NHS 24 **BOARD MEETING**	**20 JUNE 2019** **FOR ASSURANCE**
PRIMARY CARE REFORM (inc GPT)	
Executive Sponsor:	Medical Director
Lead Officer/Author:	Medical Director
Action Required	The NHS 24 Board is asked to note the content of the paper.
Key Points	This paper is an early version of a more comprehensive update that will submitted to all Committees as part of the new planning cycle.
Financial Implications	In line with Service Transformation Programme
Timing	There are no timing issues associated with this paper.
Contribution to NHS 24 strategy	• Realistic Medicine Framework • NHS 24 Strategy • Lewis Ritchie Pulling Together Urgent Care Report • Primary Care Transformation • Service Transformation Programme
Contribution to the 2020 Vision and National Health and Social Care Delivery Plan (Dec 2016)	Through this work NHS 24 is collaborating and delivering on reform of demand management and capacity in Primary Care. Specifically, by maximising the potential of the multidisciplinary team and community assets, the GP as Expert Medical Generalist is being delivered as per the 2018 GP Contract.
Equality and Diversity	EQIA is being completed as part of the STP.

1. PURPOSE

1.1 This paper will update committees on relevant areas of governance underpinning delivery of the Primary Care Reform Programme, substantially our GP triage service model in collaboration with Health Boards/IJBs/HSCP and GP Practices and clusters. This is the first of this type of report and is likely to evolve in format. It is envisaged that there will be sections that are relevant to the various committees and where they are included in papers the reader will be pointed towards the relevant section for that committee.

The paper will describe the project under the following headings:

- Programme background and overview
- Responding to and setting the conditions for change

- Partnership and External Relations
- Assessing and measuring Impact
- Resources including people, budget and infrastructure

2. TIMING

2.1 There are no timing issues associated with this paper.

3. BACKGROUND

In June 2018 NHS 24 completed an evaluation of its GP Triage service model, following a 6 month test of change into the implementation in East Lothian. The purpose of GP Triage as part of the Musselburgh Model is a radical and game-changing transformation of same day Primary Care access and it currently supports about 20% of the population of East Lothian with plans to more than double this during 2019-20.

Scale of the problem

- Prior to the implementation, the demand for same –day appointments with the practice was unmet in 40-50% of cases following a manual data review by the practice. The specific intent was to improve this access demand management.

- Much of the focus of GP time was managing on the day demand and they felt at times volumes were unsafe.

- The complexity of case load managed by GPs was measured at 44% prior to implementation i.e., the case could have been safely and appropriately seen by another health professional.

- The neighbouring practice was a 2c practice i.e., not run by independent contractors and with a very temporary set of staff could not provide the continuity of care required. Sustained by locum GPs it cost significantly more to run.

- GP retention and recruitment was a challenge and morale was low

- Public frustration with access was evident and this was reflected in the GP Experience survey for 2017/18 where access questions were answered negatively by 68% of the patient cohort compared to 20 % nationally.

The Proposed Solution

To support demand management flows NHS 24 would triage 50 calls per ten thousand patients for Riverside Medical Practice from Nov 2017-Jan 2018. The specific aim was to maximise the triage outputs to safe self care and referral to other resources/professionals so GP appointments were reserved for the most complex cases. This is in line with the new GP contract where the GP is designated the Expert Medical Generalist.

From Jan 18 when the Riverside Practice subsumed the neighbouring 2c Esbkridge Practice and also linked to the CWIC hub (multidisciplinary team). From this point

NHS 24 took 100 calls per day as the practice had grown to 22,000 and with the merger with CWIC, had access to a multidisciplinary team to see patients as output of NHS 24 triage. A simple abstraction of the model is in Figure 1.

The Stakeholders

Riverside Medical Practice: Remaining the single point of contact for all its approx. 20,000 patients, the practice has developed a team of Care Navigators working alongside the duty GP in its "Call Centre". This Riverside Call Centre team's key role is to assist those patients who seek same day primary care access. The majority of these patients are suitable for allocation to a telephone call back from NHS 24 Primary Care Triage team.

NHS 24: The dedicated in-hours NHS24 Primary Care Triage team provide call-back telephone triage of Riverside patients allocated to this service by the Riverside Call Centre team. This triage call allows an in-depth telephone-based assessment of the patient's concerns and needs and is supported by clinicians in the NHS24 team. Where suitable they can support patients to self-manage a range of self-limiting conditions. Where a same day appointment need is established, the NHS24 team can book patients directly into appointments in CWIC or RMP with the most suitable clinician. Currently NH24 receives up to 100 requests for triage calls from Riverside per day. The agreed volume equates to 50 calls per 10,000 patients. It is about 20% of the complete volume of calls for Riverside Medical Practice.

ELHSCP's Collaborative Working for Immediate Care Service (CWIC**):** This is a multidisciplinary team providing care alongside the core RMP team to its patients who seek and require same day primary care face to face assessment by a clinician. The patients are booked into the CWIC appointments via the Riverside Call Centre and via the NHS24 Primary Care Triage team. The CWIC service comprises a range of skilled professionals: Nurse Practitioners; Advanced Nurse Practitioners; Advanced Physiotherapy Practitioners; Mental Health Nurses; and Mental Health Occupational Therapists. These staff can assess, treat and discharge or refer patients and work in parallel with the clinicians at RMP to care for the patients within the Primary Care Team.

4. RESPONDING TO CHANGE

It is relevant at this stage to review the strategic alignment with internal and national priorities.

Overall the collaboration meets a number of strategic aims

- In line with Lewis Ritchie's Pulling Together report on delivery of unscheduled care to the people of Scotland, this is a development that involves a community care 'hub' and multidisciplinary team working. By improving access for service users during the day it is anticipated that it will benefit the delivery of OOH care as well. Through this project NHS 24 have also worked closely with SAS colleagues, another high level recommendation of the Ritchie report.

- The Health and Social Care partnership multidisciplinary team in support of Riverside Medical Practice supports delivery of a number of elements of the

Memorandum of Understanding in the new GMS GP contract e.g. provision of urgent care.

- NHS 24 strategic aims outlined in its Strategy on supporting connecting, caring and collaborating for living longer healthier lives. (Put simply, by breaking the focus of on-the-day care as a main driver of demand management in General Practice, more focus can be given to continuity of care e.g., long term conditions and polypharmacy).

- NHS 24 Digital Strategy

- Realistic Medicine promotes putting the person at the centre of their care and emphasises the importance of staff in delivery of high quality care.GP Triage has involved a collaboration of the deepest kind to co-design a service that is fit for purpose now and into the future.

- National Board Collaborative intent to support H&SC Integration and support to implement the new GMS contract.

- At all times the NHS 24 Quality Management Framework has informed change and there has been a focus on quality planning, improvement and assurance which will inform the development of Primary Care Reform support by NHS 24.

Horizon Scanning

It is worth picking out the implementation of the GMS contract in terms of horizon scanning. One year on since the contract offer, Integration Authorities are developing the second iteration of their Primary Care Improvement Plans (in support of the GP contract MoU delivery) in collaboration with their local GP sub-committee. Whereas the first plans received in September 2018 set out proposed intentions for service redesign, the May 2019 plans (second iteration of PCIP) describe actual progress on implementation and with it reassurance to the four MoU signatories on scale and pace of progress.

The PCIPs nationally currently have a varying pattern of investment depending on which areas of the MoU they choose to focus on initially. In East Lothian 80% of the PCIP is invested in the Musselburgh Model' with intent that its benefits will extend across the county this financial year. This is not mirrored across the country as a model. NHS 24 will review the PCIPs in May /June 2019 to assess where there are opportunities beyond those currently exploited that align with our AOP and SPRA process.

5. ASSESSING IMPACT

The range of metrics used to measure impact will be discussed and demonstrated below. The starting point will be the lessons learned from the 6 month collaboration

The WHO defines a Health Impact Assessment as Health Impact Assessment (HIA) as" a means of assessing the health impacts of policies, plans and projects in diverse economic sectors using quantitative, qualitative and participatory techniques". https://www.who.int/hia/en/

The Primary aim of the GP triage provided by NHS 24 was to improve GP appointment access and to ensure safe provision of - same day access to the 'right person, right time, right place' in a person centred way. From the outset the process of clinical triage applied by NHS 24 reduced the output to GP appointment. The merger of the second practice and extension of triage outcomes to the MDT in the ELHSCP further reduced the use of GP appointment to meet on the day demand and re directed service users to the correct resource/person.

- Figure 2 outlines outcomes for NHS 24 triage to RMP alone.
- Figure 3 outlines outcomes following merger of MDT hub and second practice in Feb 2018
- Figure 4 demonstrates sustained benefit from the collaboration in March 2019.

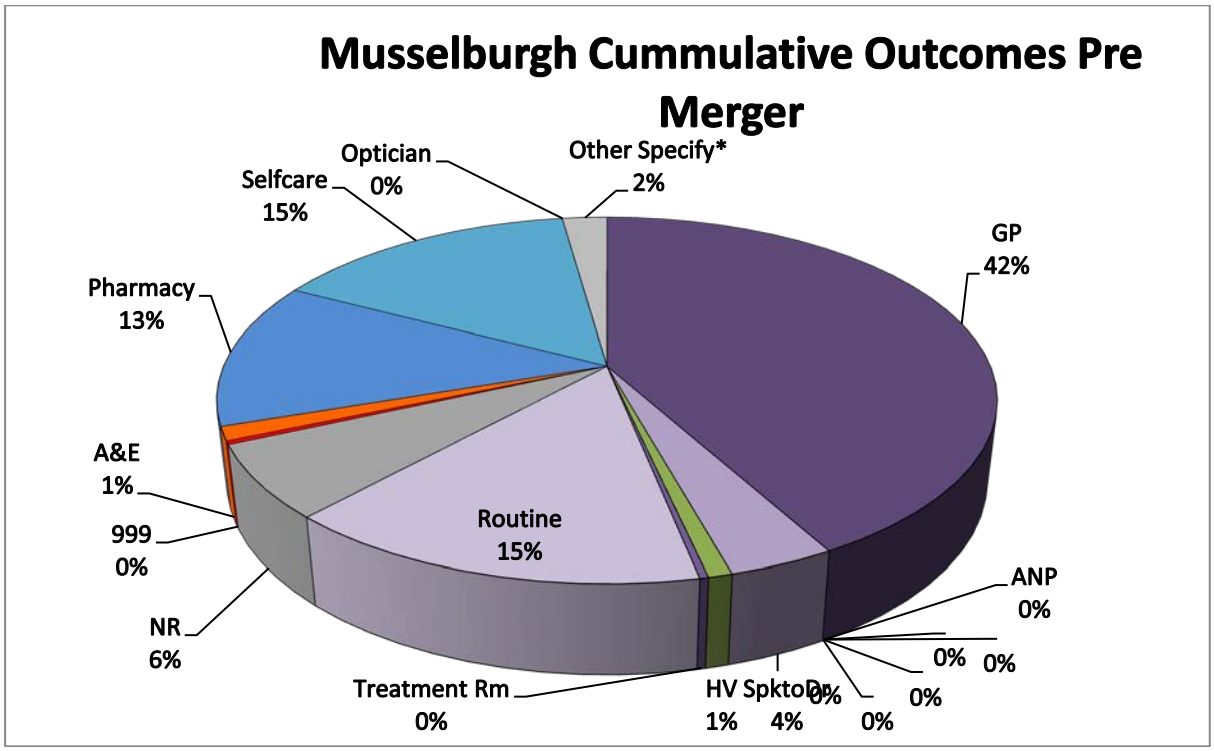


Figure 2: Outcomes following triage November 2017

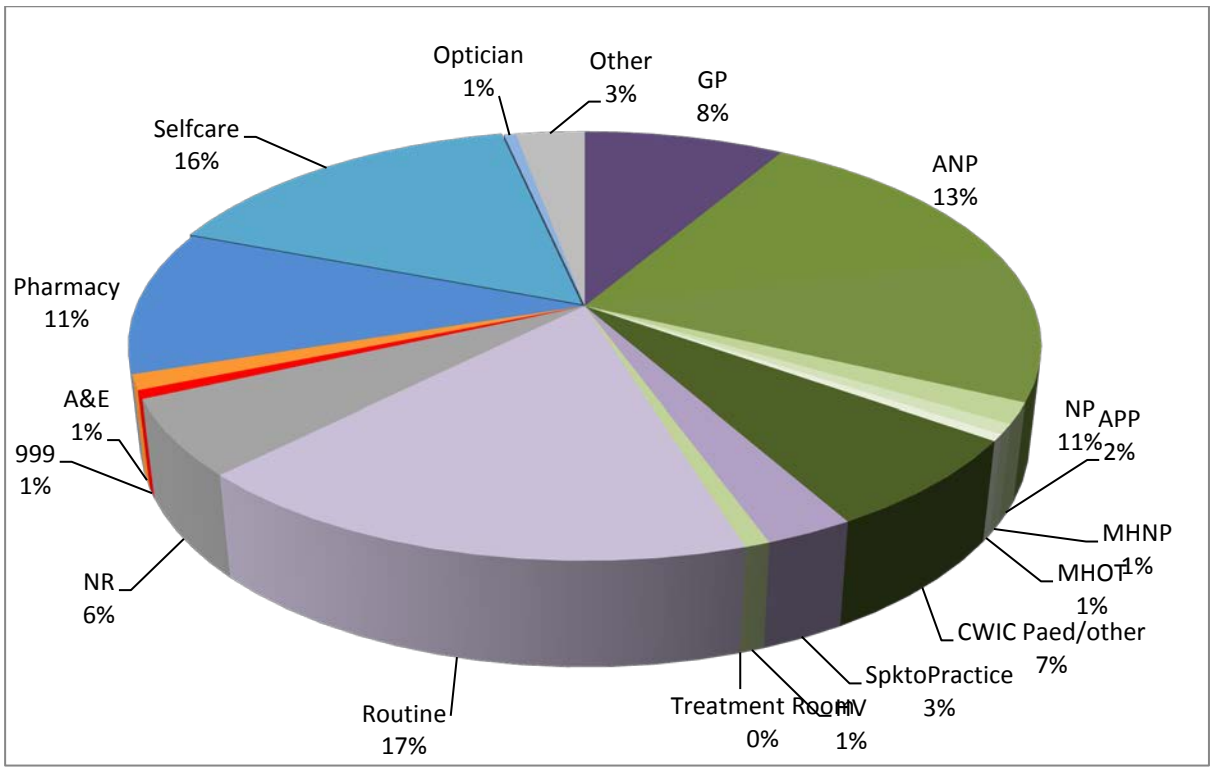


Figure 3: Outcomes 6 month evaluation

Improvement has been sustained in March 2019.This is illustrated in Fig 4

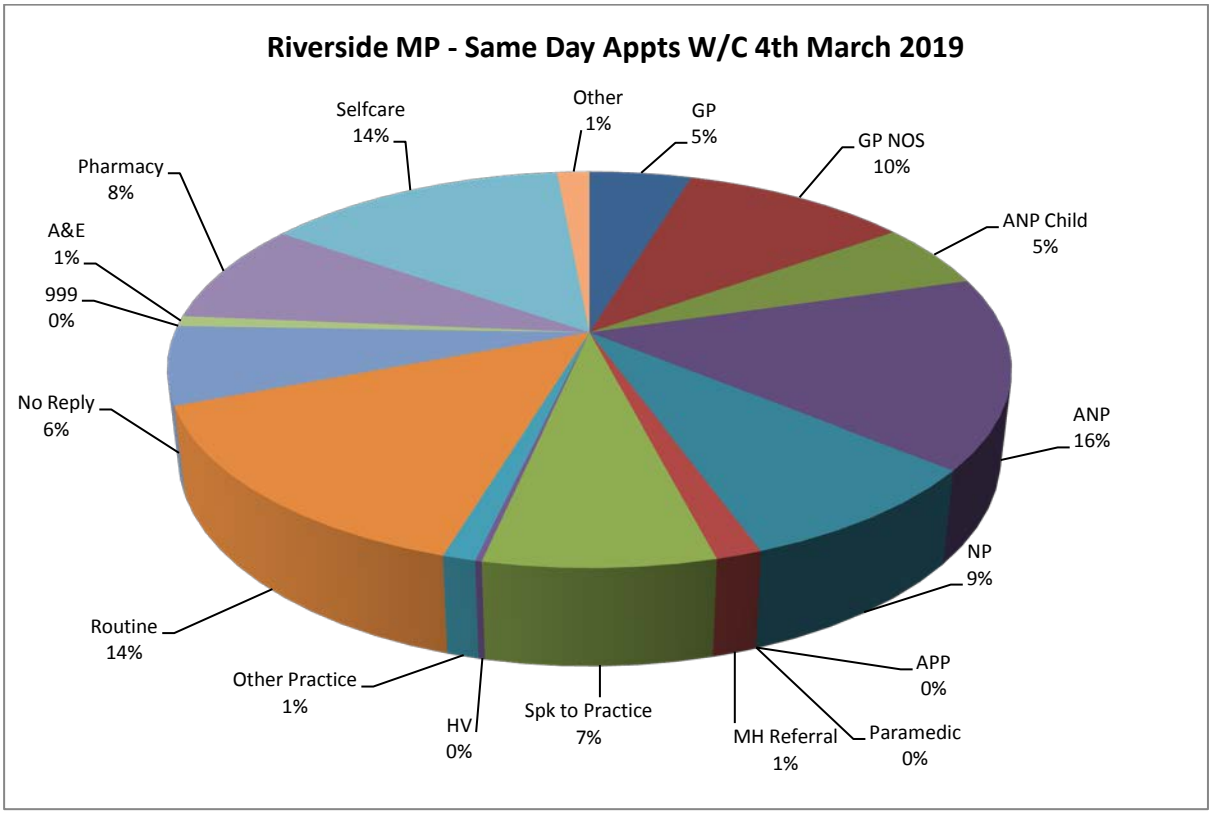


Figure 4: GPT outcomes March 2019

6. LESSONS LEARNED UPDATE

As part of the collaborative evaluation in 2018 a ‘lessons learned’ exercise was completed jointly with partners. This evaluation was shared at NHS 24 committee. An update on these lessons is below as an update for the Committee and reinforces NHS 24 intent to be a learning organisation.

Topic	**Lesson from Evaluation 2018**	**Progress**
Technology	Implement changes to NHS 24's core records management system (SAP CRM) to support the GPT model and pland for redesign of the end-to-end business process to improve efficiency and the staff and public's experience of the service.	Updates to SAP are on track for implementation in June 2019 and will deliver efficiency in terms of record creation and the patient journey from calling RMP through to triage and return to local services/self-care.
Digital Provision	Expand use of digital services to offer increased choice and flexibility in accessing and navigating local services e.g. on line consulting, video consultation, Home and Health Monitoring.	A report of this area will come back to the Committee
Data	Increase investment in gathering insight from service users, from the earliest stages of planning for service adoption and throughout delivery	Over the past year a robust Service Adoption Process has been developed as a direct output of the process and iterative learning approach taken with partners. This is now being used to engage with NHS Dumfries and Galloway. Appendix 1: Contains the Service Adoption Process Appendix 2: Contains the Primary Care Modernisation Purpose Agreement for In Hours Primary Care Triage which has been agreed and signed by all partners. Appendix 3: Data Protection Agreement

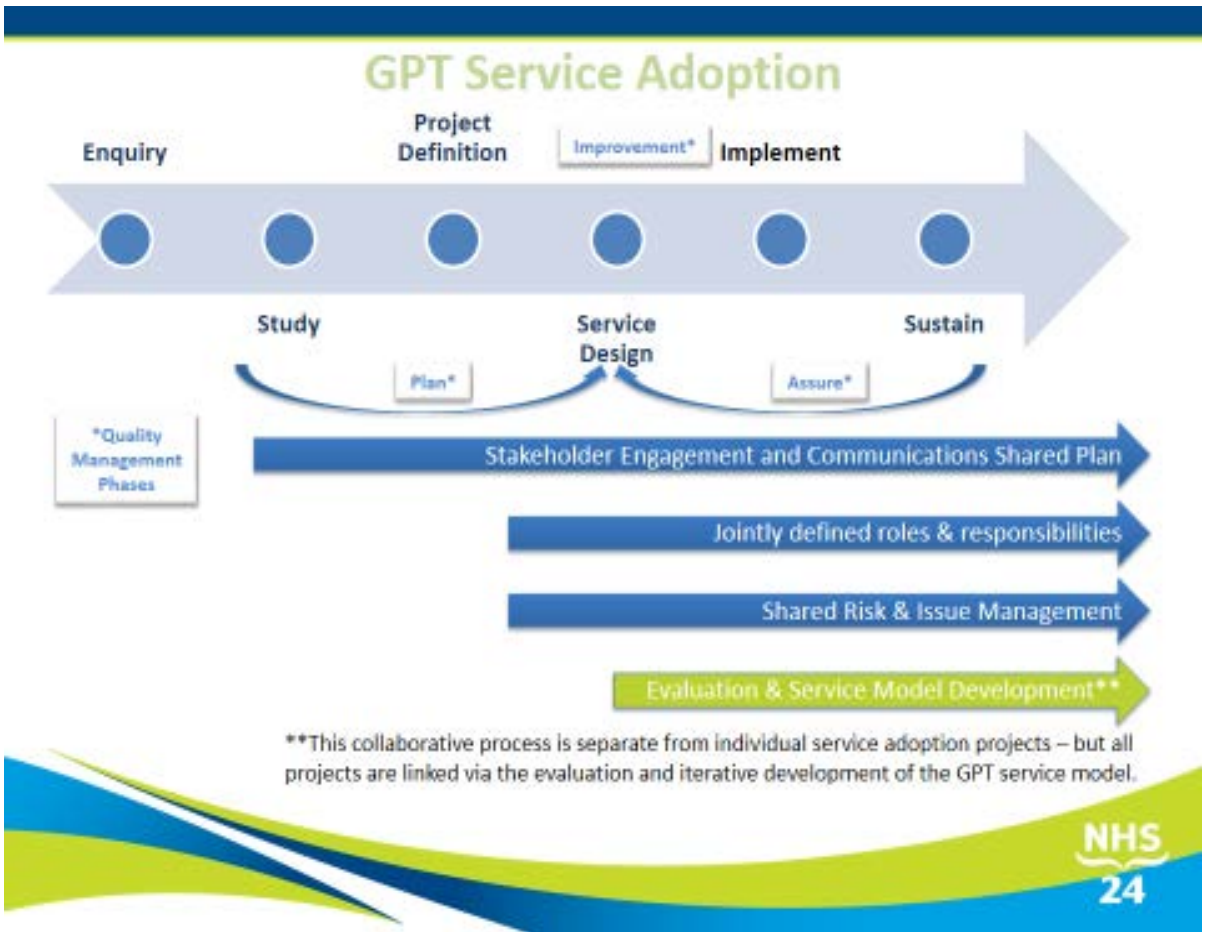


Figure 5 Service Adoption Process End to End Flow

Information Governance

To assure the committees, Information Governance in this change covers a range of areas

1. Data Protection Agreement with the practices including the access to the patient GP record by NHS 24 staff. Currently this occurs in 2% of records and where doing it benefits the patient journey. NHS 24 staff can see the Key Information summary and ePalliative Care Summary as they can in the Out of Hours period.

2. The safe management of data including retention of records as across the organisation.

3. Supporting partners as they expand their digital telephony capability eg signposting to data protection considerations as they develop their offering

4. Assurance that a Privacy Impact Assessment has been completed.

Topic	Lesson from Evaluation 2018	Progress
Data	Develop detailed and robust plans for data collection, including comparative and baseline data from GP IT systems, with an increasing emphasis on understanding the whole system implications of the model. Develop capability to analyse and report on the impact of the GPT service across all Out of Hours services.	Extraction of data for service improvement from GP systems is challenging. This is well documented in the evidence base (Newbold et al, 2017). As set out within the DPIA (appendix 3), all required data to support the evaluation of the project and ongoing weekly updates/learning will be shared between stakeholders. For example, baseline data or same day outcome codes are recorded to analyse call flow. • The NHS Services Scotland ISD division have new Local Intelligence Support Teams have been working with East Lothian to help with data extraction. The implementation of the digital telephony solution will allow measurement of demand, calls waiting and call recording in order to plan services. • Within NHS 24 the extraction of service data is currently a manual process but automated reporting will be available from June 2019. • In term of whole system impact discussions with LIST team lead are as follows "We will need to engage with the Unscheduled Care team in ISD who hold most of this but the bit about within 7 days of consultation with practice might be trickier given that the practice/OOH/ED systems don't really talk to one another". This is an ongoing piece of work with meetings in diary with LIST team following a collaborative governance workshop in June with the next tranche of practices joining in the East Lothian model.
Data	Develop capability study variation in demand levels and call handling.	• Within NHS 24 the extraction of service data is currently a manual process but automated reporting will be available from June 2019. • Nonetheless a consistent pattern of demand has been established for East Lothian which is illustrated in Figure 6

		below for three weeks in February 2018. • Baseline data gathering with Dumfries and Galloway will be used to plan call demand but is currently based on 50 calls per 10,000 patients.

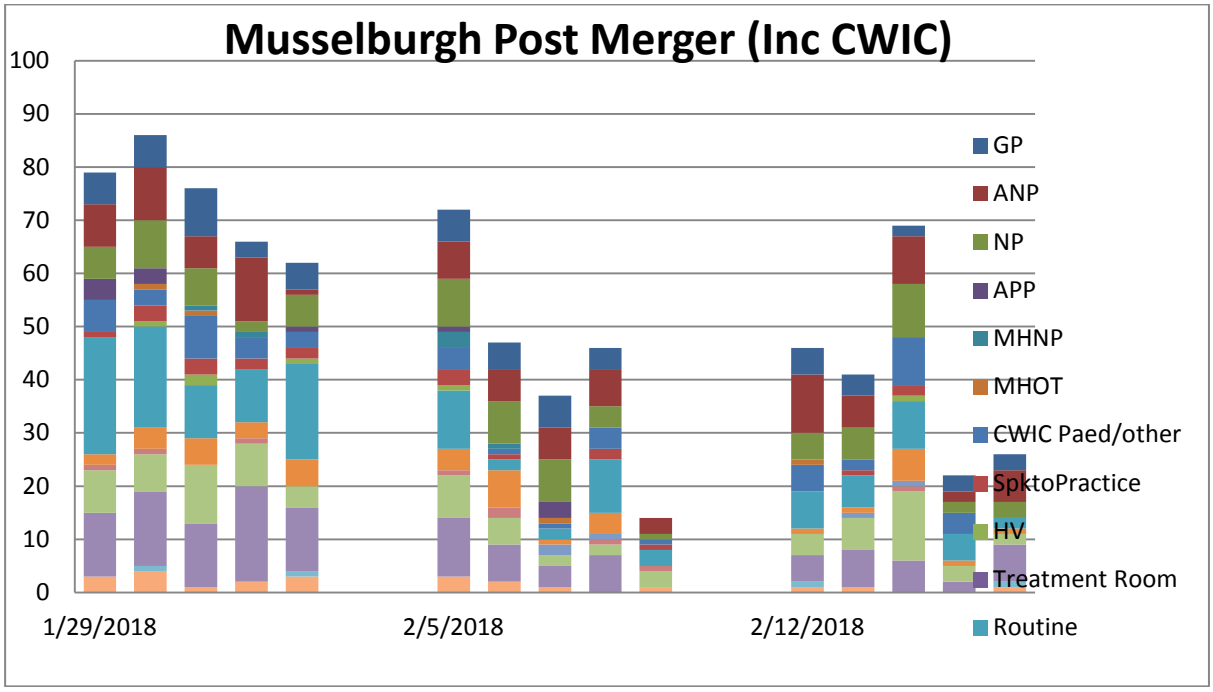


Figure 6.Weekly call pattern February 2018

Topic	**Lesson from Evaluation 2018**	**Progress**
Patient Journey	Map the full end-to-end patient journey. Extend the detailed basis of agreement on workflow with practices to Routine appointments	This has now been completed with more than 18 reviews of the process in order to streamline. Fully reviewed endpoints with associated coding development as part of SAP upgrade in June 19.Ongoing monitoring of patient journey will continue as we on-board new partners. Current flows and flows post June 19 are in Appendix 4
SAS Working	Develop a workflow with SAS Specialist Paramedic as an available option, effectively as an extension of the practice level MDT	The SAS practitioners have been in place since January 2019 and a deeper report will be presented at a later date. Funding for 19/20 is in place.

Complexity of care seen by the GP	Consider development of a scale for clinical complexity to support workflow design and yield improved data on service impact.	Since implementation of the GPT model and merger with the MDT hub the GPs have measured through notes review that 88% of what they see is now appropriate for a GP (44% beforehand).In terms of definitions of complexity, this was agreed and co-created with our GP colleagues. Definitions are below. One of the GP partners reviewed over 50 sets of records before and after implementation. She has also reviewed outcomes to ANPs for safety as part of this process. No concerns have been raised and this review format will continue. High clinical complexity: requires a GP from the outset Medium Clinical Complexity: appropriate for another health professional but if resource is not available, then a GP is the appropriate triage outcome Low complexity: suitable for self -care or community pharmacy
Stakeholder engagement	Develop with partners a range of cross-channel communications and involve local people directly in service design and development.	Riverside Medical Practice recognised that it would be necessary to engage their stakeholders as the In hours GP Triage Model developed between NHS 24 and Riverside. This would be particularly important as there were a number of major changes happening sequentially over the period of a couple of months winter 2017/18. • Introduction of In Hours GP Triage • Merging of neighbouring Practice (Eskbridge) • Introduction of the HSCP CWIC multidisciplinary Hub (on Riverside Site) NHS 24 provided advice and support re. communications messaging and engagement activity throughout the period and worked in conjunction with the HSCP Communications Lead where possible. Key public messaging was developed in a range of formats for dissemination via a number of channels: • Riverside Website o Short news item and Q&A developed for news section of website o Full website section dedicated to the new ‘way of working’ between NHS 24 and Riverside

		o Video clip developed providing an overview of developing model with Introduction of CWIC, referencing NHS 24 triage. • Twitter channel established as an additional communications tool, managed locally. Engagement: • Staff Engagement: o NHS 24 supported discussion with staff in Riverside about the changes and new ways of working o NHS 24 provided an awareness session available to all staff (Clinical & Administrative) re. broader aspects of care navigation and digital signposting • Patient Engagement Riverside established a Patient Participation Group over winter 2017/18. NHS 24 helped support the initial session facilitated by HSCP Communication Team. NHS 24 has since participated in a further PPG Meeting and provides ongoing guidance to the group in the development of materials for use in Practice i.e. posters etc. A further patient participation group has been launched which includes service users from the GP Practices which will join the extended model in 19/20

7. RISKS

The full update of STP programme for Board and Committees will cover this but it is worth reflecting on the following risks.

- Ensuring alignment with NHS Board Annual Operating Plans. To ensure alignment with PCIP all the second iteration will be reviewed internally to assess opportunity

- Staffing resource. In the context of the national picture the ANP is a prized resource and we may end up competing with Primary Care and other settings for more senior staff if our offer is not attractive enough. Thinking about this is ongoing with work advancing through our internal ANP development which will facilitate this.

- If funding is not extended medium long term ,then the 'closest' route could be the PCIP and these are already stretched and it is not known if an offer from NHS 24 will be a choice made nationally by stakeholders over e.g. other priorities for each area.

- Ability to improve the link between national data sets is an imperative to demonstrate value of the endeavour to other services beyond PC.

8. PATIENT SAFETY AND PRIMARY CARE COLLABORATION

This document intends to set out the framework for clinical governance that is an integral element of any primary care collaboration

'Clinical Governance describes the structures, processes and culture needed to ensure that healthcare organisations, and all individuals within them, can assure the quality of the care they provide and are continuously seeking to improve it'[1].

Purpose of the Governance Framework

Overall this Clinical Governance Framework should ensure that there is an organisational and stakeholder focus on improving clinical quality and includes:

- The scheme of accountability and delegation across all areas for the quality of clinical services and practice

- The structure and constitution of key groups through which objectives and priorities are set, monitored and reported on

- The resources, methods and activities that seek to improve the quality of clinical services and practice

- The rules and procedures for making decisions (e.g. in policies and procedures)

- The collaboration across distinct but complementary functions and responsibilities

- The underpinning organisational values, behaviour and practices; ensuring a culture of openness, fairness and learning from experience is encouraged

Evaluation of the Framework

In practice, the governance aspect of Clinical Governance can be seen as a collaborative system of evaluation that can analyse and enable improvement in clinical care, but whose activities also link to external communication and reporting for public assurance as to how each partner is realising its clinical quality aims.

A constant challenge for services is the judgment as to whether all the reports, actions and plans reflect detectable and sustained improvement or merely describe change and good intentions. Evaluation is the formal and structured collection,

[1] (Department of Health, 2011)

analysis and interpretation of data about any aspect of clinical practice, service (or improvement programme).

Self assessment and evaluation of improvements are regarded as being built into everyday management activities but broader systems and change processes should be supported by formal evaluation plans. The plans should seek to reflect consideration of the effectiveness of arrangements or systems as well as the realisation of their aims and objectives.

Accountability for the quality of care lies in the primary line of management for clinical services/service delivery. Therefore monitoring/evaluation of the operating standards and improvement plans for the clinical governance framework rests in the primary line of general management and the associated planning/performance review processes. This is supplemented by the Clinical Governance Implementation Group and various Clinical Governance Forums, linked to the oversight role of Quality and Performance Committee.

To confirm the governance framework supports learning within NHS 24 and stakeholders, and provides assurance on the standards of clinical quality, the key committee/groups will inquire through reports from clinical services and their supports. This routine of inquiry must be consistent with and supplementary to the requirements of performance management, including those for jointly established Partnerships.

NHS 24 and stakeholders could also use a variety of internal and external mechanisms to monitor and evaluate the effectiveness of the Clinical Governance Framework.

The effectiveness of the overall framework and its constituent elements will be evaluated on annual basis, with identified improvement noted in a Clinical Governance Improvement Plan.

NHS 24 uses the Health Foundation Measurement and Monitoring of Safety Framework. The Figure below outlines this process.

Figure 7 Framework for Measuring and Monitoring Safety (Health Foundation , 2013) https://www.health.org.uk/publications/the-measurement-and-monitoring-of-safety

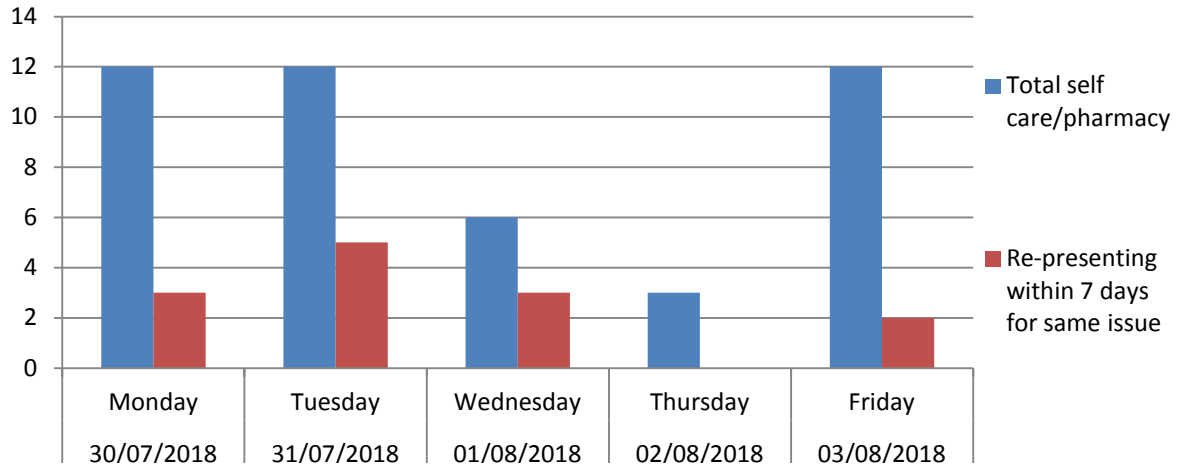
Past Harm

This includes review of the patient feedback. Our clinical governance process and complaints handling process means that complaints are jointly investigated where relevant. In total 71 patient feedback have been received and 5 have referred to NHS 24.There were no patient safety issues.

Reliability

- Routine call review
- Case review
- Routine reporting
- Schedule of review for all clinical and operational processes
- Collaborative approach to standard operating procedures
- Return visit to Riverside with same clinical issue. This is a very manual task completed by one of the GP partners. Assessment from GP of 24 cases returning within 7 days is laid out below.

24 cases were reviewed.15 cases had ‘no return’ to any service at 7 days.4 returned to a CWIC appointment within 7 days following re contact - all seem to be ‘reasonable’ i.e., no improvement/worsening. One patient was signposted to dental (so didn’t re-present to any medical services).Two patients had pre-booked GP follow up appointments, i.e., phoned and received self-care whilst already holding that pre booked appt.1 A+E attendance and one 1 disputed outcome and called duty Dr back in same day



999 outcomes

7 of the 999 outcomes in 2018 at 6 month point and all were found to be safe and appropriate with no safety concerns. This constituted 50% of all 999 outcomes at that point.

Sensitivity to Operations

Is care safe today?

- Using designated clinical governance lead
- Meetings and twice-daily handovers

- Day-to-day conversations
- Staffing resource
- Collaborative approach to patient comments and complaints.

Anticipation and Preparedness

The following activities relate to sensitivity to operations in the context of service management and patient safety

- Evaluation of dashboards against key indicators
- Risk management
- Clinical audit
- Human-centered design to understand challenges and develop innovative solutions
- Staffing and staff management
- Education, training and continuous personal development
- Clinical effectiveness
- Twice daily operational conversation ‘huddle’ to monitor local issues and adapt if required
- Business continuity process which covers both Riverside and NHS 24
- Use of demand patterns to predict demand and staffing profiles
- Measurement and monitoring of operational quantitative data relating to outputs.
- Full review of triage outcomes to match expanding MDT

Integration and Learning

Sources of information to learn from include:

- The staff working in GPT all have call reviews as per the NHS 24 Call Review Process. This includes joint case listening. The Calls are selected by the staff themselves. They are compliant with the organisational KPI. Moreover, they have individual coaching sessions regularly.

- Each site has an operational meeting monthly (operational staff) and a Senior Steering Group which his constituted of senior leaders across the three partners. All aspects of governance are covered at both these meetings

- Planning workshops for further extension of East Lothian Model are in place.

- Evaluation of processes is ongoing.

- Opportunities to share the learning from the collaboration has occurred at NHS Lothian Board level ,national GP sustainability events, the NHS Scotland event in 2018 and acceptance of a poster at the NHS Scotland event 2019.Primary Care leads and RCGP Chair Scotland have received updates on outputs. Commitment for RCGP to be involved in assessment of outputs for opinion. See appendix 5 for NHS Scotland poster

- Secondment of a GP partner from NHS Borders with eHealth expertise who works in OOH and ED setting to ensure whole system view.This ensures safe and competent peer engagement with practices who are ‘on –boarding’.IT also provides expert clinical oversight to process and content development.

- Clinical governance national meetings and committees will receive updates regularly. A new template for all service developments will include one for GP Triage. CGC Agenda item 7.3 are example of reports going to Clinical Governance Committee as quarterly update on new developments and services. These are in development and will be refined as time passes and data gathering improves

- Outputs from GPT are going to a Primary Care Change Governance Group in East Lothian HSCP.

- Automated information management systems highlighting key data (e.g. evidence building)

- Using dashboards and reports with indicators, set alongside financial and access targets.

- Evaluation of themes and trends from identified learning

- Evaluation of patient and stakeholder feedback

9. FINANCIAL IMPLICATIONS

NHS 24 are expecting circa £1.7m from the Transformational Change Fund for GPT in 2019/20. The table below shows the forecasted phasing, including a breakdown between pay and non pay.

Forecast Expenditure GP Triage 2019/20	Qtr 1 £,000	Qtr 2 £,000	Qtr 3 £,000	Qtr 4 £,000	Full year £,000
Pay costs	125	359	359	541	1,383
Non Pay	100	210	0	0	310
Total	225	569	359	541	1,693

The table above reflects the planned expansion of GPT as per the request to the Transformation Fund. This was predicated on phasing to 72,000 population coverage by the start of Qtr 2 and remaining steady until 127,000 is achieved by taking on additional practices at the end of Qtr 4.

Recruitment authorisations forms totalling 20 WTE were approved in April to allow expansion into Dumfries & Galloway. A further 40 WTE would be required by the end of QTR 4 to match the predicted budget. Close monitoring will be required in order to flex the expenditure profile to match any changes to the predicted growth of the service. To ensure any potential deviation from the budget is caught early, Finance have agreed to work with the GPT team to develop a bespoke costing model that will aid with planning and forecasting.

10. RECRUITMENT FOR PRIMARY CARE TRIAGE TEAM

Recruitment is currently underway for an additional 7 WTE Call Handler resource for the East Contact Centre. This will bring the total up to 10.97 WTE

Recruitment is also underway to recruit a further 4 WTE Nurse Practitioners to bring the total resource up to 9.68 WTE for the East Contact Centre.
A pipeline for both skill sets will be kept warm to bring in additional resource in Quarter 4. Any deficit in resource will be recruited in Quarter 4 with advertising prior to festive, to bring in additional 40 WTE Call Handlers.
There is 1 WTE Team Manager in place currently as well as 2.30 WTE Senior Charge Nurses.