NHS Southwark Clinical Commissioning Group

Management Response – Extended Primary Care Service (EPCS) Independent Evaluation (May 2017)

INTRODUCTION

NHS Southwark CCG (the CCG) commissioned the Extended Primary Care Service (EPCS) to provide additional GP and nurse appointments for Southwark patients from 8am – 8pm, 7 days per week. This service is delivered by groups of GP practices working together in GP federations; Quay Health Solutions (QHS) in the north and Improving Health (IHL) in the south. The service has been operational since November 2014, with full coverage across the borough from April 2015.

In 2016/17, NHS Southwark CCG commissioned Deloitte LLP to undertake an independent evaluation of the Extended Primary Care Service (EPCS) to inform developments and ensure the service fully delivers on commissioning objectives, including improving access to, and reducing pressure on general practice. The report was finalised at the end of May 2017 and this document outlines the recommendations from this report and the CCG's management response to those recommendations. This response has been informed by a joint review of the evaluation report with federations as providers of the service, in recognition of the partnership working that will be required to fully deliver on its recommendations.

This document is intended to be read in conjunction with the summary evaluation report, which includes key findings and high level analysis from the evaluation. The summary evaluation report can be found on the publications page of the CCG website.

	Evaluation Recommendations	Status	Management Response	Timeframe for Completion
1.	**Focus on developing consistent buy-in to EPCS across practices through the use of incentives, transparency and advocacy** To generate a higher level of practice 'buy in' and referrals across all practices in the absence of contractual agreements between CCGs and practices, a number of areas could be explored:	**Accepted**	Improved access is one of the CCG's key priority areas outlined in its primary care commissioning intentions, alongside proactive preventative care, and coordinated care for people with more complex needs. In recognition of this, the CCG has included a range of incentives linked to improved access within its local Primary Medical Services (PMS) premium contract offer to	Ongoing

	• Incentives. Are there any areas where federations can provide non-monetary incentives for cooperation (e.g. access to support or training and development)? What contractual levers could be implemented, e.g. between CCGs and practices? • Transparency. For example, are there ways to show practices how their referral levels compare to their peers in more compelling ways? • Advocacy. For example, by estimating how much 'capacity' and time practices save per referral; publicise good patient and practice reviews of EPCS; publicise the benefits for practice staff of having close links with the hub		practices. This includes: - A review of practice appointment systems and access, monitoring of need for appointments and capacity, and identifying ways to address gaps in provision including looking at different modes of access (including the EPCS) - Patient experience of access (via the Friends and Family Test). GP federations as providers produce monthly dashboards to benchmark practice utilisation, which are shared regularly with their member practices and Patient Participation Groups (PPGs). Both federations are working with their practices to establish cluster/neighbourhood working, where groups of practices l come together around a range of contract data and service and quality improvement areas linked to the GP Forward View. This will include reviewing ways of sharing data to improve the quality and effectiveness of services provided, including managing patient need within member practices and the use of the Extended Primary Care Service. Linked to recommendation 14, the CCG and federations will work with practices to identify ways of raising awareness of the service and its benefits with practice staff; through practice facing materials, cluster/neighbourhood working, workforce development initiatives (such as signposting training), and the Practice Manager's Forum.	
2.	**Explore if the pooled telephone management**	**Accepted**	Learning from both GP federation's pilots of telephone management identified that a centralised model was not	Dec 17

	system should be started again A pooled telephone management system/ other digital technology or support could help practices who are not able to offer efficient telephone management even with support in redesigning their ways of working. While centralised management was attempted before, it was at a time when the EPCS process was relatively new and uptake was lower. Now that the hubs are established, it may be worth drawing on learnings from the initial centralised system and undertaking a new pilot. It is important to note that telephone management will not have same rates as SELDOC in relation to the number of calls that do not require a face-to-face appointment following telephone advice as there is no option to refer patients back to the practice. Recent telephone management experiences and audits within QHS and IHL should be fed into this exploration.		viable due to the number of telephone triage appointments that still resulted in a face to face appointment for patients, rather than being able to give the patient advice or signposting over the phone. This was significantly higher than clinicians experience in their own practices with telephone triage models, and is in part due to the local knowledge (e.g. services within the practice the patient can access) and relationships that practice clinicians have with their patients. While a centralised model may not be the most appropriate solution, we do recognise the challenges that smaller practices may have in embedding telephone management into their appointment systems and therefore being able to more effectively refer patients with same day/next day needs to the EPCS. To support this, the CCG and both federations will work together to explore smaller scale pooled telephone management (e.g. practices buddying up or working in groups) and other digital technology solutions to ensure patients are seen at the right time, right place and by the right service in order to meet their care needs. In addition, both GP federations are expanding their services to include pre-bookable routine appointments to increase the scope of services available at the EPCS so that it is more of an extension of general practice. These appointments will be able to be booked without the need for telephone management for specific appointment modes (e.g. routine smear appointments). The CCG would wish to continually learn from other areas which have implemented this process with a view to test this locally.	

3.	**Share best practice and promote cooperation across practices on telephone management** For some practices, telephone management implementation continues to be a challenge, with practices needing to change the way they work on a day-to-day basis. For some practices, it might be helpful to develop 'best practice' case studies to help provide models for practices or have 'buddies' in addition to the hands-on support provided.	**Accepted**	Those practices that have embedded telephone management into their appointment booking systems tend to have a better experience in referring to the EPCS. However, we recognise that reviewing appointment systems takes time and requires a significant amount of effort within each practice if benefits are to be fully realised. In addition to supporting practices to review their appointment systems as part of the Southwark PMS Premium offer (see response to Recommendation 1), we recognise the benefit in sharing learning and experiences of 'good practice' across each federation. Both GP federations already share good practice with their member practices, including through case study examples and site visits. Building on this, we will use the cluster/neighbourhood meetings and the Practice Managers forum to review practice -based recommendations and identify any further opportunities for the CCG or the federations to support practices in this area.	Ongoing
4.	**Explore the possibility of allowing Federations to refer to either hub** There is inconclusive evidence around the drivers of low EPCS utilisation by some practices. Patient familiarity with transport links to hubs could affect utilisation, although again this is uncertain. Federations could explore the possibility of cross-site working, however this would require	**Accepted**	The CCG and federations recognise that some patients may prefer to access a hub that is closer to them, rather than the hub linked to their registered practice. However, we need to better quantify this preference/need (beyond anecdote) and work through the potential barriers/issues to undertake a cost-benefit analysis so we can make an informed decision. To support this, we will work with both federations on a	Jul 18

	agreement from commissioners and depend on factors including the financial implications of cross-hub referrals. The data sharing relationship would also need to be resolved, and would require further consideration.		longer-term piece of work to quantify practice/patient preference and need for cross-referral, including whether location is in fact a barrier to utilisation (e.g. transport costs and ease of access, proximity). We will also work through the range of issues that we have identified as requiring further consideration, including: - impact on Local Care Network plans and the development of place based commissioning - information governance and data sharing (to allow for sharing of patient notes) - capacity and resourcing (so as not to do so at the detriment of the service offer to member practices and their patients) - financial implications and processes for cross-referral - contractual implications (e.g. contract variation).	
5.	**Offer new types of appointment in a targeted way** Given the number of unused appointments, exploring highly targeted routine offerings may increase use. For instance, Southwark has a high proportion of relatively young people (working age and children). Targeted weekend offerings such as women's health appointments and vaccines have already been included in service improvement plans, and dressing clinics, travel clinics, and GP routine appointments have started to be offered. High Type 2 diabetes	**Accepted**	As noted in the EPCS Evaluation, both federations have been exploring routine appointment offerings within their respective EPCS hubs, and are progressing implementation. North Southwark EPCS are targeting routine appointments to areas where practices have identified there is the most need for a 'hub based' service. This includes reproductive health services and wound dressings. In addition, the CCG is exploring a pilot with the north GP federation for a young people's drop in clinic, which will offer health care and support on a range of issues such as healthy eating, smoking, substance misuse, mental and emotional health	Mar 18

	prevalence might indicate that e.g. diabetes clinics – such as the service in Cumbria's Workington model – could also provide value for Southwark's population. Once specific services are agreed, targeted marketing to the patient segment may create a 'push' where patients ask their GP about these services. There may also be scope to expand the ways that people can access existing types of appointments, for example online appointments as set out by the General Practice Access Fund (GPAF).		and sexual health working with other providers. South Southwark EPCS have recently rolled out their routine appointment service across all practices in Southwark, which will complement the existing offer of same day/next day unscheduled care needs. This includes a range of GP and nurse appointments that can be pre-bookable by the practice. This has already resulted in a significant increase in the number of appointments used. Later this year both EPCS hubs will be launching direct booking from the South East London NHS 111 service, initially focused on evening and weekend appointments where utilisation is lower. The CCG is also taking forward opportunities to work with and support practices to increase the mode of appointment offerings within general practice, such as online appointments. The CCG recently had a provider showcase to identify potential suppliers for this, and will be undertaking a series of engagement events with practices and patients to progress this through to implementation. Within this programme we will work in partnership with GP federations to identify opportunities for these solutions to be implemented within the EPCS.	
6.	**Explore ways of ensuring telephone management does not exclude particular patient groups, in particular those whose first language is not English or those who are hearing impaired** Because same and next-day appointments	**Accepted**	The CCG completed an Equalities Impact Assessment to support the commissioning of the EPCS and identify actions required in order to minimise any negative effects on people who share any of the characteristics that are protected under the Equality Act. Given the length of time the service has been in place, and	Jan 18

	through EPCS are booked via telephone management, they may not be as accessible to non-English speakers or those who are hearing impaired. While there was an Equalities Impact Assessment on the service model before the service was commissioned, alternative options such as text and email might be explored, to ensure that differential systems do not exacerbate inequalities in access. For example, there should be a way to accommodate those patients who have highlighted a preference for email communication.		the CCG's commitment to ensure that disadvantaged groups are not further disadvantaged by services that we commission, we will be undertaking a deep-dive review of the EPCS from an equalities perspective as part of our 2017/18 Equality Delivery System (EDS2) approach. This will help us to target areas where we need to make improvements to our offer to patients, including those who are hearing impaired and/or where English is not their first language. We will undertake this review in partnership with federations, with the annual equalities report expected to be signed off for publication by 31 January 2018.	
7.	**Develop a consistent way of collecting improved metrics across the two hubs** To enable further understanding of the services, there is a need to standardise data collection from across practices and between the two EPCS hubs to strengthen comparative analysis. While data collection tools by themselves have not been successful, it may be helpful to gather feedback on potential tools from stakeholders to make a more tailored (and easier to complete) format. There could then be dedicated support to roll out the tool. An optimal solution would go beyond static templates to involve collecting more real time data. Some metrics that could be collected are e.g. how many EPCS referrals required a practice follow up appointment and whether patients were referred appropriately,	**Accepted**	In order to support comparative analysis between practices and the hubs, we need to ensure that we have a standardised set of metrics that are reliable, relevant, and measurable. Further, these metrics need to enable commissioners to ascertain whether the service is meeting the commissioning objectives/expected outcomes and NHS England GP Access fund requirements. The CCG and federations will work together to implement a revised minimum data set to ensure consistent contract reporting across both sites that meets commissioner and NHS England GP Access Fund requirements from October 2017. We recognise some of the issues with data collection to date, and would seek to work with the GP federations to review current KPIs and outcome metrics, and include a revised set of metrics in contract variations for 17/18 -	Oct 17 – Mar 18

	and these could be integrated into the EMIS system.		18/19. As part of this review, we would expect federations to work with their member practices to ensure data can be more easily collected at a practice level to inform whether or not the service is delivering on its objectives (including exploration of reviews/audits as well as key performance indicators to provide a greater depth of quality and performance information). We would also look to good practice from elsewhere to identify locally applicable developments in measuring access (recommendation 8).	
8.	**Keep abreast of national developments to collect outcomes data from practices** One of EPCS' main objectives is to increase access to primary care. In order to assess the impact that the service is having on patients and practices, metrics such as waiting time for appointments could be collected from practices. At present, there is no consistent measure of this type of data, although there is national work to pilot a measure of waiting time based on third available appointment. Federations should keep up to date with developments in measuring access, and seek to implement data collection of good metrics for access. It will be critical to work with practices on the best and easiest way to collect these types of measures, and be realistic about what can be achieved.	**Accepted**	As outlined above, we would look to include good practice from other areas in a review of EPCS metrics as part of our response to recommendation 7. In addition, the CCG is working with the federations and Southwark Local Medical Committee (LMC) to commission a modelling tool to support practices to review their access in line with practice demography as part of the access specification outlined in the Southwark PMS Premium offer (linked to recommendation 1 above). This model will take into account evidence-based good practice, and will support practices to review their access so that it meets the needs of their specific patient population.	Mar 18

9.	**Collect additional data to understand the main drivers of patient utilisation of EPCS** This evaluation included a snap-shot survey of c. 300 patients across the patch to understand EPCS use. However, only a fraction of the sample had been offered EPCS appointments (and none declined). This provided a relatively limited sample for drawing strong conclusions on the main drivers of patient utilisation of EPCS. Ways to collect further data on this could therefore be explored. For example, it might be possible for the duty GPs to integrate a standard set of wording into patient notes as part of telephone management, or it could be added to practice systems as an 'outcome' of the call. To get a more representative picture of why patients might not use EPCS, targeted focus groups or surveys to those that were offered EPCS could be conducted.	**Accepted**	Patient experience data will form part of the outcome metrics review outlined in recommendation 7 above. Healthwatch Southwark is currently undertaking a review of patient access within general practice, including awareness of the EPCS. Following this review, we would seek to work with Healthwatch Southwark and GP federation leads to identify key themes and opportunities to continue to engage with patients to understand drivers for, and barriers to, utilisation (e.g. through focus groups, outreach, patient surveys)In addition, we will also identify a set of measures to measure the impact of the communications campaign (recommendation 14) on utilisation and awareness of the EPCS.	Jan 18
10.	**Explore what works in terms of attracting a stable complement of staff to minimise use of locums in the context of a challenging national workforce environment** In terms of GP recruitment, initiatives that fit with career preferences of GPs (e.g. GP "portfolio" contracts) should be continued. In addition, flexible salaried working, the possibility of continued on-the-job learning with a strong	**Accepted**	The General Practice 10 Point Plan and General Practice Forward View highlight the range of workforce challenges that currently exist within primary care. GP federations are already testing new ways of working to support general practice workforce development (e.g. practice-based clinical pharmacists, advanced nurse practitioners, care navigators, portfolio/shared posts). Workforce development, and reduced reliance on out of area locum cover is a key part of federation service	Ongoing

	Federation can be emphasised. Nurses will be in greater need once targeted routine services roll out fully, and joint recruitment with practices will be critical in helping find the right staff.		development plans linked to the EPCS contract. The CCG and federations will continue to work together to support these workforce initiatives through Southwark's Community Education Provider Network (CEPN), and to ensure that the EPCS provides an opportunity to strengthen the local workforce and test innovations relating to recruitment and retention.	
11.	**Work with non-practice referral in pathways to redirect to EPCS (SELDOC, A&E, 111) in order to maximise the system-wide impact** To make sure EPCS is used in the best way, further advocacy and exploration of, for example, contractual levers, could be undertaken with existing non-practice referrers. For instance, this could include making sure that all A&E staff are aware of EPCS. Also, referrals are still going to SELDOC treatment centres, even though all of these should be referred to EPCS. This could be investigated. Traditionally, the South site had more UEC referrals, with more SELDOC referrals and being on the same site as the old WiC.	**Accepted**	Both Federations have a partnership agreement in place with SELDOC to support appropriate referrals into the service during the out-of-hour's period. The CCG will support both Federations to work with SELDOC to ensure that the opportunity to refer suitable patients to the EPCS is maximised, including the ability to pre-book appointments into under-utilised slots (e.g. early morning, weekends) through regularly sharing commissioning data about practice utilisation of SELDOC visits. Federations also meet regularly with staff from King's College Hospital NHS Foundation Trust A&E Department, and Guy's and St Thomas' NHS Foundation Trust Urgent Care Centre/A&E Department in order to support increased redirection from A&E/UCC to EPCS hubs for patients who would be more appropriately managed in a general practice setting. Direct booking via EMIS is available at both sites, and GP Federation leads offer training to Trust staff on the booking system and referral criteria. The CCG and both federations will work with both Trusts to review redirection and minor's attendance data to identify opportunities for increased redirection. In addition, the	Ongoing

			communication campaign (recommendation 14) will support both patient and staff awareness of the service and how to access it, as ideally we want patients to use the right service to meet their needs at first point of contact.	
12.	**Explore further alignment between EMIS systems to make EPCS a true extension of general practice rather than being a referral system** Historically, EPCS hub clinicians did not have Read/Write access on EMIS, which could lead to duplication of effort. Currently, both Federations have purchased functionality to enable Read/Write access on patient records, and QHS has piloted this. This allows for synchronous effort and will help enable a wider set of services (e.g. diabetic clinics). However, it is important to note that efforts may be needed to encourage practice acceptance of other clinicians being able to write on their notes, in what is truly an extension of primary care rather than a referral system.	**Accepted**	The north Southwark federation has piloted direct read/write access in 5 practices since March 2017. Feedback to date is positive from EPCS clinicians and practices. Rollout to all practices in north Southwark will be considered in July. Learning is being shared with the south Southwark federation who are also piloting this version of EMIS and are intending to roll this out more widely to practices by December 2017.	Oct – Dec 17
13.	**Keep flexibility to adjust the number of slots by time, day and season of appointments** To maximise sustainability, it may be worth further adapting and continually reviewing patterns in utilisation to provide the right level of service. For example, if Sunday has low utilisation, sessions could be further reduced,	**Accepted**	Any service provider would seek to continually review how best to meet the service delivery and patient needs, including adjusting capacity to ensure patient access. The commissioner would seek to enable providers to do this on a continual basis within the service model.	Ongoing

	and then increased when utilisation is close to 90% to provide sufficient head room for unexpected activity. Now that there is historic data on EPCS use, this could be fed in to update the EPCS session capacity model. This will need to be combined with data on routine referrals as these increase. Targeted work to get the right routine/urgent mix in sessions will be helpful as utilisation increases, and noting that at some times (Sunday afternoons) there is already only the minimum service provision to ensure 8-8 seven day service (i.e. one GP).			
14.	**Explore a way of developing a stronger awareness of EPCS** When EPCS was launched, it was not marketed directly to patients because the EPCS could only be accessed following referral from general practice. Whilst this is still an important principle, a focused communication campaign (with a consistent message) would be necessary to increase patient recognition of EPCS as a trusted extension of their general practice and GP out-of-hours.	**Accepted**	The CCG maintains the principle that EPCS can only be accessed following an assessment of need for on the day appointments by the patients registered practice. When the EPCS was established in 2014/15, the CCG promoted the service through an outreach campaign, which consisted of face to face conversations with local people. This was because at the time, the pathway to access the service needed more explanation than could be done through traditional communication methods. The CCG recently commissioned patient information for use in local hospital emergency departments in partnership with NHS Lambeth CCG who also commission an 8-8 7 day primary care service. In addition, the CCG will run a refreshed communication campaign from August/September 2017. This will include posters, leaflets, maps for practices referring patients to	Aug – Sep 17

			the EPCS, pharmacy communication materials and a campaign webpage. The CCG has already begun work to develop the posters, with feedback from patients, Healthwatch, GP federations, and locality PPGs. The final version of the poster is attached for information. The same format and key messages will be used across the full campaign.	
15.	**What we would do differently next time: consider phased expansion to help smaller practices adjust** In the future, a phased expansion (rather than a longer pre-launch timeframe) may be used to maximise momentum whilst giving practices the time they need to adapt their ways of working. However, this is not always possible (e.g. IHL needed to go live 100% from day one because the Lister WiC was decommissioned).	**Accepted**	The design and mobilisation of EPCS provided a rich source of learning for the CCG, federations and practices in relation to large-scale service development within general practice. In addition to the formal evaluation, the CCG and federations have also undertaken reflective lessons learnt sessions to identify opportunities to translate learning into other contracts or service initiatives. In 2017/18, both federations will be supporting practices to embed a new approach to delivering care coordination for people with multiple long-term conditions, which will require cross-organisational working with other health and care partners. Building on our experience of the EPCS, federations have undertaken significant engagement and co-design work with practices and patients, and are undertaking exploratory testing work to ensure that challenges are identified early and practices are appropriately supported to implement new ways of working both in the lead up to, and following mobilisation of the pathway from 1 October 2017.	Ongoing
16.	**What we would do differently next time: focus on culture change and developmental support recognising that changing the way practices work takes time** One of the biggest implementation challenges expressed in interviews with Federations and practices was the need to change the way the practice worked on a day-to-day basis rather than the technical challenges to telephone management. In the future, these 'soft' changes	**Accepted**		Ongoing

	should be specifically tested at an early stage to see if a high level of support may be needed. If this is a challenge, it might be appropriate to develop 'best practice' case studies to help provide models for practices or have 'buddies' in addition to the hands-on support provided.			