

<b>ADULTS AND HEALTH SCRUTINY COMMITTEE</b>	AGENDA ITEM No. 6
<b>27 SEPTEMBER 2022</b>	<b>PUBLIC REPORT</b>

Report of:	NHS Cambridgeshire and Peterborough ICB	
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<b>PRIMARY CARE SERVICES UPDATE</b>
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<b>RECOMMENDATIONS</b>
<p>It is recommended that the Adults and Health Scrutiny Committee:</p> <ol style="list-style-type: none"> <li>1. Note the contents of this report in response to the questions raised at the Group Representatives meeting on 2 August 2022.</li> <li>2. Discuss the contents of the report and make any recommendations necessary.</li> </ol>

**1. ORIGIN OF REPORT**

- 1.1 This report is submitted to the Adults and Health Scrutiny Committee following a request from the members of the committee at the annual planning meeting on 16 June 2022 and the Group Representatives' meetings on 4 August 2022.

**2. PURPOSE AND REASON FOR REPORT**

- 2.1 The purpose of this report is to provide an update on Primary Care Services and respond to specific questions and request for information from the Primary Care Team.
- 2.2 This report is for the Health Scrutiny Committee to consider under its Terms of Reference Part 3, Section 4 - Overview Scrutiny Functions, paragraph No. 2.1 Functions determined by Council:
3. Scrutiny of the NHS and NHS providers.

**3. BACKGROUND AND KEY ISSUES**

**Sections set out in response to specific queries raised.**

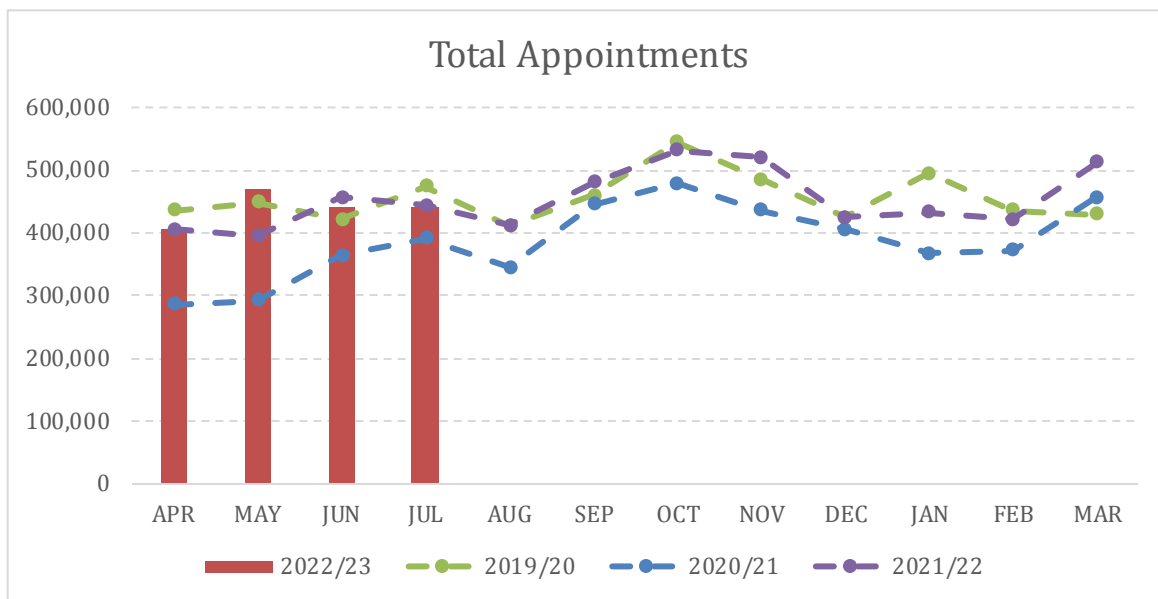
**3.1 GP Access and what we are doing to improve that.**

- 3.1.1 During the COVID-19 pandemic, the Cambridgeshire and Peterborough health and care system was not alone in experiencing unprecedented pressures and activity across all its health services as the system journeyed through the pandemic and subsequently moved into recovery and restoration.

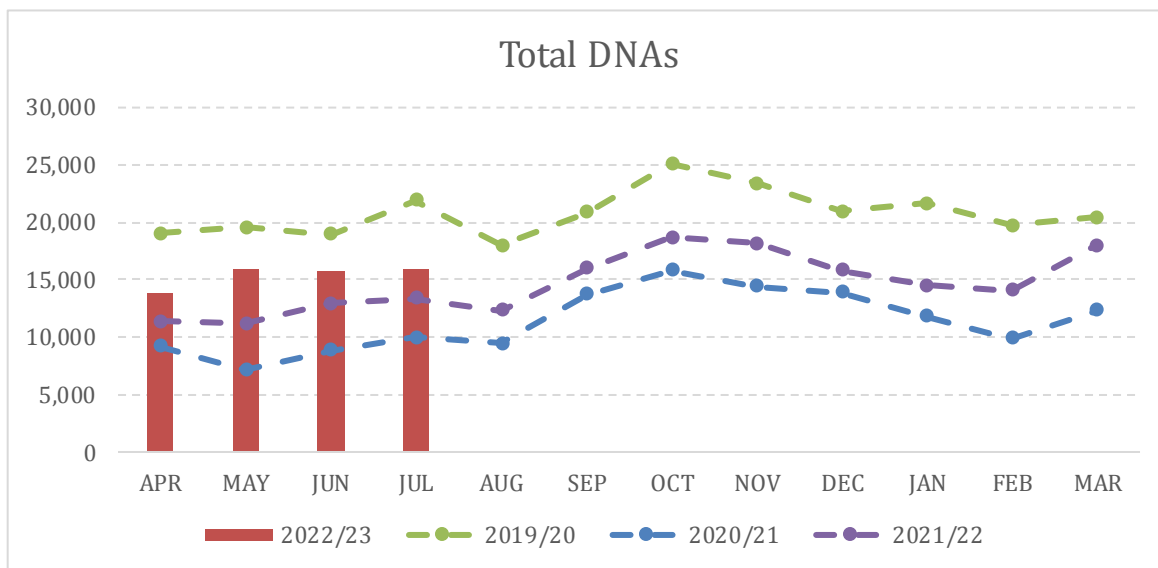
NHS England instructed general practice to re-prioritise work to support the COVID vaccination programme in 2021 and the booster programme into 2022. This focus has shifted to addressing non-COVID needs in 2022/23 with general practice encouraged to see patients face to face where clinically appropriate.

There continues to be significant demand and pressures for general practice above and beyond pre-pandemic levels. General practice has responded and is accommodating additional

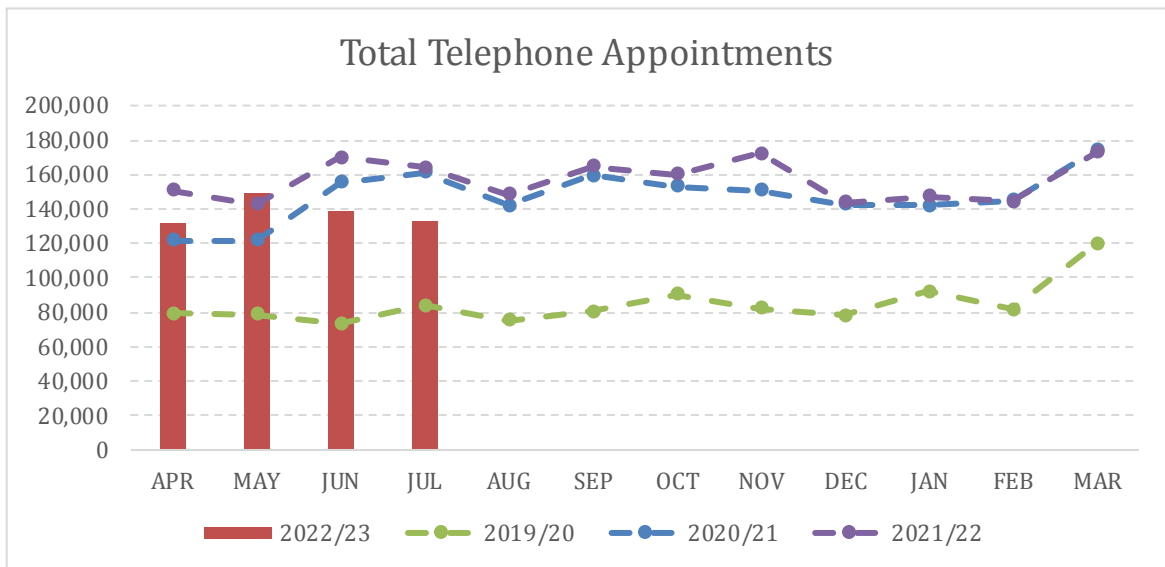
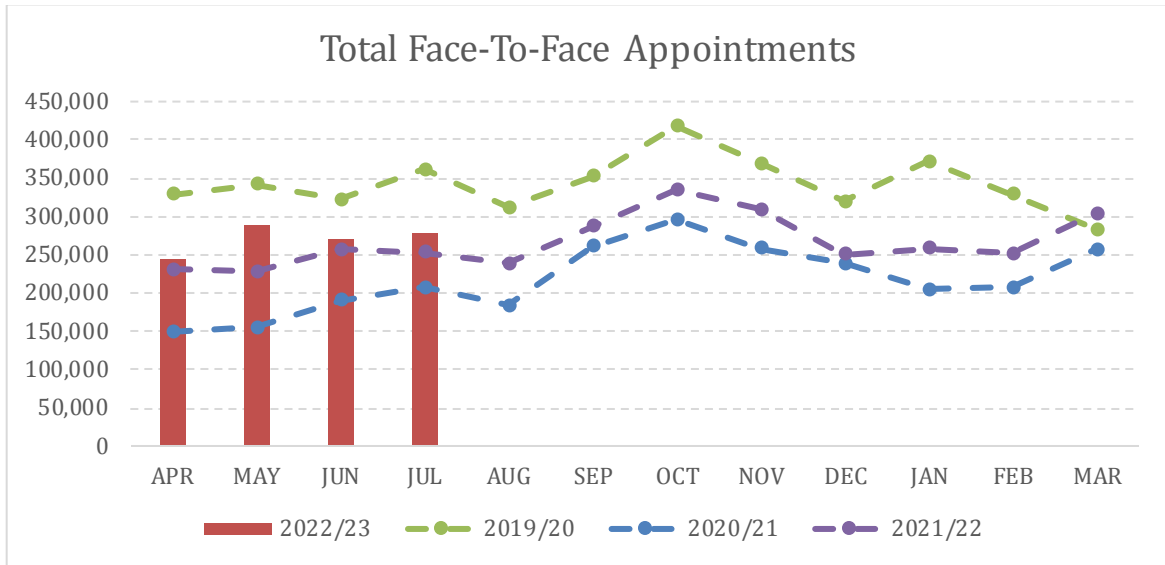
appointments with the 4 months year-to-date activity back to pre pandemic levels as illustrated below:



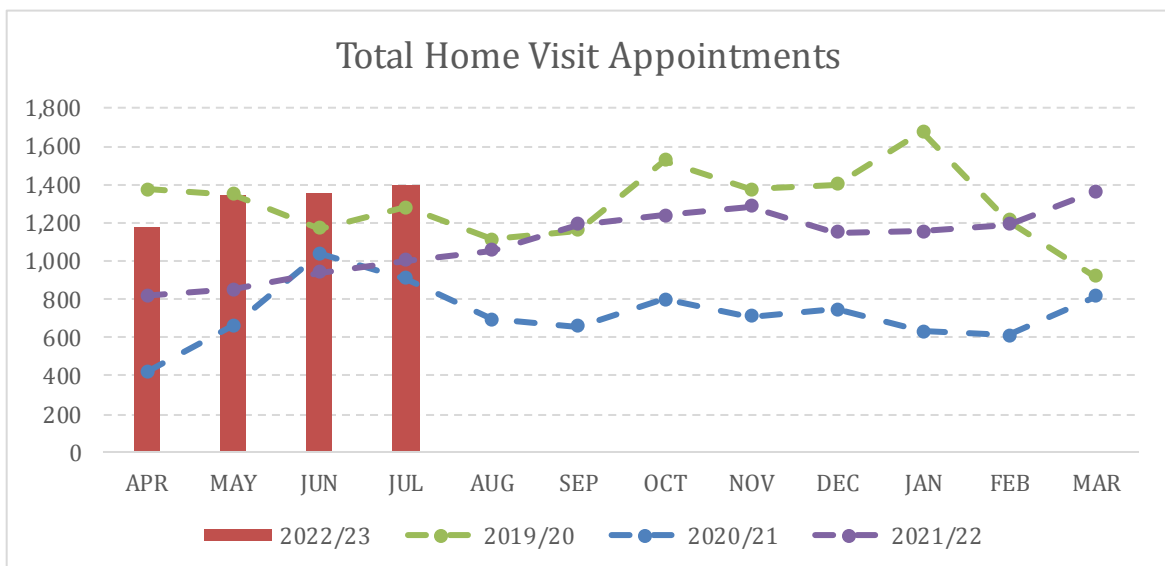
As a result of a national initiative to embed telephone triage into primary care we have seen the level of patients not arriving for appointments reducing.



As health adapts to new ways of working and managing workforce constraints, primary care has adopted virtual appointments where clinically appropriate. At present we are still seeing almost 70% of appointments as face-to-face



Primary care has put in considerable time and effort into ensuring that home visits have returned to pre-pandemic level.



## Enhanced Service

Expanding primary care capacity remains a top priority for NHS England and our Integrated Care Board (ICB) in Cambridgeshire & Peterborough. There will be more patient access from 1<sup>st</sup> of October 2022 under the Enhanced Access scheme.

The new offer is based on Primary Care Networks (PCNs) providing bookable appointments outside normal hours between 6.30pm-8pm weekday evenings and 9am-5pm on Saturdays, utilising the full multi-disciplinary team, and offering a range of general practice services, including 'routine' services such as screening, vaccinations, and health checks, in line with patient preference and need. The Enhanced Service will contract PCNs to provide 60 minutes per 1,000 PCN population (so a PCN population of 50,000 will need to deliver 50 hours of additional clinical appointments per week), from an identified hub(s). Previously this was 30 mins per 1,000 population so a 100% increase in service provision.

The PCN(s) must deliver a mixture of in-person face-to-face and remote (telephone, video or online) appointments. To enable delivery PCNs have made excellent progress in recruiting to roles under the Additional Roles Reimbursement Scheme (ARRS), which sees an additional 430 WTE clinicians across Cambridgeshire and Peterborough ICS, with 134 WTE clinical roles across the six Peterborough PCNs.

### 3.2 How Primary Care is managing long-term conditions, including any increases in prevalence.

3.2.1 Primary care has always managed long term conditions in the community where possible to support care closer to home. In addition, NHS England have commissioned the Impact and Investment Fund (IIF) to help PCNs deliver better outcomes for Long Term Conditions (LTCs). For example, general practice teams will be:

- Providing effective long-term condition management and rapid response to acute presentation, aiming for a moderate reduction in emergency admissions.
- Ensure lower gastrointestinal two week wait (fast track) cancer referrals are accompanied by a faecal immunochemical test (FIT) result.
- Refer patients to social prescribing where this could be beneficial.
- Provide Structured Medication Reviews (SMRs) to patients who are eligible for them. Review patients who are prescribed medicines, alone or in combination, which have higher risk of harm such as dependency or gastrointestinal haemorrhage.
- Increase use of inhaled corticosteroid (ICS) inhalers for appropriate asthma patients to improve disease management.
- Cardiovascular Disease management to include confirming or excluding hypertension diagnosis for more patients with high blood pressure, through clinically appropriate follow-up. Prescribe statins to patients with higher CVD risk and refer suitable patients with high cholesterol levels to assessment for familial hypercholesterolaemia. Treat patients with atrial fibrillation with Direct Oral Anticoagulation (DOACs) in line with NICE guidance.

In Peterborough, a targeted approach for supporting patients living with high-risk Long-Term Conditions (LTC) was commissioned to identify and manage all high-risk patients with diabetes, hypertension, atrial fibrillation, heart failure, Chronic Obstructive Pulmonary Disease (COPD) and asthma. The early indicators and results of this pilot are:

1. Nearly 200 patients have been referred to a home-based blood pressure monitoring service from 19 practices across Peterborough and Wisbech.

2. Nearly 1,600 diabetic and respiratory patients have received diabetic or COPD health checks (including foot checks, urine samples and Blood Pressure monitoring), with 20% of this cohort being urgently escalated to Podiatry, Cardiology or had their insulin regimes urgently adjusted. Two-foot amputations were avoided as a result of this intervention, across 15 participating practices.

The success of the pilot attracted additional national funding that has enabled us to roll out the service to the Cambs GP Network, ensuring there is equitable service to patients suffering from diabetes and hypertension across the county, eliminating the potential for further health inequalities based on a person's postcode.

C&P also continues to provide services to patients who were considered high users of primary care but have low complexity of health needs working across PCNs, neighbourhood teams and the voluntary sector.

South Peterborough PCN and Integrated Neighborhood are providing Art Therapy to Adults and Children in a confidential, safe space where service users can share, explore, understand, and work through their thoughts, feelings, and experiences. The aims of the group which will serve 12 patients at a time for 12 weeks are:

- To support service users to feel empowered to manage their own emotional health.
- To provide connectivity for group members and reduce loneliness.
- To reduce the demand on primary care.
- To provide onward signposting to other supportive services.

The courses started in May 2021 and continued with 4 cohorts of patients. The courses will finish in November 2022 and be evaluated in December 2022.

### **3.3 Patient take-up of screening and health checks**

Screening of otherwise well patients is an important public health tool to identify risk in early detection of disease.

#### **3.3.1 Learning Disability Health Checks**

Annual Health Checks (AHC) are available for all patients registered with a GP as having a Learning Disability and over the age of 14yrs. The national target for completion of these health checks is 75%.

AHCs are commissioned to be delivered within Primary Care, all practices within our footprint have signed up to this Direct Enhanced Service (DES). The DES includes the completion of a Health Action Plan which is integral to ensuring that where a patient has identified health needs, there is further action to address them, whether that be accessing further health interventions, or healthy lifestyle support for example.

Our year end position for 2021/22 was 62.1% which needs to be improved. To support that improvement, we have implemented the following workstreams:

1. Hosted within the Local Authority, the recruitment of a Band 6 LD Nurse and administrative support to ensure contact with all GP practices across Cambridgeshire & Peterborough to:
  - Validate registers
  - Upskill staff
  - Advise on Reasonable adjustments
  - Promote use of Health Action Plans
  - Be a point of contact for all GP Practices
2. LD Nursing Support from Community Operational Teams so each surgery has a link nurse who is based within the district Social Care Team. These nurses can offer additional support regarding Annual Health Checks.

3. Provide desensitisation and support for patients by providing all LD Nurses across C&P with access to a 'Kit Bag', containing medical equipment used within the Health Checks and can work with individuals to ensure they are de-sensitised prior to their appointment. Referrals via link LD Nurse/ Care Co-ordinator.
4. Recruitment to a fixed term post to support Children and their families, educational settings, and primary care to ensure increased uptake of HCs for children aged 14+ who attend specialist educational settings.

### 3.3.2 Other screening programmes:

NHSE/I and Cambridgeshire and Peterborough ICB recognise that recovery of screening programmes is essential for the early detection of potential health problems and results in better outcomes for patients. This is a key priority for the ICB.

#### **Women, aged 25-49, with a record of cervical screening in the last 3.5 years (denominator includes PCAs) (Female, 25-49 years)**

Period	Cambridgeshire & Peterborough	East of England	England
2019/20	68.6%	73.2%	71.5%
2020/21	67.0%	71.8%	69.4%
2021/22	66.3%	70.8%	68.6%

Source: [Cervical Screening Interactive Resource](#)

#### **Women, aged 50-64, with a record of cervical screening in the last 5.5 years (denominator includes PCAs) (Female, 50-64 years)**

Period	Cambridgeshire & Peterborough	East of England	England
2019/20	76.6%	77.8%	77.6%
2020/21	75.5%	76.4%	76.0%
2021/22	75.2%	76.1%	75.0%

Source: [Cervical Screening Interactive Resource](#)

### 3.3.3 NHS Health Checks offered to eligible population

Period	Cambridgeshire	Peterborough	East of England	England
2019/20	13.1%	11.1%	17.5%	17.7%
2020/21	1.4%	3.0%	5.2%	3.1%
2021/22	5.0%	9.2%	10.9%	8.6%

Source: [Fingertips](#)

### 3.3.4 Physical Health Checks for people with Severe Mental Illness

Period	Cambridgeshire & Peterborough	East of England	England
2019/20	38.4%	33.0%	35.8%
2020/21	20.3%	24.6%	23.4%
2021/22	39.4%	44.1%	42.8%
Q1 2022/23	52.0%	45.9%	43.5%

Source: [NHS England](#)

## 3.4 GP capacity

### 3.4.1 Workforce and workload

Workforce as well as workload remains challenging in primary care in C&P, which is a national issue.

We have a headcount of 602 GPs (excludes Registrars) working across our ICS (June 2022), which works out to be 446 Whole Time Equivalents (WTE) or a ratio of 1 GP per 2,304 pts.

If you include the 101 Registrars to the GP workforce that we have across Cambridgeshire and Peterborough, the ratio is 1:1,878, which is the common metric for comparing workload with the National and Regional average. You will see from the table underneath that Cambridgeshire and Peterborough compare favourably within our region with two other systems reporting more GPs per population. However, we are less favourable to the National average of 1 GP per 1,732 pts.

Nationally GPs make up 20% of the workforce employed to deliver Primary Care in General Practice, which is important to note as much of the new investment for expanding the workforce from NHS England is recruiting other Allied Health Professionals (AHP) to deliver direct patient care.

The GP workforce numbers nationally have declined since 2019, but all other areas of workforce (Registrars, Nurses, Allied Health Professionals and Administrators) have increased since 2019.

	Population	GP		Nurses		Direct Patient Care		Admin/Non-Clinical	
		FTE	Pop/FTE	FTE	Pop/FTE	FTE	Pop/FTE	FTE	Pop/FTE
England	61,695,076	35,626	1,732	16,629	3,710	15,395	4,008	72,816	847
Bedfordshire, Luton and Milton Keynes	1,081,054	506	2,135	267	4,049	262	4,132	1,143	945
Cambridgeshire and Peterborough	1,027,362	547	1,879	367	2,801	413	2,487	1,195	859
Hertfordshire and West Essex	1,612,800	920	1,753	311	5,183	253	6,384	1,753	920
Mid and South Essex	1,254,011	603	2,081	292	4,289	260	4,820	1,309	958
Norfolk and Waveney Health and Care Partnership	1,075,694	637	1,689	438	2,457	561	1,916	1,674	643
Suffolk and North East Essex	1,048,884	556	1,886	339	3,091	413	2,539	1,308	802
Region Total	7,099,805	3,768	1,884	2,014	3,524	2,162	3,284	8,383	847

### 3.4.2 Additional Roles Reimbursement Scheme (ARRS)

The NHS Long Term Plan committed to funding Primary Care Networks (PCNs) to recruit a number of clinicians and non-clinicians, known as the Additional Roles Reimbursement Scheme (ARRS) to provide more specialised healthcare in General Practice at scale.

There are 12 roles that can work in General Practice:

- 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

The impact of these roles will be to align patients' healthcare needs to the most appropriate healthcare clinician, which in turn will release GPs time to focus on more complex LTCs, disease management and continuity of care.

### 3.5 Workforce sustainability

#### 3.5.1 Cambridgeshire and Peterborough Training Hub (CPTH)

National and Regional NHSE/I colleagues worked alongside Health Education England (HEE) to complete a procurement exercise to focus on training, recruiting, and retaining workforce across General Practice.

Cambridgeshire and Peterborough Training Hub (CPTH) were successful in their bid and were awarded a contract for three years with an option to extend for a further two years, which commenced in April 2022. The CPTH have been contracted to:

- Provide high quality primary and community care education and training.
- Approve additional learning environments to support Government manifesto commitments.
- Support PCNs and provider partners to undertake effective workforce planning to inform the Integrated Case System (ICS), regional and national workforce plans.
- Ensure that the appropriate educational resources are in place to provide a level of education and training, in a consistent manner, for primary care.

The three-year ambitions and workstreams for CPTH are illustrated below:





Peterborough has the highest proportion of GPs and Nurses over the age of 55 years across the ICS at 29% and 42% respectively. To help mitigate this, our Training Hub are working on increasing the number of trainees to be allocated to Peterborough, by increasing the number of Practices that are accredited to be a Training Practice. Currently 21% of GP Practices are accredited to accommodate Trainees on placement. Peterborough has the highest rate of Practices (across the ICS) that are providing student Nurses with training placements in General Practice.

In addition, we have 17 apprentices employed across our Peterborough practices that are being trained in several different areas from direct health care to dispensing pharmacy prescriptions.

The Training Hub is investing in GP and Nurse Fellowships to consolidate their training and provide Continuing Professional Development (CPD), which helps maintain a healthy, retained, and effective workforce

### 3.5.2 **Other Workforce Programmes**

**GP Retainer Scheme:** The ICB remains responsible for the funding of GP retainers, working in partnership with NHSE. We employ the largest number of retained GPs in the Region, investing over £515K to retain GPs who would otherwise have retired.

The National GP Retention Scheme is a package of financial and educational support to help doctors, who might otherwise leave the profession, remain in clinical general practice.

The scheme currently has 34 GPs across C&P and is aimed at doctors who are seriously considering leaving or have left general practice due to personal reasons (caring responsibilities or personal illness), approaching retirement or requiring greater flexibility. The scheme supports both the retained GP and the practice employing them by offering financial support in recognition of the fact that this role is different to a 'regular' part-time, salaried GP post, offering greater flexibility and educational support.

Retained GPs may be on the scheme for a maximum of five years with an annual review each year to ensure that the doctor remains in need of the scheme and that the practice is meeting its obligations.

This scheme enables a doctor to remain in clinical practice for a maximum of four clinical sessions (16 hours 40 minutes) per week – 208 sessions per year, which includes protected time for continuing professional development and with educational support.

**International GP Recruitment programme (IGPR):** The ICB continues to work with the regional team to deliver the International GP Recruitment programme. Cambridgeshire and Peterborough currently host five International GPs (IGPs):

Regionally we are working to secure placements for 7 more IGPs to the UK who have passed their Occupational English Test (OET) exams. Locally we have 1 practice who has registered an interest in hosting an IGPR.

## 4. **REASON FOR THE RECOMMENDATION**

- 4.1 The report is given so the Adults and Health Scrutiny Committee can be updated on specific areas of progress and work within Primary Care Services.

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