NHS
South West London

Merton Primary Care

Healthier Communities and Older People Overview and Scrutiny Panel

September 2023

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Access

Primary Care Access in Merton

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Primary Care Services available 8am-8pm, 7 days a week
Appointments can be booked via practices, NHS 111, Emergency Departments (ED)

- 21 GP Practices
  - Core Hours 8am-6:30pm Monday – Friday
  - Additional hours – varies by practice
  - 85,000+ appointments a month
- 4 Primary Care Networks (PCNs)
  - Enhanced Access: Network Standard hours: 6:30pm-8pm Monday to Friday; 9am-5pm Saturday
  - Additional hours – varies by PCN
  - Available to all patients registered at practices within the PCN
  - 4000+ appointments a month
- 2 Borough Wide Extended Access Hubs
  - Friday 4pm-8pm; Saturday/Sunday/Bank Holidays 8am – 8pm
  - Delivered by Merton Health Ltd from Wide Way Medical Centre & The Nelson Health Centre
  - Available to all Merton registered patients
  - Offers GP and nurse (specifically wound care and childhood immunisations) appointments
  - 800+ appointments a month

General Practice Appointment Data (GPAD)

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- Nationally Collected and published
- Web link: https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice#summary

- Contains data on appointments that have taken place in general practice.
- Data does not currently include numbers of appointments provided through Hubs (borough / PCN)

- Contains details on who the appointment was with, mode, appointment status, time between when the appointment was booked and took place, the recorded national category and duration

- Work ongoing with practices to ensure appointment data coded accurately

Merton GPAD October 2022 – June 2023

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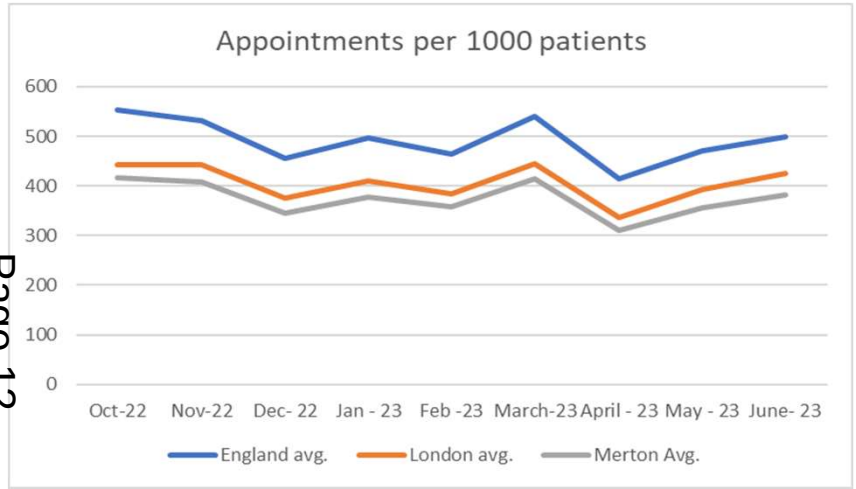
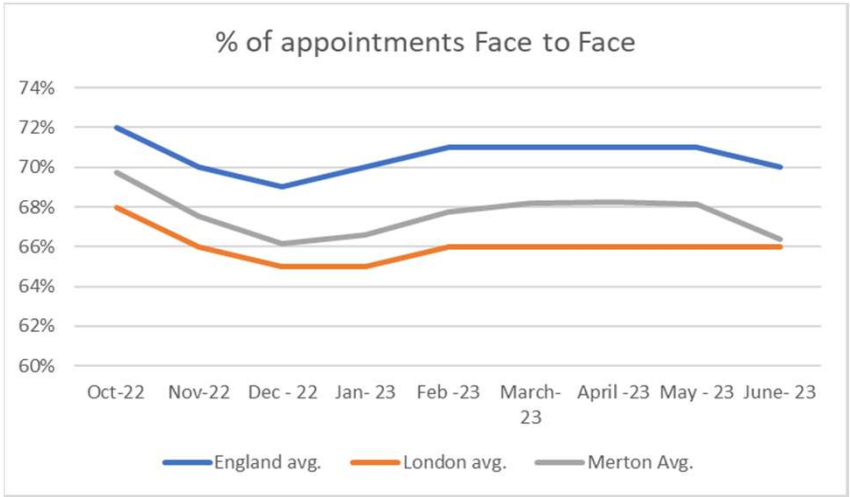
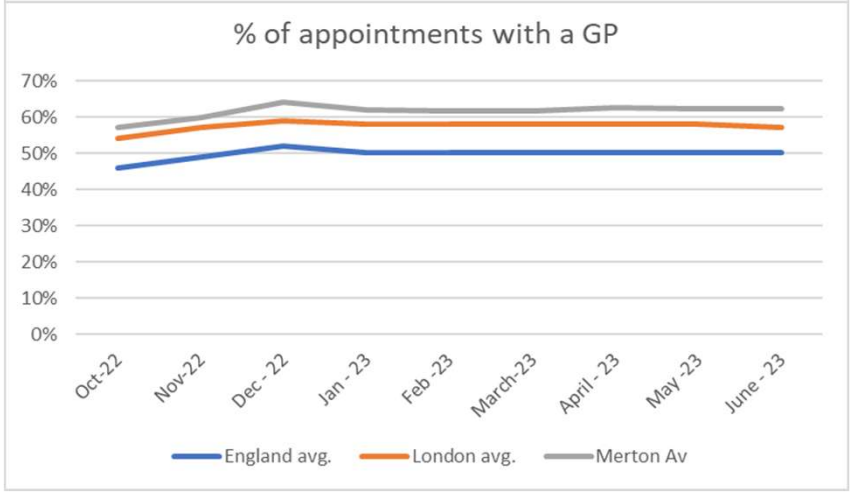
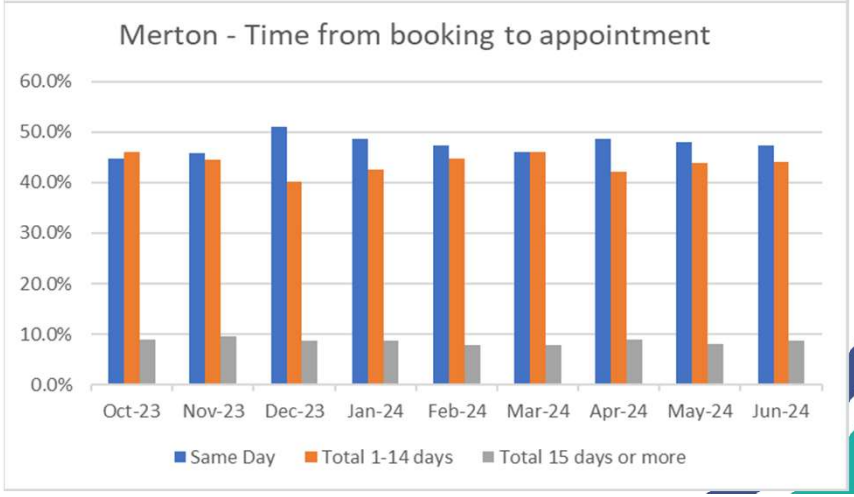
Does not reflect PCN delivered hours or Borough wide hub appointments









GP Patient Survey 2023

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- England-wide survey, providing practice-level data about patients' experiences of their GP practices administered by Ipsos MORI
- Fieldwork: January - March 2023
- Limitation - Small sample size
- Web link: GP Patient Survey (gp-patient.co.uk)

2023 Data	Forms issues	Forms Returned	% Returned	Overall experience of making an appt. (% Good)	Overall experience of GP practice (% Good)	Ease of getting through on the phone (% Easy)	Confidence and trust in healthcare professional saw/spoke to (% Yes)
Merton	10,822	2527	23%	60%	75%	55%	93%
SWL ICS*	84,219	20,470	24%	62%	76%	60%	94%
National	2,654,180	759,149	29%	54%	71%	50%	93%

* SWL ICS - South West London Integrated Care System

New Access Requirements

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NHS England Delivery Plan for Recovering Access	GP Contract Requirements
Empower patients to manage their own health including using the NHS App, self-referral pathways and through more services offered from community pharmacy.	Offer of assessment will be equitable for all modes of access. Patients should be offered an **assessment of need, or signposted to an appropriate service, at first contact** with the practice, with practices no longer able to request that patients contact the practice at a later time.
Implement **Modern General Practice Access** to tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another day to book an appointment	Patients seeking routine care should have an **appointment within two weeks** of contact where appropriate
Build capacity to deliver more appointments from more staff than ever before and add flexibility to the types of staff recruited and how they are deployed.	**Prospective (future) record access** to be provided by 31st October 2023
Cut bureaucracy and reduce the workload across the interface between primary and secondary care, and the burden of medical evidence requests so practices have more time to meet the clinical needs of their patients	Mandated use of a **Cloud based telephony** (CBT) national framework

Improving Access in Merton

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- 75% Practices already using Cloud Based Telephony
- All practices have Online Consultations available
- Promoting use of NHS App
- Digital Change Managers to support practices
- All PCNs had Capacity and Access Improvement Plans approved
- All practices on track to enable prospective records access by 31st October 2023
- Recruitment and Retention programmes in place
- Patient engagement including through surveys, patient groups; Patient communications on new roles and changes to access routes

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Primary Care Networks

Primary Care Networks (PCNs)

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- There are 6 Primary Care Networks in Merton:
  - East Merton PCN
  - North Merton PCN
  - West Merton PCN
  - North West Merton PCN
  - South West PCN
  - Morden PCN

PCN Service Requirements

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Covered in this presentation:

- Additional Roles Reimbursement Scheme (ARRS)
- Enhanced Access
- Social Prescribing Service
- Personalised Care (Proactive Social Prescribing)
- Anticipatory Care (now Proactive Care)

Other Service Requirements

- Medication Review and Medicines Optimisation: Focus on Structured Medication Reviews
- Enhanced Health in Care Homes: Focus on: Align Care Homes to PCN / Weekly “home round” / Care Planning
- Early Cancer Diagnosis: Focus on: Review referral practices and use of pathways / improve uptake cancer screening
- Cardiovascular Disease (CVD) Prevention and Diagnosis: Focus on: diagnosis of hypertension & Atrial Fibrillation
- Tackling Neighbourhood Health Inequalities – Focus on: patients with a learning disability & recording ethnicity

Additional Roles

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- Each PCN has access to the Additional Roles Reimbursement Scheme (ARRS), which allows them to employ additional roles into the PCN and claim a reimbursement for the salary cost of the employee to NHS England through the claims portal.
- There are a total of 13 roles available through the ARRS. These are split across Merton with each PCN recruiting different roles dependent on the local health needs and their needs as a Network.

Merton ARRS 2022-23

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- Of the ARRS roles available Merton PCNs currently employ staff in 12 of these roles
- Most common roles employed are: Care Coordinators, Clinical Pharmacists, Social Prescribers, Physicians Associates, Adult Mental Health Practitioners and Paramedics
- PCNs develop annual plans on their use of ARRS to make full use of the funding available
- Challenges around recruitment and retention

Social Prescribing in Merton PCNs

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- In 2016 Merton Health and Care commissioned a Pilot social prescribing programme in East Merton in partnership with Wide Way Medical Centre and Tamworth House Medical Centre for an initial 2-year period
- In March 2019, following the announcement of the PCN Contract, SWL Integrated Care Board (ICB) ICB saw an opportunity to further enhance the service and deliver a boroughwide model.
- SWL ICB approach all Merton PCNs with the offer to commission an enhanced social prescribing model and manage the contract on their behalf.
- In October, SWL ICB in collaboration with Merton PCNs commissioned Merton Connected to deliver Merton's boroughwide social prescribing model.
- This includes the original 3 Link Workers from the first expansion

Activity and Outcomes

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Last 12 months data:

- 3695 referrals to Social Prescribing from Practices, Merton Uplift and the CLCH* Long Covid team
- 7330 appointments delivered by the Social Prescribing Team
- 85% of patients reported improve life satisfaction
- 75% of patients reported improved worthwhileness
- 70% of patients reported improved happiness
- 75% of patients reported reduced levels of anxiety
- Reduced inappropriate Primary and Secondary Care activity

* CLCH – Central London Community Healthcare

Enhanced Social Prescribing

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- Children and young person's (CYP) Social Prescribing Pilot in East Merton and Morden PCN.

- PCN Proactive Social Prescribing programmes to increase access and uptake of Social Prescribing. Each PCN has identified a specific cohort to work with which are currently underrepresented in the current Social Prescribing referrals.

- MacMillan Cancer Link Worker programme which operates across Merton, Wandsworth and Croydon. The programme aims to improve the awareness of, access to, and uptake of services available to those living with and beyond cancer, whilst ensuring that holistic support is offered locally at key points in the cancer pathway.

SWL Investment Fund

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- In 2022-23, SWL ICB launched two funds:
  - The Innovation Fund
  - The Health Inequalities Fund
- These funds were designed to do the following:
  - Support new novel ideas
  - Improve sustainability and system resilience
  - Support in reducing health inequalities
  - Improve elective recovery
- A number of Merton PCNs put in bids for a range of projects The following slide shows those that were successful in being awarded funding

Successful Merton PCN Bids

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No.	Idea – brief description	Delivery partners
1	**CYP Hub and Together clinics:** Pilot new integrated CYP hub incorporating MDT together clinics across Merton building integrated locality working	St Georges Hospital, Merton PCNs & CLCH NHS
2	**Pilot a Respiratory Hub to cover Merton & Wandsworth:** Proof of Concept Pilot for 2 PCN Respiratory Hub. Aim to Reduce UEC Winter respiratory presentations, Reduce health inequalities and health inequity, Improve health outcomes in respiratory disease,	Wide way Practice and Morden Hall Practice
3	**Frailty Prevention Pilot:** Using PCN data to target those at risk of frailty and offer a proactive GP appointment and then GP led MDT approach together with partners CLCH to proactively support and build resilience through winter.	Morden and South West Merton PCNs, Age UK Merton, CLCH and wider voluntary sector partners
4	**Expansion of CYP Social Prescribing:** To scale-up the CYP social prescribing pilot into a second PCN address this unmet need in the borough and prevent further exacerbation and escalation of these health issues facing CYP	LBM, East Merton PCN
5	**Social prescribing pilot for Learning disability:** Pilot to roll out social prescribing for people with learning disability, creating connections between PCN and learning disability community sector.	Morden Primary care network

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Proactive Care & Development of Integrated Neighbourhood Teams

Proactive Care

South West London

What?

Proactive Care aims:

-intervening earlier,

-proactively,

-in a personalised and holistic approach.

- Whilst the person is at home.

Who?

People living:

-with 2 or more multiple long-term conditions (LTC)

-with frailty.

-admitted as an emergency twice or more often in the last 12 months

-reliant on unplanned care

-experiencing health inequalities(30%)

-Identified through stratification or risk prediction tools.

Why ?

- Reduce use of avoidable unplanned care

- Reduce avoidable exacerbation of ill health.

-Reduce health inequalities

- Improve patient experience

- Improve staff retention and satisfaction,

There is a growing evidence base that supports proactive, integrated care in community settings.

Note: Proactive care was formerly known as anticipatory care.

Integrated Neighbourhood Teams (INTs)

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What is an integrated neighbourhood team (INT)?

Integrated neighbourhood teams are fundamental building blocks of integrated care systems. These teams will be dedicated to improving the health and wellbeing of a local community and tackling health inequalities.

The intention is to bring together all providers within a PCN's geographical area to work seamlessly to support that local population's needs.

It means aligning the clinical and operational workforces of community health providers with neighbourhood areas or 'footprints' and working alongside dedicated, named specialist teams from acute and mental health trusts, particularly community mental health teams. It will bring together previously siloed teams and professionals doing things differently and improving patient care and outcomes.

The Merton Vision for INTs

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- Integrated Neighbourhood Teams evolved from our existing Integrated Locality Teams – learning from what has worked well and building these teams where there are gaps

- Multidisciplinary professionals working together as one team with a shared vision
- Delivering proactive, personalised care to those who most need it
- Patients at the center of everything the teams do
- GPs with the time and headroom to provide clinical leadership
- Central role for voluntary and community sector leaders
- Patient Care Coordinators and necessary admin support
- Specialised teams that link in across neighbourhood boundaries to deliver care closer to communities
- Space and time for all stakeholders to engage and shape the work
- PCN leads equipped and supported to lead

Next Steps

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Goal	Actions	Timescale
Professionals working together as one team	Deliver an externally facilitated programme of training and organisational development for our existing PCN and ILT teams to maximise the potential of our existing teams.	September 23 – January 24
Reviewing existing contracts to ensure commissioning arrangements support the vision	Review and update relevant locally commissioned service specifications to support the proactive care agenda and local delivery of INTs.	By April 2024
Grow our multi professional workforce	Work with PCN Clinical Directors and Merton Training hub to identify recruitment and development priorities for delivery of proactive care. Maximise how new roles such as paramedics and mental health practitioners can support cross organisational working and delivery of joined up care for patients	Ongoing
Pilots and Innovation	Review outcomes from existing pilots (such as the Living Well pilot in Morden, South West Merton PCN) and explore how these can be expanded more widely. Support our PCNs and other primary care organisations to make capitalise on opportunities for innovation	Ongoing