



AGENDA ITEM

5.1

CTM BOARD

PRIMARY CARE UPDATE

| | |
|---|---|
| Date of meeting | 27/05/2021 |
| FOI Status | Open/Public |
| If closed please indicate reason | Not Applicable - Public Report |
| Prepared by | Dr David Miller, Deputy Medical Director Professional Standards and Primary Care, and Ms Sarah Bradley, Assistant Director Primary Care |
| Presented by | Dr David Miller and Ms Sarah Bradley |
| Approving Executive Sponsor | Chief Executive |
| Report purpose | FOR DISCUSSION / REVIEW |

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)

| Committee/Group/Individuals | Date | Outcome |
|------------------------------------|--------------|-----------------|
| (Insert Name) | (DD/MM/YYYY) | Choose an item. |

ACRONYMS

| | |
|--|--|
| | |
|--|--|

1. SITUATION/BACKGROUND

This paper will outline some of the developments, learning and opportunities in Primary Care Clusters, Digital Health, Primary Care Estates and the COVID-19 Recovery.

This paper has not considered developments in Primary Care Dental, Optometry and Community Pharmacy. These areas could be considered in future reports, as could areas of urgent primary care developments including Think 111 First and the introduction of an Urgent Primary Care Centre.

- 1.1 In common with all parts of the health and care sector, since the outset of the COVID pandemic, Primary Care has faced and responded to unprecedented challenge in sustaining existing services and supporting the community assessment and treatment of COVID-19, including both acute illness and continuing debility.

Within a matter of days in March 2020, the constraints of Infection, Prevention & Control (IPC) necessitated wholesale change to the traditional delivery of Primary Care. This was most visible with a switch to a remote first assessment model with controlled face to face where needed. Our 51 General Practices have shown flexibility in adapting their working patterns to best support the population.

- 1.2 The pandemic has provided an opportunity for revolution rather than the evolution in primary care that preceded it. Measures once considered quite radical such as digital imaging and video consulting to support remote assessment of patients are now widely accepted by professionals and patients.

In this context, there is positive and negative learning. Looking towards the next stage of digital development for Primary Care, the integration of the current multiple patient care record sources into a single accessible usable one is sought by users. This should be patient facing and transferrable with the patient across care settings.

- 1.3 Current demand in Primary Care is at unprecedented levels. The workforce is under the strain of high volumes of telephone enquiries, meeting urgent care requests and a dramatic uptake of digital consultation options. All of this in the setting of a deterioration in population wellbeing and mental health, which is in itself a reason for presentation, unhealthy lifestyle choices and a contributing factor to worsening physical health. In common with secondary care, there is a considerable backlog, specifically in review of long-term conditions, which has unavoidably accumulated during the pandemic. A whole system approach to this is needed with greater horizontal and vertical

integration with Community Services, Secondary Care, Local Government and the third sector.

- 1.4 In serving the whole spectrum of age and disease groups, Primary Care professionals are well placed to describe both unmet need and the opportunity for whole system improvement. There is an appreciation now of the need for significant change like never before, there is much potential for development of Primary Care, but this needs to attach resource to responsibility.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

CLUSTER DEVELOPMENT AND MULTIDISCIPLINARY WORKING

- 2.1 CTM has seven Primary Care Clusters; each has a Cluster Lead Clinician, a Practice Manager Lead and support from a full-time Cluster Development Manager.
- 2.2 In the early years, Clusters were very much General Practice focused concentrating on the sustainability of their services, but through this developed some links with other parts of the NHS, Local Government and third sector. By no means was CTM an outlier on this shortcoming, which has markedly improved with Allied Health Professionals represented now in all Clusters.
- 2.3 There is however, a persisting lack of consistency in the form of representation, and their contribution to decision making on allocation of resources and leadership. It is hoped that a recent national review of Clusters by the Strategic Programme for Primary Care led by Alan Lawrie, will provide answers to some of these difficult questions and much needed direction on the function, structure, relationships and funding.

An ambitious model of a significantly greater role for Clusters in the planning and delivery of services is being considered. There are likely to be opportunity for some Clusters to act as pacesetters for accelerated development. Within CTM, there are Clusters that have demonstrated a strong and consistent sense of their purpose and direction, coupled with at times frustration at some of the constraints imposed by their current structure, so it is likely at least some will express interest.

- 2.4 Work done in 2017 in conjunction with Dr David Carson of the Primary Care Foundation, highlighted to Practices that around 20% of patients seeing a General Practitioner could more appropriately see another professional. This in part reinforced Cluster thinking and practice in



putting engagement of other roles at the centre of their funded sustainability projects. The result was, whilst Practice Pharmacists, First Contact Musculoskeletal Physiotherapists, Mental Health Workers, Social Care Workers and Occupational Therapists were not widely involved in Cluster structures, they were very much part of clinical teams within Practices. The roles have been widely acknowledged to add value, but we have struggled collectively to achieve mainstream funding for Clusters to embed the roles. This has restricted some of the potential for Clusters to move on to more transformative projects. The reasons behind this inertia are in part the form of evaluation undertaken, and the difficulty of affecting considerable movement of funding within a complex organisation.

- 2.5 A selection of Cluster workforce development plans for 2021-22 include, the introduction of a Frailty Nurse to support Care Homes, Pharmacy Technicians in Practice to support quality and safety and Counselling Services. In Merthyr Tydfil there is the continuation of a bespoke Support Officer role, which guides patients in accessing Local Government and third sector resources.
- 2.6 Whereas no cluster has had resource to trial and evaluate all the roles simultaneously. The Community Health and Wellbeing Teams were an attempt to provide intensive case management to complex patients from a fully formed multidisciplinary team, whose needs could not be understood or met within existing teams or care pathways. The teams were aligned to Clusters but not managed by them, but this would appear to be a natural progression as Clusters develop.
- 2.7 The General Medical Services Contract has not seen a significant increase in funding since the introduction of the new contract in 2005. Therefore, there has not been funding potential for Practices to create new posts for some, let alone all, the new roles. Where practices have had either the capacity to fund, through General Practitioner recruitment failure, reprioritisation when vacancies arise or economies of scale with practice merger, we have seen the adoption of Pharmacists and First Contact Physiotherapists. In a couple of settings, Occupational Therapy and Mental Health Worker roles have been adopted. However, none of this is at sufficient scale to have meaningful whole system impact.
- 2.8 In summary, the role of wider healthcare professional teams within Primary Care is widely accepted and can reduce demand on other parts of the system, but a sustainable source of funding to embed this has yet to be found.

- 2.9 In keeping with the 'Wider Determinants of Health' (Marmot 2010), Primary Care has come to understand the importance of sign-posting to a wide range of non-medical interventions to support health and well-being, most visibly through the Community Co-ordinator roles and the 'Grow Rhondda' Therapeutic Gardening project. There is growing acceptance in our population for what is called 'Social Prescribing' and ease of access and a positive first experience are key in individual continued engagement.
- 2.10 From an early stage in their evolution Clusters have understood to utilise a wider team and social prescribing, Care Navigation is a pivotal role. Care Navigators are usually non-clinical staff trained to signpost to a range of resources both inside and outside Practices. Consistency of approach and public messaging across boundaries is key. The Communications Team with public campaigns, including Your Team and Choose Well, have supported this.
- 2.11 During the pandemic Clusters have become more unified. Practices have come to understand their interdependency and through the development of contingency plans have formed buddying and cross cluster support arrangements. Clusters have shown strong leadership and self-direction; daily communication and support has become embedded and is here to stay. This has facilitated a consistency of approach and public messaging in key areas of concern during the pandemic such as Personal Protective Equipment (PPE), Shielding and Vaccination.
- 2.12 Going forwards Clusters have the opportunity to be a strong voice, working with our Integrated Locality and Systems Groups in making our aspiration for disease prevention, population and value based health care of sustainable high quality services delivered close to home, whilst putting patients at the centre of everything we do.

DIGITAL INNOVATIONS DURING THE PANDEMIC AND FUTURE POTENTIAL

- 2.13 The pandemic has forced Primary Care as per other parts of the health and care system to adopt Digital Health models out of necessity. Video Consulting and digital images sharing had been discussed within CTM as far back as 2017 and formed part of the original Cwm Taf UHB transformation funding bid submission (prior to the merger with Bridgend). However the gains were considered hard to quantify; and with technical and data sharing agreement constraints also casting doubt over the project, it did not become part of the eventual transformation work within Primary Care. With the advent of the pandemic remote assessment by telephone, supplemented by video and still images, became undisputable

essentials overnight. This has provided a rich learning opportunity; some of the previous judgements about these forms of consulting have proved accurate, others less so.

- 2.14 To support video consulting Welsh Government procured the *Attend Anywhere* platform, and commissioned TEC (Technology Enabled Care) Cymru to support the roll out within Care Homes. Future video consulting platform procurement is the subject of an ongoing review.
- 2.15 A key change in Digital Health has been the implementation of the **Wales Primary Care Access standards**. These state ambitious targets for availability of the population to be able to contact their practice by “appropriate accessible alternative methods of contact, including digital solutions” and to “offer access to repeat prescriptions via a digital solution” (Standard 4) and “request a non-urgent consultation, including the option of a call back via email” (Standard 5). This is coupled with the requirement of 90% of incoming calls to be answered within two minutes of the end of the introductory message ending (Standard 2). The Health Board provided support in meeting the Standards for digital access by the fixed term procurement of the *eConsult* platform, which allows patients to send an administrative or clinical enquiry for a timed response.
- 2.16 The adoption of **eConsult** and the Wales Access Standards were prior to the pandemic leading to some unintended consequences. Under the combined influences of: assessment of suspected COVID-19 related illness; the time consuming nature of remote consulting (compared to the face to face model); a widespread deterioration in mental health and a steady absence level around 15% amongst Primary Care staff for much of 2020, led many practices to report demand has become unsustainable. Added to this the opening up of digital access via *eConsult*, without any increase in clinical staff to support and respond, has in the view of some opened up a new channel for a younger demographic who might have accessed other services or appropriately self-cared. By some, this was felt to be a self-created demand and capacity problem. With some practices electing to switch the platform off overnight and at weekends. To date the suppliers of *eConsult* have not proved entirely responsive to user requests for control of their practice configuration or input into development. The Primary Care team are progressing this with the providers.
- 2.17 A more predictable set common observations in respect of digital innovations has been success is limited to those areas where there is the capacity to adopt change in working patterns, technical support and IT infra-structure. Less success was noted where there existed problems with Wi-Fi networks (extending throughout a large building

such as a care home) or broadband coverage was poor. Further to this where multiple IT platforms are in use, multiple monitors are required and image and sound quality really matter in user experience and clinical effectiveness.

- 2.18 Despite these constraints a noteworthy positive has been the remote support for Community Teams and Care Homes using video consulting, particularly in the out of hours period. With the caveat that the viewing of video consulting at the clinician end within CTM Urgent Primary Care Services (formerly known as the GP Out of Hours Service) has been constrained by local network issues and the need to work across multiple clinical systems, which remains a live problem.
- 2.19 In the first wave of the pandemic, the Community Respiratory Hub sited at Ty Elai, used video consulting to provide remote support for COVID19 in the community including care homes, with urgent delivery of medication to patients receiving supportive care. However, this required the parallel use of four non-integrated systems which had no inter-operability. Whilst this was effective, and highlighted what could be done as a contingency, this would be far from ideal as a long-term solution to the challenge of providing a service and is emblematic of how Primary Care IT has developed.
- 2.20 There is an increasing strength of feeling within Primary Care that the need for a single integrated patient record and the case of Electronic Prescribing. Both of these needs have been long expressed but not delivered. One CTM Practice has been proactive in working with *Cegedim*, the providers of *Vision*, the most commonly used Primary Care system in use locally, to develop an application to integrate into one place the various existing silos of patient information. Coupled with this would be a patient facing view, with the ability for users to add agreed forms of information (such as symptom diaries, blood pressure and weight) and share in other settings such as the Emergency Department or Outpatient Clinic. The Application is in a testing stage using dummy patient data but could be ready for use within six months.
- 2.21 The national Primary Care Clinical System procurement exercise is due to be restarted in the coming months. The features promised by providers at the last procurement exercise have not been delivered to date. The two products in use in has remained largely unchanged over a decade and lack the essential digital consulting features previously described. A new nationally procured more integrated software system was expected in autumn 2021 for NHS 111 and Urgent Primary Care, but this is delayed.

- 2.22 Video Group Clinics, allowing a facilitator, who may or may not be a clinician, to host a virtual patient education session, has been taken up initially by two CTM practices. Used with appropriate consent and governance processes these have an evidence base and the potential to support chronic disease management, lifestyle interventions, mental health and more.
- 2.23 *Consultant Connect* was provided to Health Boards in Wales at the outset of the pandemic. This is a smart phone application, which gives community clinicians from all disciplines rapid phone advice from a Consultant. The system safely records the conversation and is configured to allow a rota of local Consultants to respond; with the back-up option of defaulting to a national network of Consultants provided by the supplier. Since launch in mid-July 2020, 626 have been answered with feedback provided on 42% of calls that a hospital attendance was avoided on 73% occasions. Users have expressed a strong preference for local Consultants to provide the advice. But this has been challenging for Secondary Care teams stretched like never before during the pandemic
- 2.24 Within **Eye Care**, there are a number of opportunities for value based pathway redesign with parts of service for Diabetic Retinopathy, Cataract and Glaucoma care long identified for movement from Secondary Care to Primary Care Optometry Services. Much of this is underpinned by IT challenges, which remains a challenge, and there is a danger of missed opportunity for Welsh Government funding if these are not resolved.
- 2.25 A summary of the **high value Digital developments** during the pandemic has been:
- (1) The remote support for Community Teams and Care Homes by video imaging.
 - (2) Digital still images for simple skin problems.
 - (3) Cluster level Primary Care records (read and write) access as part of the Community Health and Wellbeing Teams, extended to pan Health Board access as part of the Community Respiratory Hub in the first wave of the pandemic in the Spring of 2020.
 - (4) Digital Access platforms for in hours care in providing rapid access for a demographic who might not have previously accessed General Practice.

- (5) In terms of Digital inclusivity, many who were not immediately digitally enabled were able to access via support from friends, family, carers and community support agencies.

2.26 The **negative findings in respect of Digital developments** during the pandemic were:

- (1) IT infrastructure, including device compatibility and functionality, broadband access and Wi-Fi connectivity, were persistent constraints in some settings. This impacted image and sound quality and the judgement as to when this became unsatisfactory and to discontinue was a subjective one for the clinician concerned.
- (2) The creation of a new digital access channel may have increased demand that could have been met in other ways outside General Practice.
- (3) A small number of patients used the Digital Consulting platform outside guidance, ignoring entry level warnings and incorrectly completing filtering safety questions, to later enter free text describing symptoms potentially needing immediate medical attention such as, chest pain and significant bleeding, breathing difficulty or features of a Stroke.
- (4) The adoption of new Digital Health innovations coincided with the recent introduction of the Wales Primary Care Access standards putting a significant parallel pressure on practices during a pandemic.

PRIMARY CARE ESTATES

2.27 On 19 March this year, the Health Board celebrated the completion of Ty Calon Lan, in Mountain Ash. It is a £4 million Primary Care Centre, and it houses a GP practice (just over 11,000 patients) and a range of community services, including district nursing, health visiting and the cluster community, health and wellbeing team. This was a great achievement considering the challenges of the pandemic and it was the only scheme funded under the Welsh Government's 'Primary Care Pipeline' to be delivered within the original timeline.

2.28 We would like to build on the success of the two schemes above to continue to improve the primary care estate. This will be achieved through an Estates Strategy for Primary Care and Community. At present, a condition survey of all the GP primary care premises is being undertaken and this is due to be finalized by August 2021. This will feed into the overall Health Board Estates Strategy. There are

two important drivers: Cwm Taf Morgannwg population is projected to grow by 2.1% by 2026. Secondly, the Health Board actively promotes a social model of healthcare with a focus on building a multidisciplinary approach. A fundamental part of this model is the provision of a purpose built estate throughout the community to create a platform from which these multidisciplinary services can be delivered effectively and efficiently.

- 2.29 Running in tandem with the creation of the Estates Strategy is ongoing work to improve the primary care estates. This includes the development of the Bridgend Health and Wellbeing Centre. This is a larger scheme, which will combine health, social care and wellbeing services, and is due to be completed in August 2022. Early discussions and planning is also taking place for a couple of other priority areas, which include Llanharran, Llantrisant and Ton Pentre.

Primary Care pandemic recovery

- 2.30 In common with other parts of the health and care system Primary Care staff have worked tirelessly for a sustained period of time. Some have been ill and some have suffered bereavement during the pandemic. Practices have delivered 177,629 COVID19 vaccinations by 12 May 2021.
- 2.31 Data drawn from the Primary Care Information Portal on the position in respect of Long Term Condition (LTC) management provided to Wales Primary Care Assistant Medical Director's Group on 21 April, demonstrates a fall in the recording and achievement of targets in the areas of Diabetes, Chronic Obstructive Pulmonary Disease and Prescribing.
- 2.32 In the case of Diabetes, the percentage of CTM patients having completed all eight measures of care falling from 32.3% (2020-21 Quarter 1), by c. 1% per month, to 19.0% (2020-21 Quarter 4), with a Wales mean of 21%, range 14.2% to 25.7% (2020-21 Quarter 4). With a 40% relative reduction in those considered to have good outcome markers for all Diabetes indicators, falling from 24.6% (2020-21 Quarter 1) to 17.7% (2020-21 Quarter 4), with a Wales mean of 16.0%, range 13.0% to 17.7% (2020-21 Quarter 4). The Primary Care team is in the process of reviewing this data and working with GP Contractors to discuss potential supportive measures with a paper due to the Planned Care Board at the end of May 2021.
- 2.33 In line with the July 2020 Ministerial directive to Health Boards, as part of improving Urgent and Emergency Care, the Primary Care Team is preparing a proposal for a 'Flow Centre' known as '111 First' to navigate callers to NHS 111 identified as having a condition which

is urgent but not needing immediate attendance at an Emergency Department. This fits within the Urgent Care Improvement Programme and an options appraisal will be presented to the next Management Board Meeting. The launch is dependent upon the transfer of Bridgend Urgent Primary Care Service, which is currently provided by Swansea Bay, which is now delayed until September 2021.

- 2.34 In January 2021 four North Rhondda practices successfully bid for Welsh Government **Urgent Primary Care Pathfinder** funding and commenced an in hours Urgent Primary Care Service sited in Ysbyty Cwm Rhondda. The model is designed to allow care navigation of a range of urgent conditions from call reception in the participating practices to a Multi-Disciplinary Team (MDT) workforce. The service has been very well utilised since launch and an extension to funding has been obtained.
- 2.35 Other recent developments during the pandemic include the successful return of New Tynnewydd Surgery to independent contractor status, leaving just one managed GP Practice in Ferndale and Maerdy. In respect of Ferndale and Maerdy, consideration is underway with partners about the future development of the practice including the possibility of GP training status for the practice.

3. KEY RISKS FOR CONSIDERATION

- 3.1 The Primary Care team has an ambitious vision of Multidisciplinary Care delivered by the independent contractors working closely together, empowered rather than impaired by IT, using consistent care navigation to access a wide range of resources, close to home to meet the needs of the population.
- 3.2 Despite successfully trialling, a number of workforce development projects involving Allied Health Professionals Clusters have not been able to consistently mainstream these roles. This has led to in some cases their continuation as cluster funded projects which supports the delivery of care, but restricts further innovation and support for Clusters.
- 3.3 During the pandemic Primary Care Clusters have become more cohesive with improved lines of communication and a greater understanding of the inter-dependency between General Practice, Community Pharmacy, Community Optometry and Dentistry.
- 3.4 At present, there is uncertainty on the future strategic direction, function and leadership of Primary Care Clusters. The Strategic Programme for Primary Care review of Clusters in Wales should help

clarify this, with an opportunity for accelerated development for some.

- 3.5 Digital innovations can only succeed with planning, communication, a change in working pattern, technical support and IT infrastructure.
- 3.6 Primary Care users want influence on the future development and integration of clinical systems, citing the current absence of integration and failure to deliver a single care record and electronic prescribing, as evidence of lack of sufficient voice.
- 3.7 Video Consulting and clinical image sharing have been widely accepted as essential for the future. There are some IT infrastructure barriers to realising the potential of current systems which are also needed for the development and integration work.
- 3.8 Electronic patient consulting has proved very popular such that previous concerns about potential low usage have been confounded. Meeting demand is proving highly challenging in some settings with the context of the pandemic and the pressure imposed by the Wales Access Standards for Primary Care.
- 3.9 Video Group Clinics have the potential for delivery or patient education, long-term condition management and supporting lifestyle interventions but are only at an infancy stage in CTM.
- 3.10 In the coming year, Primary Care faces a considerable backlog in Long Term Condition management, mixed with uncertainties around current GMS contract renegotiations, a review of Enhanced Services, an unpredictable Seasonal Influenza vaccination programme, further potential spikes in COVID19 infection and a possible COVID19 booster vaccination programme.
- 3.11 Addressing the Long Term Condition management backlog will require similar planning, resource and project management support as per the Secondary Care Elective Restart with Primary Care Clinicians from all disciplines integral to its development.
- 3.12 Primary Care has a developed Estates Strategy with a clear vision of the importance of collocating clinical services, training and professional development, collaborative working with partners and accessibility for patients.



4. IMPACT ASSESSMENT

| | |
|---|---|
| Quality/Safety/Patient Experience implications | Yes (Please see detail below) |
| | Quality, Safety, Patient Experience |
| Related Health and Care standard(s) | Governance, Leadership and Accountability |
| | If more than one Healthcare Standard applies please list below: |
| Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services. | No (Include further detail below) |
| | If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. |
| | If no, please provide reasons why an EIA was not considered to be required in the box below. |
| | This paper does not cover a new, changed, or withdrawn policy or service. |
| Legal implications / impact | There are no specific legal implications related to the activity outlined in this report. |
| | |
| Resource (Capital/Revenue £/Workforce) implications / Impact | There is no direct impact on resources as a result of the activity outlined in this report. |
| | |
| Link to Strategic Well-being Objectives | Provide high quality, evidence based, and accessible care |

5. RECOMMENDATION

- The Board is asked to **NOTE** and consider the issues within this paper and in particular, the constraints on embedding established MDT roles within Primary Care, the case for a single patient clinical record and the support, which will be needed in addressing the pandemic related backlog in Primary Care.