Bubble	44004	
	BD4+	41460	
	Bradford North West	50690	
	Five Lane Ends	34710	
	Bradford South	62945	
	WISHH	36324	329474
	Total	**648426**	**648426**

13. Members may wish to comment on the contents of the report.

14. Recommendations

Members of the Health and Social Care Overview Scrutiny committee are asked to:

Note the contents of this report detailing the current developments in primary care both nationally and locally.

15. Background documents

None

16. Not for publication documents

None

17. Appendices

17.1. **Appendix A**: Autumn Winter Covid Campaign
17.2. **Appendix B**: Covid Vaccinations
17.3. **Appendix C**: 1st October PCN Enhanced Access Summary
17.4. **Appendix D**: GP Appointments
17.5. **Appendix E**: Mode of GP Appointments
17.6. **Appendix F**: Time taken from booking to receiving an appointment
17.7. **Appendix G**: GP Online Consultation /e-Consult Data
17.8. **Appendix H**: Consults by age
17.9. **Appendix I**: Summary of PCN Objectives 2021/22 and 2022/23
17.10. **Appendix J**: Patient 111 Calls (April 21 to June 22 Data)
17.11. **Appendix K**: Fuller Review and Framework for Shared Actions

Appendix: A

Autumn Winter Covid Campaign

Bradford District and Craven Health and Care Partnership

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The government have accepted final JCVI advice which states the following people should be offered a COVID -19 booster vaccine this autumn:

residents in a care home for older adults and staff working in care homes for older adults
frontline health and social care workers
all adults aged 50 years and over
persons aged 5 to 49 years in a clinical risk group, as set out in the Green Book
persons aged 5 to 49 years who are household contacts of people with immunosuppression
persons aged 16 to 49 years who are carers

Locality (former CCG's)	PCN	Autumn Winter Covid Campaign	Designated Site
Airedale, Wharfedale & Craven	Modality	Opt in	Silsden Surgery
	WACA	Opt in	Ilkley MP, Townhead MP
Bradford City	PCN 4	Opt in	Whetley Medical Centre
	PCN 5	Opt in	Barkerend
	PCN 6	Opt in	Woodroyd Medical Centre
Bradford District	Affinity	Opt in	Shipley MP
	Bingley Bubble	Collaboration agreement pending	TBC
	BD4+	Opt in	Low Moor MP
	Bradford North West	Opt in	The Ridge MP
	Five Lane Ends	Collaboration agreement Affinity	Shipley MP
	Bradford South	Opt in	The Ridge MP
	WISHH	Collaboration agreement Affinity	Shipley MP

Appendix: B

Covid Vaccinations

Bradford District and Craven Health and Care Partnership

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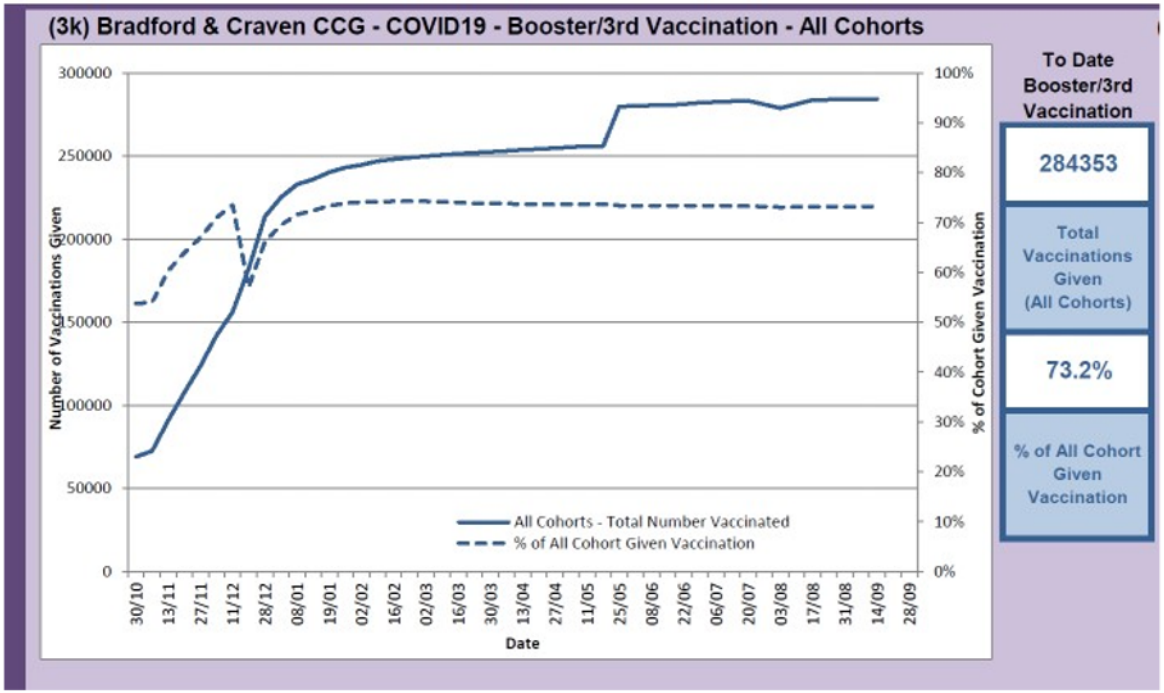


Appendix: C

1st October PCN Enhanced Access Summary

PCN	Model of delivery	Minutes / Hours Required:	Hub Locations:	Primary Medical Care Services included in the delivery model:	Indicative proportion of Face-to-Face appointments:	Evidence of Patient Engagement:	Non-Network Standard Hours Included:
Affinity	PCN Model	3,662.9mins / 61.05 hrs	Shipley Health Centre (North PCN) The Willows Medical Practice (West PCN) Sunnybank Medical Practice (South PCN)	GP Nurse Screening Pharmacy Vaccinations Mental Health	50%	PCN Patient Survey and Patient Council meetings.	Potential to include non core hours provision 7am to 8am.
AWC Modality	PCN Model	5,513.42 mins / 91.89 hrs	Fisher Medical Centre (Craven) Farfield Group Practice (Airedale) Silsden Medical Practice (Wharfedale) Central Hall (Keighley Community Hub)	GP Nurse Screening Pharmacy Vaccinations Mental Health Community Outreach	53%	Health Inequalities award (engagement with faith centres, colleges, community centres). PCN Patient Survey SMS to all patients. Social Media posts.	No

WACA	PCN Model	4,449.23 mins / 74.15 hrs	Ilkley Medical Centre (Wharfedale) Townhead Surgery (Craven) Ling House Surgery (Airedale) Dyneley House Surgery (Craven) Varied additional community outreach	GP Nurse Screening Pharmacy Vaccinations Mental Health Community Outreach	50%	PPG WACA Extended Access Patient Survey GP Patient Survey	Sunday mornings included as alternative to Saturday afternoon. This provision confirms overall required minutes are met.
PCN	**Model of delivery**	**Minutes / Hours Required:**	**Hub Locations:**	**Primary Medical Care Services included in the delivery model:**	**Indicative proportion of Face to Face appointments:**	**Evidence of Patient Engagement:**	**Non Network Standard Hours Included:**
Bingley Bubble	BCA Subcontract	2,544 mins / 42.41 hrs	Bingley Medical Practice Saltaire & Windhill (Idle Medical until renovations completed)	GP Nurse Screening Pharmacy Vaccinations Mental Health Physio	55%	Place based Patient Survey (results pending) Extended Access Patient survey	Additional 60mins appointments on Sunday 10am to 2pm.

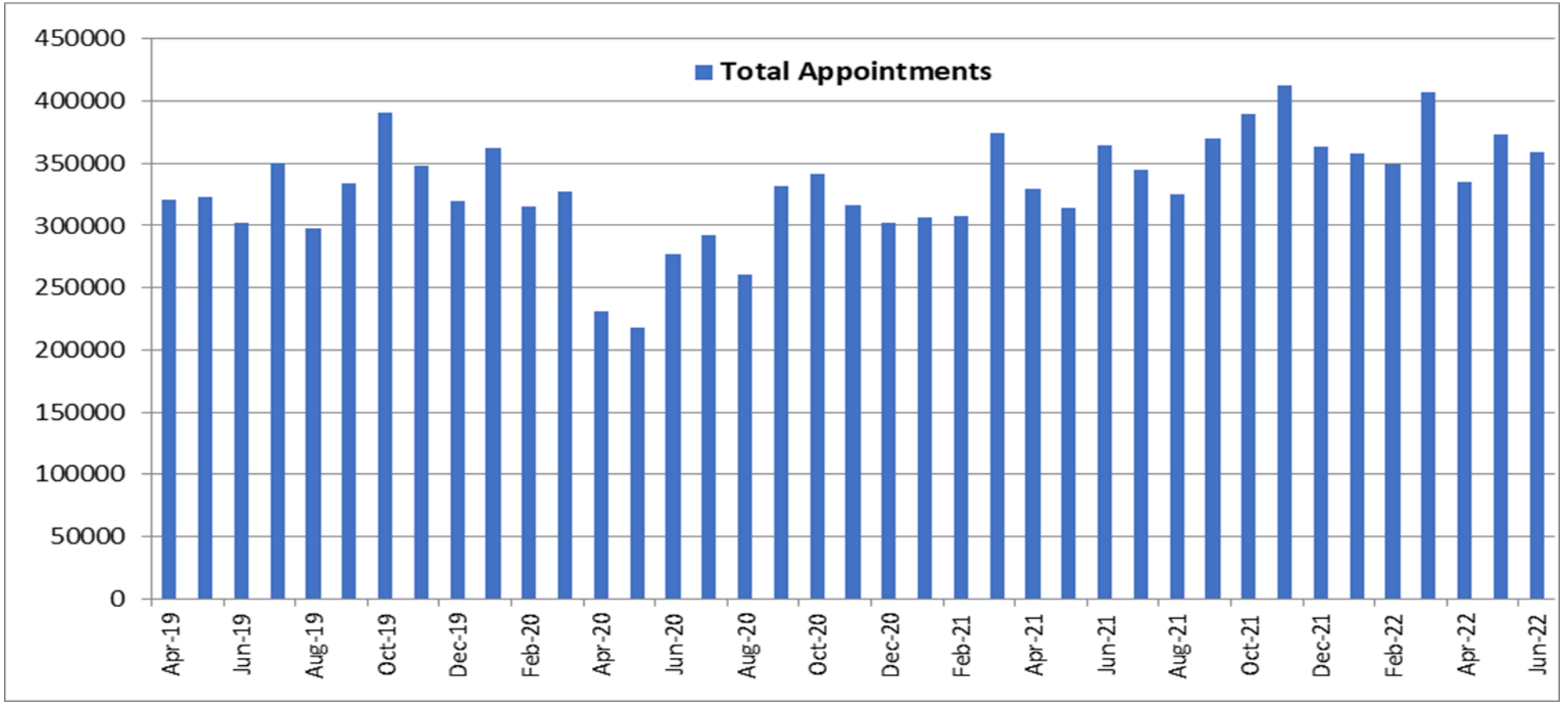
BD 4+	BCA Subcontract	2,909.97 mins / 48.50 hrs	Bowling Hall Medical Practice Hillside Bridge Medical Practice (weekends)	GP Nurse Screening Pharmacy Vaccinations Mental Health Physio	68%	Place based Patient Survey (results pending) Extended Access Patient survey	Additional 60mins appointments on Sunday 10am to 2pm.
Bradford North West	BCA Subcontract	3,092.11 mins / 51.54 hrs	Ashwell Medical Practice Picton Medical Practice (weekends)	GP Nurse Screening Pharmacy Vaccinations Mental Health Physio	68%	Place based Patient Survey (results pending) Extended Access Patient survey	Additional 60mins appointments on Sunday 10am to 2pm.
PCN	**Model of delivery**	**Minutes / Hours Required:**	**Hub Locations:**	**Primary Medical Care Services included in the delivery model:**	**Indicative proportion of Face to Face appointments:**	**Evidence of Patient Engagement:**	**Non Network Standard Hours Included:**

Five Lane Ends	BCA Subcontract	2,239.18 mins / 37.32 hrs	Moorside Medical Practice Saltaire & Windhill (Idle Medical until renovations completed)	GP Nurse Screening Pharmacy Vaccinations Mental Health Physio	60%	Place based Patient Survey (results pending) Extended Access Patient survey	Additional 60mins appointments on Sunday 10am to 2pm.
PCN 4	BCA Subcontract	2,864.70 mins / 47.75 hrs	Picton Medical PracticePicton Medical Practice (weekends)	GPNurseScreening PharmacyVaccinationsMental HealthPhysio	64%	Place based Patient Survey (results pending)Extended Access Patient survey	Additional 60mins appointments on Sunday 10am to 2pm.
PCN 5	BCA Subcontract	3,637.72 mins / 60.63 hrs	Barkerend Medical Practice Hillside Bridge Medical Centre (weekdays and weekend)	GP Nurse Screening Pharmacy Vaccinations Mental Health Physio	75%	Place based Patient Survey (results pending) Extended Access Patient survey	Additional 60mins appointments on Sunday 10am to 2pm.

PCN	Model of delivery	Minutes / Hours Required:	Hub Locations:	Primary Medical Care Services included in the delivery model:	Indicative proportion of Face to Face appointments:	Evidence of Patient Engagement:	Non Network Standard Hours Included:
PCN 6	BCA Subcontract	3,178.79 mins / 52.98 hrs	Park Grange Medical Practice Picton Medical Practice (weekends) Little Horton Lane Medical Centre (Core Hours)*	GP Nurse Screening Pharmacy Vaccinations Mental Health Physio Paediatrics (core hours) Health Inequalities clinic (core hours)	91%	Place based Patient Survey (results pending) Extended Access Patient survey	Additional 60mins appointments on Sunday 10am to 2pm.
Bradford South (PCN 7)	BCA Subcontract	3,987.29 mins / 66.45 hrs	The Ridge Medical Practice (main site) Picton Medical Centre (weekends)	GP Nurse Screening Pharmacy Vaccinations Mental Health Physio	77%	Place based Patient Survey (results pending) Extended Access Patient survey	Additional 60mins appointments on Sunday 10am to 2pm.
WISHH (North Bradford PCN)	BCA Subcontract	2,172.60 mins / 36.21 hrs	Saltaire & Windhill (Idle Medical until renovations completed), (weekdays and weekends)	GP Nurse Screening Pharmacy Vaccinations Mental Health Physio	64%	Place based Patient Survey (results pending) Extended Access Patient survey	Additional 60mins appointments on Sunday 10am to 2pm.

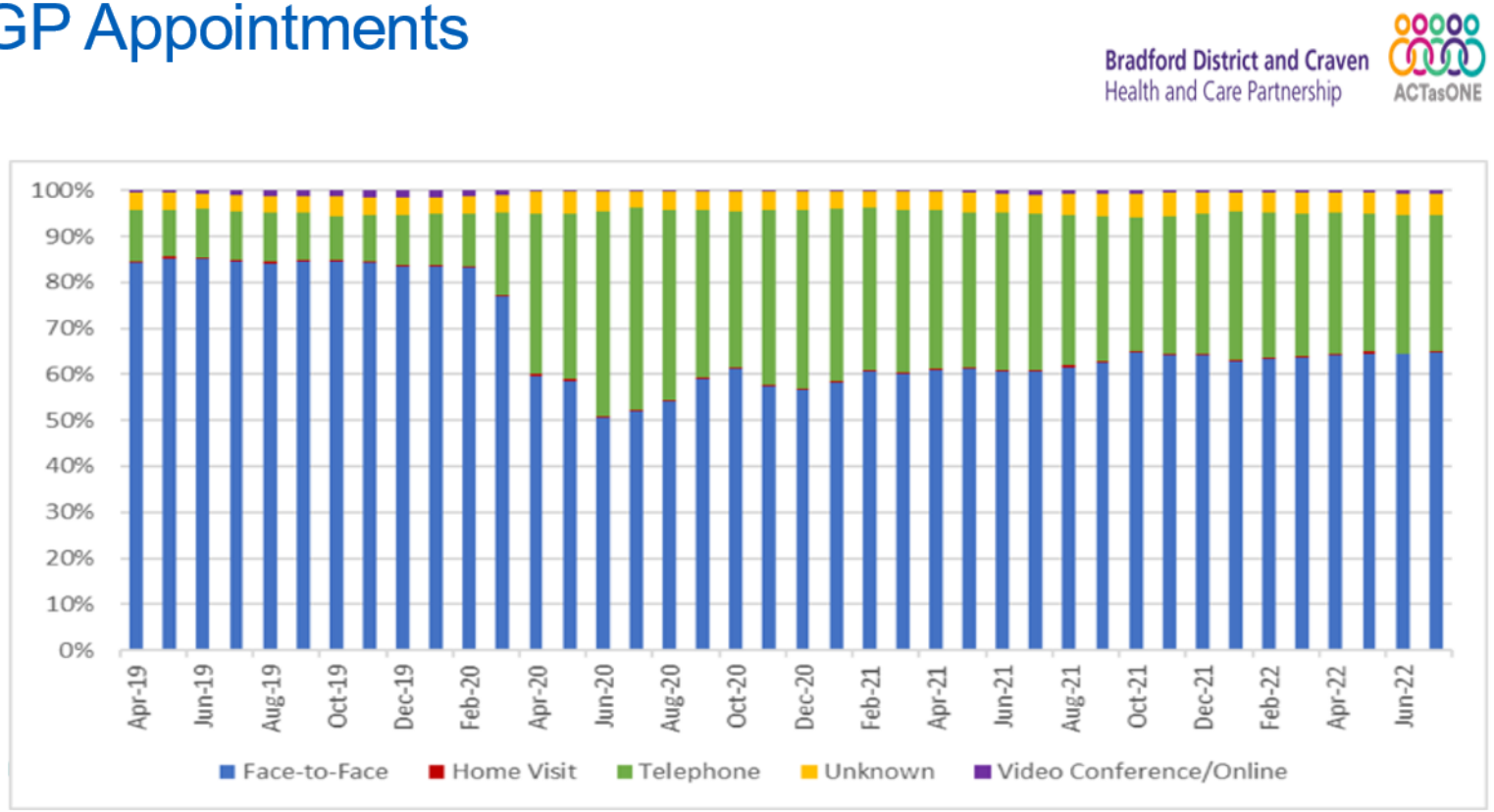
Appendix: D

NHS Digital GP appointment snapshot for Bradford District and Craven and GP appointment data presented in a bar chart (Source NHSD)



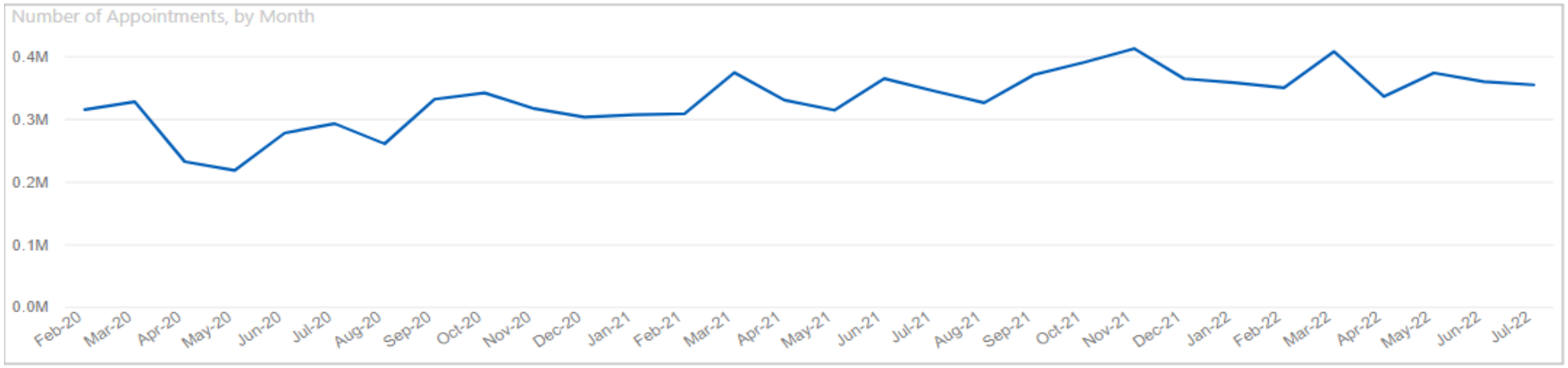
Appendix: E

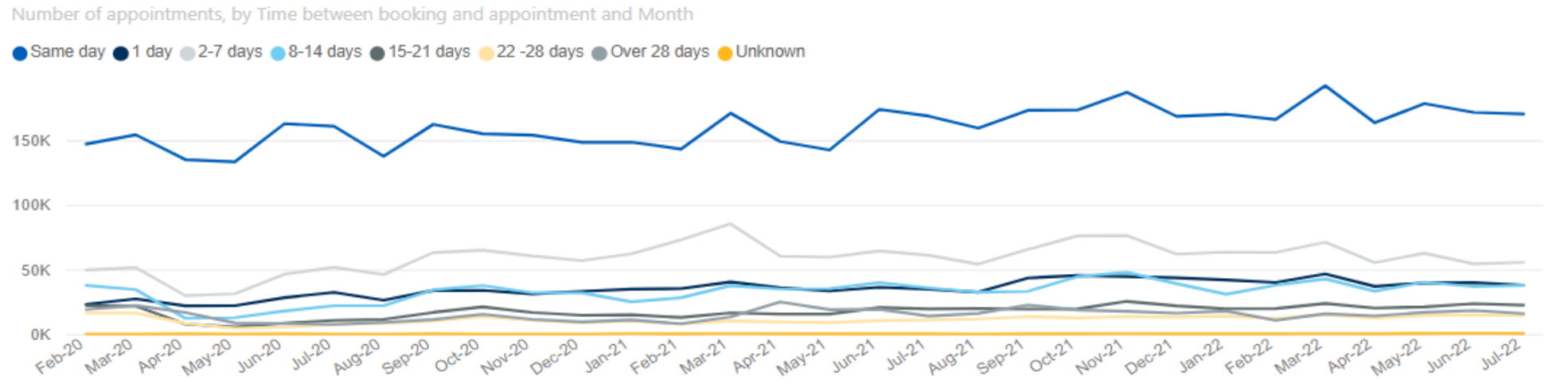
Mode of GP Appointments



Appendix: F

Time Taken from Booking to Receiving an Appointment

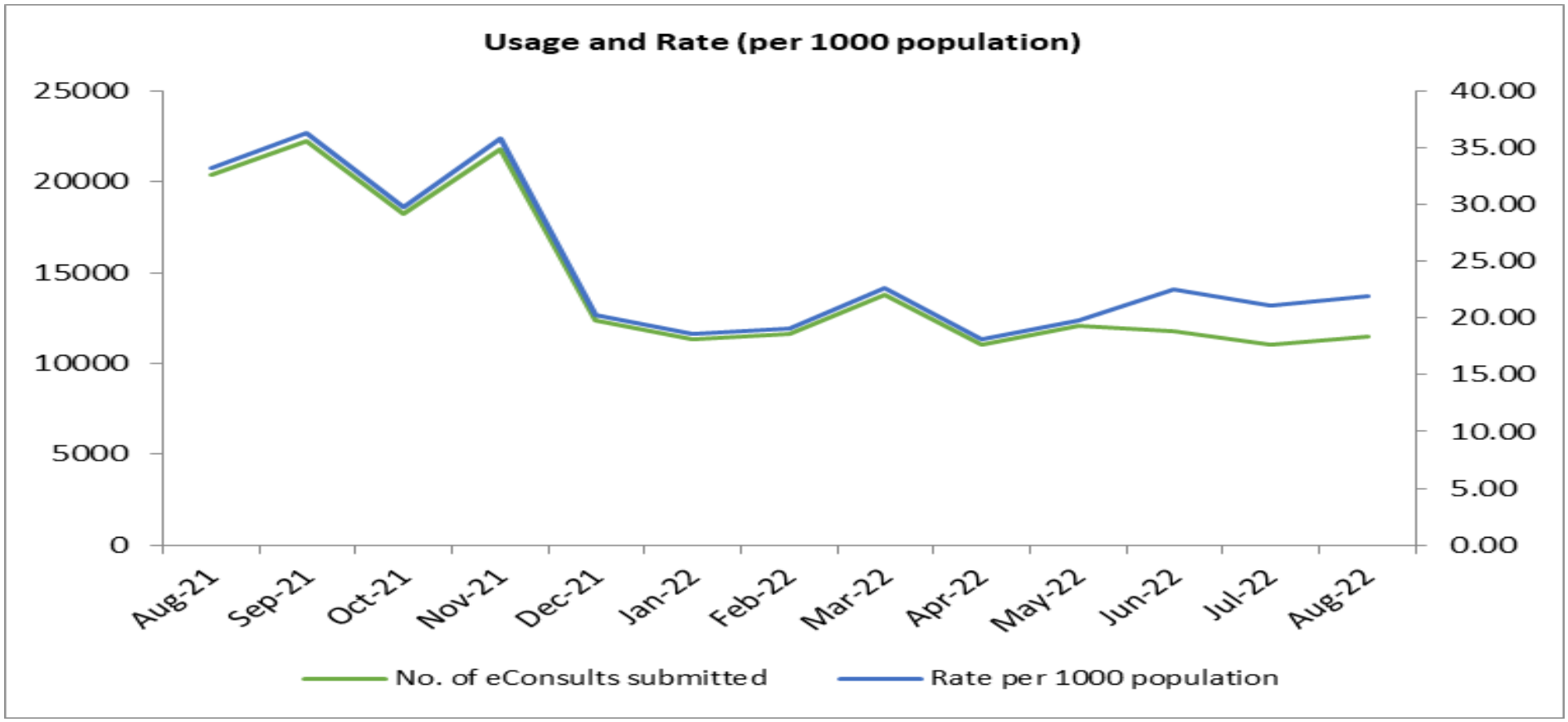




Appendix: G

GP Online Consultation / e-Consult Data

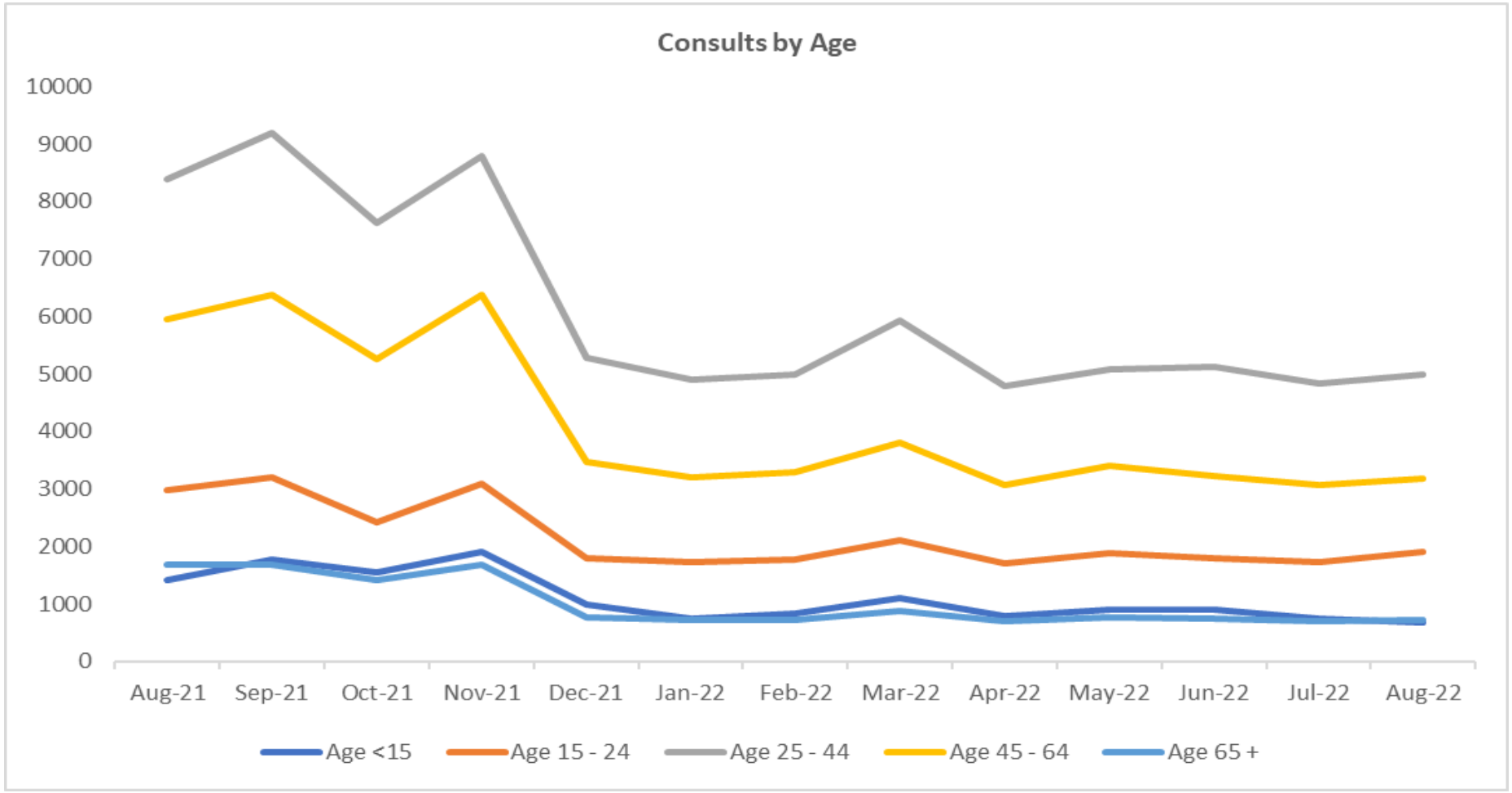
1.) Usage (11,472) and Rate of Submissions (21.91):



*Data does not include AWC Modality PCN GP Online Consultation submissions

Appendix: H

2.) Consults by Age:



Appendix: I

Summary of PCN Objectives 2021/22 and 2022/23

The table below sets out the 5 key objectives for PCNs in 2021/22 and 2022/23, and how different elements of the Network Contract DES will support them.

Key Objectives. Aligned to general practice priorities, LTP priorities and NHS response to Covid-19	**Service requirements** New requirements introduced in a phased way will support the key objectives	**IIF Indicator areas of focus** Financial indicators to improve and reward performance against DES Service requirements and wider NHS priorities

1. **Improving prevention and tackling health inequalities** in the delivery of primary care – PCNs will be required to identify high need local populations and tailor services to them, as well as address inequalities in rates of diagnosis for cardiovascular disease and cancer.	• Tackling Neighbourhood Inequalities
	• CVD Diagnosis and Prevention
	• Early Cancer Diagnosis
	• Personalised Care
		• Progress towards the national ambitions for:
		  ○ Learning Disability Health Checks
		  ○ Flu vaccinations to at-risk groups
		  ○ Closing the hypertension diagnosis gap
		  ○ Personalised care interventions e.g. social prescribing
		• More complete recording of ethnicity in patient records

2. Support **better patient outcomes in the community through proactive primary care** – including delivery of the Enhanced Health in Care Homes and Anticipatory Care services through multidisciplinary teams, offering more personalised services which will help people avoid unnecessary hospital admissions	• Tackling Neighbourhood Inequalities • Anticipatory Care • Enhanced Health in Care Homes (EHCH) • Personalised Care	• Delivery of key elements of the EHCH model and associated moderation of care home resident emergency admissions • Moderated admissions for ambulatory care sensitive conditions (ACSCs)
3. Support **improved patient access** to primary care services – implementing a PCN-based approach to extended access provision, and rewarding PCNs who improve the experience of their patients, avoid long waits for routine appointments and tackle the backlog of care resulting from the Covid-19pandemic	• Extended Access service requirements • Delivery of all new services will support improved access for particular cohorts.	• Improved patient experience of accessing general practice • Reduction in the proportion of patients waiting longer than two weeks for a routine general practice appointment • Improved provision of online consultations • Increased utilisation of Specialist Advice services, and

		community pharmacist consultations
4. **Deliver better outcomes for patients on medication** – including through the delivery of Structured Medication Reviews to priority patient cohorts, and through targeting prescribing behaviours known to improve patient safety.	• Structured Medication Reviews and Medicines Optimisation	• Improved provision of SMRs to priority groups • Targeted prescribing behaviours known to improve patient safety • Supporting more preventive treatment of asthma through increased use of inhaled corticosteroids.
5. Help **create a more sustainable NHS** - through reducing the carbon emissions generated by asthma inhalers.	• Structured Medication Reviews and Medicines Optimisation	• Encouraging clinically appropriate inhaler switching to low-carbon alternatives

Appendix: J

Patient 111 Calls (Apr21 to June 22 Data)

Bradford District and Craven Health and Care Partnership

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Total Number of Calls (In Hours)	Call Rate (Number of Calls per 1,000 Population)	Call Disposition											
		Ambulance		A&E		Primary Care		Another Service		Self Care		Unknown	
		No	%	No	%	No	%	No	%	No	%	No	%
74649	115.0	6698	9.0%	13613	18.2%	39696	53.2%	6199	8.3%	7523	10.2%	820	1.1%

West Yorkshire Health and Care Partnership

Appendix: K

Fuller Review and Framework for Shared Actions

1	**Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices.** This should be for all patients clinically assessed as requiring urgent care, where continuity from the same team is not a priority. Same-day access for urgent care would involve care from the most clinically appropriate local service and professional and the most appropriate modality, whether a remote consultation or face to face.	ICSs
2	**Assist systems with integration of primary and urgent care access,** specifically looking at the role of NHS 111, and considering the development of new metrics and standards on urgent and routine access, and introduce as planned, the new patient-reported experience measure for access to general practice.	NHS England
3	**Enable all PCNs to evolve into integrated neighbourhood teams,** supporting better continuity and preventive healthcare as well as access, with a blended generalist and specialist workforce drawn from all sectors. Secondary care consultants – including, for example, geriatricians, respiratory consultants, paediatricians and psychiatrists – should be aligned to neighbourhood teams with commitments reflected in job plans, along with members of community and mental health teams. With teams collocated within neighbourhoods, to extend models of personalised care, embed enhanced health in care homes and develop a consistent set of diagnostic tests. At place level, bring together teams on admissions avoidance, discharge and flow – including urgent community response, virtual wards and community mental health crisis teams. Focus on community engagement and outreach, across the life course. Proactively identify and target individuals who can benefit from interventions in neighbourhoods, committing to delivering neighbourhood teams first for Core20PLUS5 populations. Co-ordinate vaccinations, screening and health checks at place level, in accordance with national standards.	ICSs
4	**Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams,** across their functions including digital, data, intelligence and quality improvement, HR, finance, workforce plans and models, and estates. Specifically put in place sufficient support for all PCN clinical directors and multiprofessional leadership development, and protected time for team development. Baseline the existing organisational capacity and capacity for primary care, across system, place and neighbourhood levels, to ensure systems can undertake their core operational and transformation functions.	ICSs

5	**Develop a primary care forum or network at system level**, with suitable credibility and breadth of views, including professional representation. Ensure primary care is represented on all place-based boards.	ICSs
6	**Embed primary care workforce as an integral part of system thinking, planning and delivery.** Improve workforce data. Support innovative employment models and adoption of NHS terms and conditions. Support the development of training and supervision, recruitment and retention and increased participation of the workforce, including GPs.	ICSs
7	**Include primary care as a focus in the forthcoming national workforce strategy to support ICSs to deliver this report (NHS England).** Recognising this is not currently funded, commit to future rollout of the NHS Staff Survey in primary care. Examine further flexibilities, and better communicate existing flexibilities, in the Additional Roles Reimbursement Scheme. Specifically consider, with DHSC and HEE, how the scheme should operate after March 2024, including the role of ICSs in working with national colleagues and PCNs in delivering it. Review the GPs Performers List to enable other appropriately qualified clinicians to contribute more easily as part of the primary care workforce.	DHSC with NHS England and HEE
8	**Pivot to system leadership as the primary driver of primary care improvement and development of neighbourhood teams in the years ahead.** Move to greater financial flexibility for systems on primary care. Bring together existing national primary care funding wherever practicable. Beyond 2023/24, maximise system decision-making on any future discretionary investment, beyond DDRB and pay uplifts.	NHS England
9	**Improve data flows** including by (i) solving the problem of data-sharing liability, issuing a revised national template; (ii) working with system suppliers on extract functionality; (iii) improving data to support access (actions 1 and 2 above), and (iv) helping to identify population cohorts to be targeted by neighbourhood teams.	NHS England
10	**Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care**, taking a 'one public estate' approach and maximising the use of community assets and spaces.	ICSs
11	**DHSC and NHSE should provide additional, expert capacity and capability to help offer solutions to the most intractable estates issues,** and practical support to work through them, as well as building ICS estates expertise. DHSC and NHSE should consider what flexibilities and permissions should be afforded to systems to allow shaping and influencing of the physical primary care estate, including through reviewing the Premises Cost Directions. DHSC	DHSC and NHS England

	should ensure that primary care estate is central in the next iteration of the Health Infrastructure Plan.	
12	**Create a clear development plan to support the sustainability of primary care and translate the framework provided by *Next steps for integrated primary care* into reality, across all neighbourhoods.** Ensure a particular focus on unwarranted variation in access, experience and outcomes. Ensure understanding of current spending distribution across primary care, compared with the system allocation and health inequalities. Support primary care where it wants to work with other providers at scale, by establishing or joining provider collaboratives, GP federations, supra-PCNs or working with or as part of community mental health and acute providers. Tackle gaps in provision, including where appropriate, commissioning new providers in particular for the least well-served communities.	ICSs
13	**Work alongside local people and communities** in the planning and implementation process of the actions set out above, ensuring that these plans are appropriately tailored to local needs and preferences, taking into account demographic and cultural factors.	ICSs
14	In support of systems, **set out how the actions highlighted for NHS England will be progressed.**	NHS England
15	DHSC and NHS England should rapidly undertake further work on the **legislative, contractual, commissioning, and funding framework** to enable and support new models of integrated primary care. This work should also consider how to improve equity in distribution of resource and ultimately improve health outcomes.	DHSC and NHS England