Humber and North Yorkshire Health and Care Partnership
Primary Care Collaborative

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Primary Care in Humber and North Yorkshire HCP

The achievements of the GP Forward View, the NHS Long Term Plan, and the five-year framework for GP services for Primary Care

100% primary care network coverage last year, with a total of 39 primary care networks now in operation.

Direct enhanced service for care homes successfully implemented.

Early cancer diagnosis work supporting practices to review their referral systems and patient monitoring, began as planned

Transformation funding through the GP Forward View programme:

- Over £7.5m for delivery of premises projects planned for completion in 2022
- £4m for digital transformation.
- £1.4m for a local electronic eyecare referral project.
- £1.3m to support Covid-19 and maintaining services.

A total of £266m has been invested in primary care via the six HCV CCGs during 20/21. By the close of the five-year funding programme the total investment will be £1.2billion. Additional £5.4m allocated this year through the GP Covid-19 capacity expansion fund.

Online consultations have improved patient access to care and helped clinicians manage demands on their time. All of Humber, Coast and Vale GP practices now offer online consultations.

Digital First Primary Care programme - over £1m in revenue funding was used to support the Yorkshire and Humber Care Record.

Collaboration between community pharmacies and primary care networks - GP community pharmacist consultation service supporting patients to access the most appropriate healthcare service for their needs.

General ophthalmic services – electronic eyecare referral service pilot adopted for the North East and Yorkshire region following launch of national initiative. A provider for the system across HCV was procured and approximately £1.4m funding secured.

Work ongoing to increase training capacity in local areas - Hull, Scarborough and North East Lincolnshire.

Achievements during the pandemic

Primary Care Networks and community pharmacies instrumental in the launch of the national Covid-19 vaccination programme.

Ensured access (including face-to-face appointments) to GP services

Delivered support for high-risk patients

Provided access to adequate supplies of (PPE)

Development of the Primary Care Collaborative

- 2022-23 will be a significant year of change across Humber and North Yorkshire HCP, and primary care has an important sector role in shaping the future
- New working arrangements will be delivered within the six Places supported by the provider collaboratives working at scale to maximise impact and strengthen quality
- New relationships between collaboratives will be forged that recognise interdependencies across the sectors and co design to promote integrated service models
- In addition to the new working arrangements NHS Planning Guidance for 2022-23 has set out specific asks of Primary Care, focused on:

  a) Improving access to primary care
  b) Expanding capacity
  c) Driving integrated working at neighbourhood and Place level

- The Primary Care Collaborative is the leadership group that will influence and shape delivery of plans – recognising the value of doing things once and trusting the 6 places to determine their local delivery model

How will we work together…

- The team will work with the 4 contractor groups to understand and co design actions that support delivery of Collaborative priorities and agree draft plans
- We are proposing that each of the three workstreams should have a nominated clinical lead from primary care, and an implementation lead to test out ideas, and coordinate delivery of plans
- Links have been made across the Community, Mental Health & Acute Collaborative to identify interdependencies
- Delivery of the Collaborative priorities will be managed through two key dimensions – the priority workstreams and geographical impact
- We will use the collective expertise of the Collaborative to enhance delivery and understand hotspots and where we need to align action to level up
- We will share learning and showcase the best of what we do to accelerate transformation

Geographical Delivery

PCN

Plans which are best developed and delivered by a PCN/s with a focus on population health needs and inequalities

Place

Working at Place level where delivery partners plan together to improve population health through integrated models of care

ICS

Where there are at scale population health needs and inequalities that require a coordinated system focus and effort to bring about change

Primary Care Collaborative Priorities

Supporting and developing the workforce

Expanding roles, shared employment models

Focus on increasing access

Improved access to services using integration, digital and estates

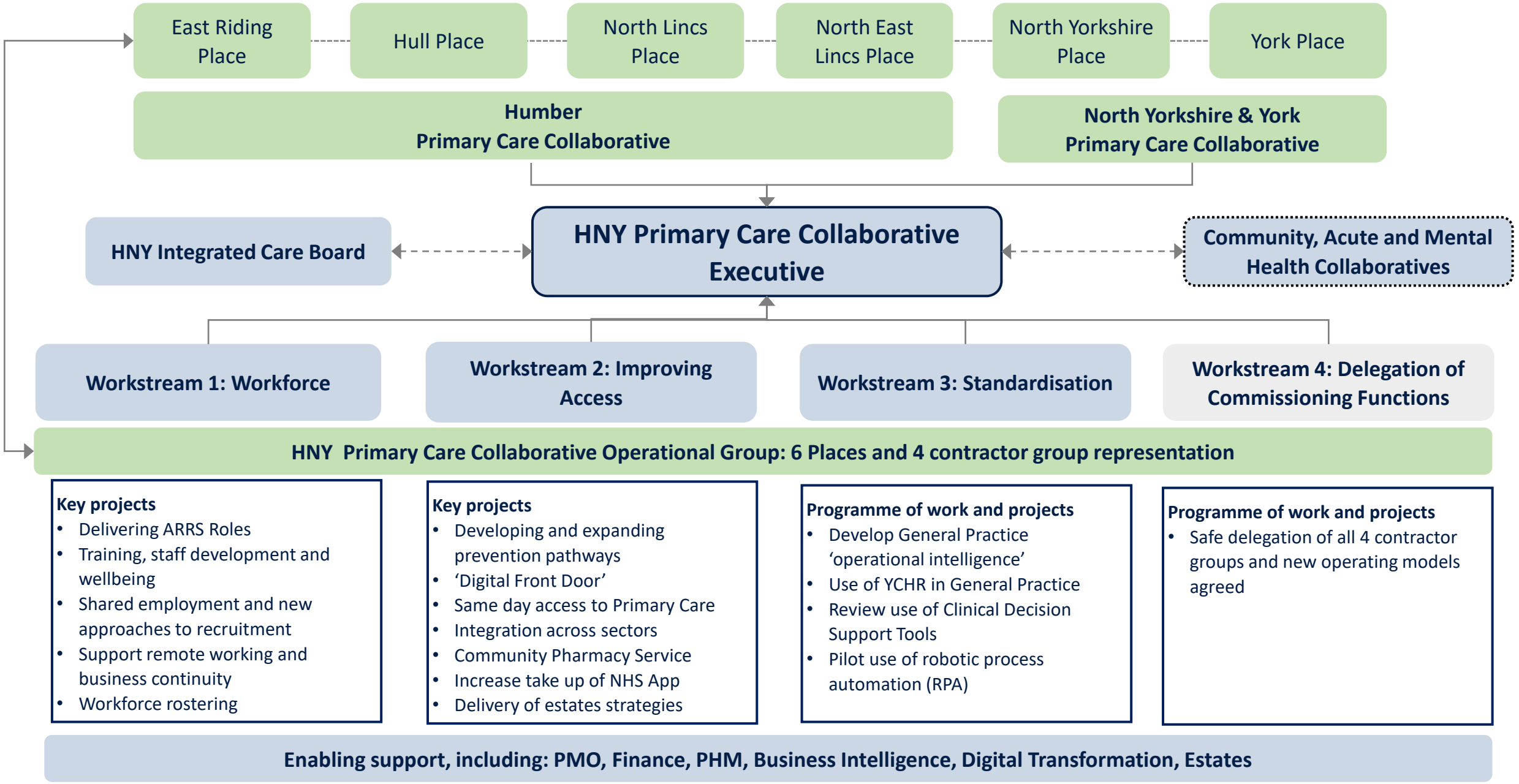
Standardisation

Using business intelligence and technology to free up clinical time

Phased delegation of commissioning functions

Across all contractor groups by 2023

Primary Care Collaborative Governance Structure



Key Actions Supported by the Primary Care Collaborative

Workforce related actions	Standardisation actions	• Increasing access actions

• GP Fellowship offer
  ○ Catalyst programme
  ○ Enhanced programme for fellowship
  ○ Phoenix programme
• Practice Nurse Fellowship offer
  ○ To be delivered by the training hub
  ○ Enhanced PN fellowship offer for PN outside of national criteria
• Rotational Paramedic programme
  ○ Working in partnership with YAS
• Recruitment support through WAF scheme lead by Yorkshire Health Partners on behalf of all PCNs in HCV with particular focus on ARRS
• Primary Care Workforce Group to continue to oversee investment in workforce related actions on behalf of the ICB
• Reduction in staff absence due to COVID – supporting with a number of Health and Wellbeing offers for the whole workforce
	• Standardisation to GPAD coding to enable the ICB to fully understand the position across all GP practices.
	• To ensure that activity is registered for appointments within Klinik and other digital solutions for appointments to ensure the full workload is registered and recognised within the overall activity for Primary Care.
	• To support levelling up on recruitment of GPs across the ICB the Fellowship programme are targeted towards under doctored / hard to recruit to areas of HCV initially and then extended to other parts
	• 111 Direct Booking – work across the system to provide a consistent offer to enable 111 to book into GP practice appointments in line with the national GP contract 2022/23
	• Standardisation of practice website homepage content and establishment of consistent update process and support where required.
		• Video Consultations to be embedded as an option across the system
		• WAF programme to increase access capacity – 127K appointments in HCV
		• NHS App – working with the Voluntary sector to promote and increase the uptake (from 40% to 60%) of NHS App for repeat prescriptions and requesting GP appointments
		• Community Pharmacy Consultation Service continue to role out the CPCS service across the whole of HCV with support the LPC
		• Community Optometry to refer direct into Community Pharmacy for any patients suspected of high blood pressure. CP can be accessed direct without the need to be referred via a GP practice

Summary of Key Actions in Place

East Riding

- Digital Health Hubs programme commissioned across the Humber and led by local voluntary sector organisations.
- Projects take a health inequality starting point including focuses on: Early cancer detection; CVD – primary and secondary prevention; mental health / self harm; frailty; residents of coastal caravan parks
- PCN level intelligence packs blending social and NHS data made available for discussions with PCNs and other system partners.
- Creation of a call hub to free-up clinical space to maximise face-to-face appointments
- Extra staff to provide more appointments for low level mental health provision
- Resource to be trained to engage with patients to optimise the use of the NHSAPP for repeat prescriptions, and improving access through the use of SystmOne-integrated health kiosks

Hull

- PCNs identified focus areas to improve uptake of their AHCs for people with an LD and SMI. Some PCNs have created specific posts to support in terms of LD.
- Developing Hull as a Trauma Informed City .
- Changing Futures Programme; to improve the outcomes of adults experiencing multiple disadvantage.
- Hull & East Yorkshire MIND will provide 2 members of staff directly into the Practices.
- Provide additional training to current HCAs/TNAs to enhance their skills and enable wider remit to their roles
- To purchase self-care equipment that is given to patients potential of reducing requirement for urgent care services
- Deliver a co-ordinated 'on the ground' support to help patients sign up to the NHS App

North East Lincs

- PCN hub model to deliver same day urgent capacity over and above current practice capacity
- Additional clinics for post school appointments for children
- Establishment of morning respiratory drop in sessions
- Chronic disease outreach sessions for hard to reach groups
- Implement a 'Call Time Screen/ LED Queue System Screen'
- Increase extended hours evening appointments
- Fund a GPA to support GP, freeing up GP time
- Funding electronic equipment for patients to complete physical health checks (weight/BMI/BP etc) prior to appointment
- Mesi Doppler kit to improve efficiency of undertaking Doppler tests across all PCNs from 60 mins to 20 mins

North Lincs

- Continue to develop PCN hub model to deliver same day urgent capacity over and above current practice capacity.
- Population Health Management and Prevention Partnership established
- Develop plan for COPD case finding utilising population health management approach
- Implementation of CCG and PCN CVD prevention plans from Q1, utilising population health management approach to case find.

North Yorkshire

- Strong emphasis in all localities on frailty services to prevent deterioration. Including specifically funded pro-active Frailty Services
- Additional clinical appointments with video and telephone consultations, to supplement practice capacity. Will enable practices to provide own F2F appointments and cover sickness and meet demand
- Use of PHM methodology to support PCN and practice priorities including reducing health inequalities
- All PCNs maximising ARRS recruitment to support additional capacity in particular mental health workers and SPLW
- East Coast Practices – increase the resilience of the urgent care system through commissioning capacity and new ways of working
- Commissioning of health coaches for high intensity GP attendees to reduce dependency and improve LTC management

York

- Primary Care Teams who were redeployed to support the Vaccination Programme have been recalled to support delivery of extended access appointments
- Vale of York place have providers increasing appointments to 20 minutes when appropriate which enables patients and clinicians to have longer together to work through any tests and consultations
- GP Practices have been incentivised to develop Personalised care approaches through transformation funding. Social Prescribers to encourage take up and support people to attend;
- the 4 City PCNs working together from GP, ANP, paramedic, admin to support clinicians, additional All support is being used to help Practices with same day urgent demand and core primary care demand pressures