



Mental Health Board
South East Severe Mental Illness (SMI) Physical Health Check (PHC) Programme

22nd September 2021

Agenda



#	Section	Time
1	Programme Overview	5 mins
2	Engagement and data findings	15 mins
3	Roadmap and recommendations	10 mins
4	Next steps	5 mins
5	Q&A	15 mins

1. Programme overview

Programme and roadmap overview









The purpose of this work – improving PHCs for SMI patients

The SMI PHC Roadmap demonstrates a **two-phase approach to improving PHC compliance**. Firstly the roadmap outlines actions to **boost PHCs by a minimum of 14,000 patients** by April 2022. Secondly it looks to grow compliance to the **national standard of 60%** by March 2023.

The roadmap has a focus on **interoperability** between primary and secondary care. Phase 1 will focus on delivery of **PHC coded information via Docman/MESH** for input into GP systems, with the second phase aiming to **land structured data into GP systems** following agreement with NHSX on required data standards. Taking a holistic approach, mid- and long-term recommendations **also consider wider initiatives** to support PHC compliance including those seen in pilots and ongoing good practice from systems across England. These are recommended as **initiatives for ICS's** in the South East to adopt alongside system and data flow improvement.

Six themes from our engagement

	Interoperability and connected data	Ensuring digital solutions are designed with the reusable building blocks that allow for integration and scaling with existing models.
	Resource, roles and responsibility	Supporting the front-line workforce when delivering Physical Health Checks and empowering them through training, support and strong leadership.
	Patient education and communication	Ensuring that the local population is at the heart of the set up and design of new services to create equitable access to services for the entire ICS community.
	Local pathways and clinical process	Optimising patient flow across services and providers and ensuring efficient and correct process is undertaken at each step.
	Reporting and business intelligence	Data collection and analysis utilized across systems to inform decision making and increase targeted activity.
	Governance and improvement processes	Forums and processes to capture best practice, plan initiatives and manage performance to boost PHC compliance.

Recommendation groups per ICS



1. People

Ensuring staff and patients receive a consistent experience in Secondary and Primary care and are supported to deliver all PHCs.



2. Process

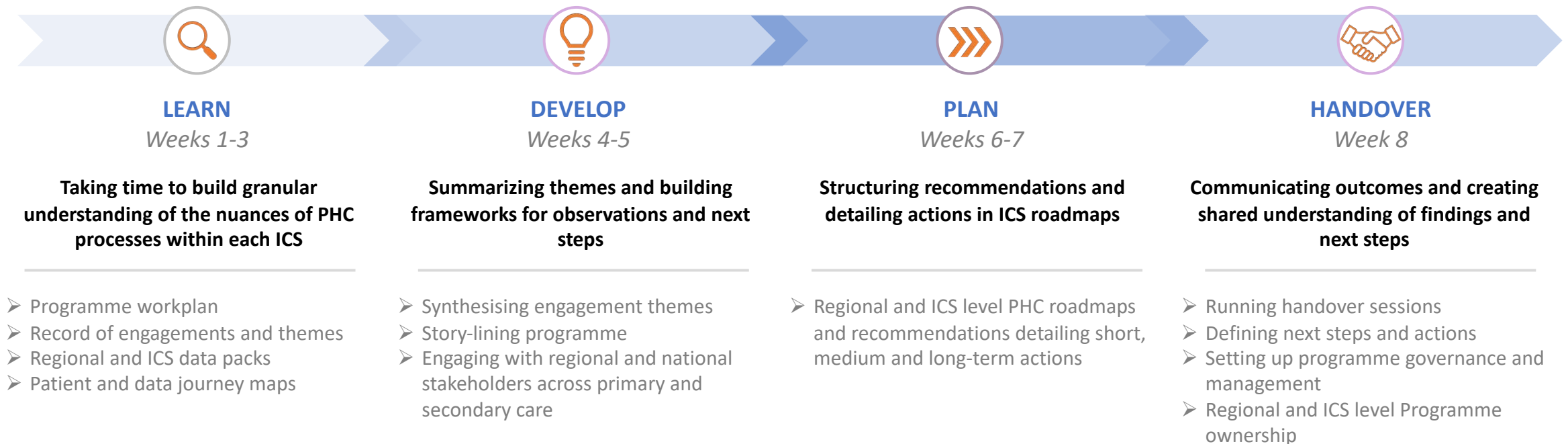
Improving the route patients take to complete their annual checks, with alignment across secondary and Primary care.



3. Technology

Ensuring systems are interoperable, with consistent and streamlined sharing, coding and reporting of information.

How the roadmap has been developed



Headline stats

- 100+ stakeholders engaged
- 200+ observations recorded
- 3 tech providers interviewed
- 6 focus groups
- 2 regional forums socialised

Stakeholder landscape

- Six ICS's of varying sizes, architecture and historic setups
- Multiple local and system PHC, Mental Health and SMI leads
- 180+ PCNs with 700+ GP Practices
- 3 Primary Care EPRs and 3 Secondary Care EPRs

Stakeholders engaged

- Mental Health and Primary Care leads within each ICS
- ICS CIOs, CCG Commissioners and PCN Leads
- National colleagues from NHSX, NHSD and NHSE&U SMI PHC and Digital MH Leads
- System providers Ardens, Servelec and GP Connect
- Programme management support within each ICS and regionally

2. Engagement and data findings

Synthesised themes



Six engagement themes emerged, giving an overview of current state and opportunities across the system and patient pathway



We used the themes to structure detailed observations per ICS



Example: Buckinghamshire, Oxfordshire, Berkshire West

ICS stakeholder engagement findings: BOB

ICS SUMMARY
The three CCGs in BOB operate relatively independently, each driving PHC in their own patch. There are some strong initiatives such as dashboards and training, as well as a good level of engagement from all leads in the area. Variability means each area is driving similar initiatives but that these are not joined up.

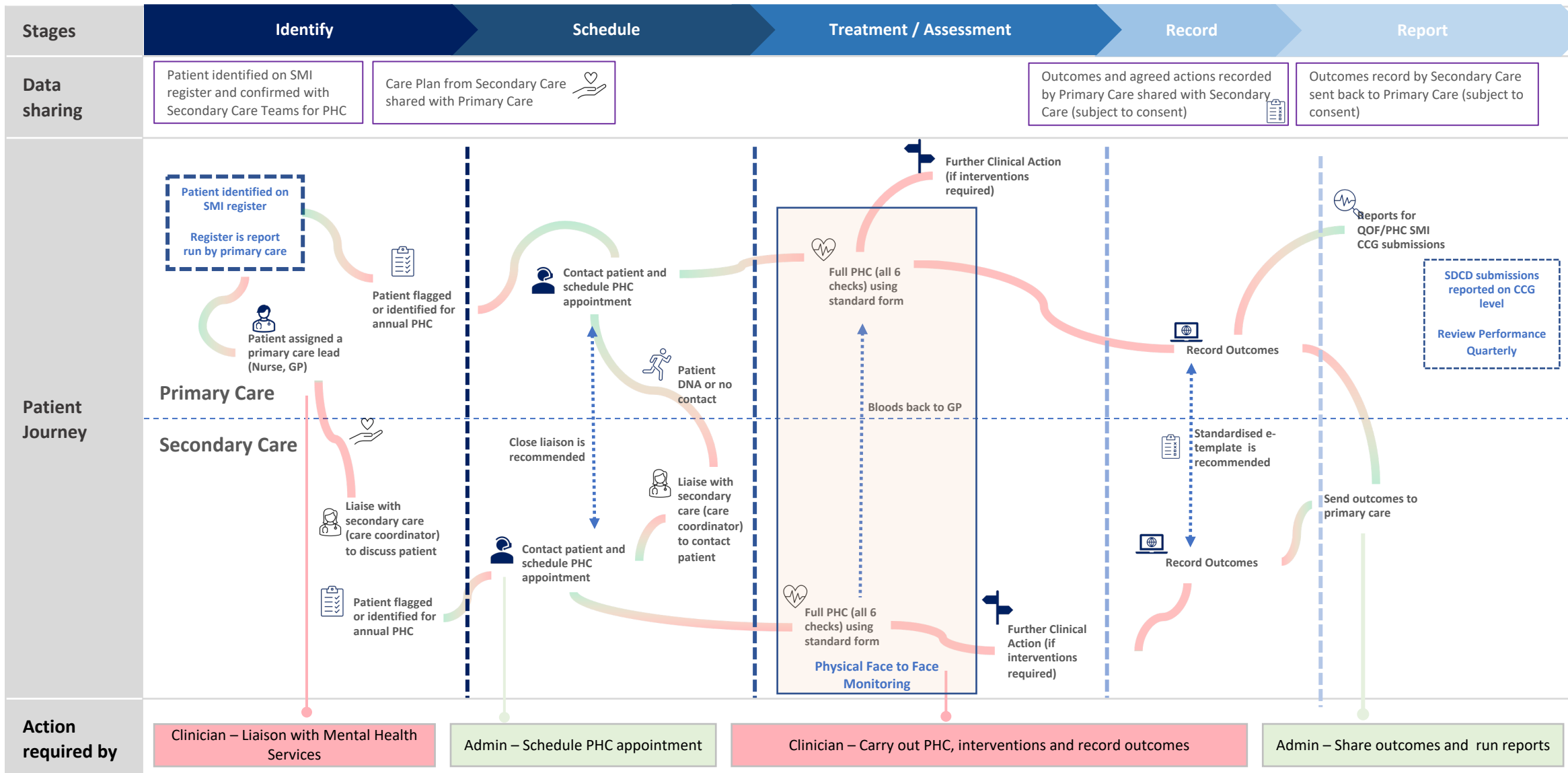
Q1 21-22 performance: 14.6k pts on SMI register, of which 3.6k full PHC (24.9%)
Architecture: 3 CCGs (Ox, Bucks, Berks W), 2 MH providers (Ox Health, BHFT)
Systems: GP – SystmOne & EMIS, MH – CareNotes (Ox Health) and Rio (BHFT)
PHC leads engaged: GP leads, MH lead

ENGAGEMENT THEMES			
<p>Local pathways and clinical process</p> <ul style="list-style-type: none"> Secondary care (OHFT) have started to introduce point of care testing in the community to increase PHC compliance. Two areas of particular challenge identified in the pathway are 1 – scheduling, as patients are difficult to engage and 2 – getting clinicians to complete all six checks. Primary care use either the national Bradford template or Ardens. The CCG is pushing for increased use of Ardens as incorrectly coded templates have been found. MH are contracted to do 10% of checks. There is breakdown in communication, scheduling and pt ownership across settings. This is variable across the patch. 	<p>Resource, role and responsibilities</p> <ul style="list-style-type: none"> Berks W CCG plans to pilot Social Prescribers trained to manage the SMI register and engage SMI patients. Some parts of the ICS utilise 3rd resource to improve patient engagement (e.g. Berkshire West Your Way) Education, comms and engagement have been important across the ICS. This is delivered via webinars and toolkits. GPs are advised to have dedicated PHC coordinators. Most GPs also have admin teams to extract and code data. This is variable across the region and the roles are not defined. OHFT have recently appointed a PH nurse lead to improve PHC in the community, supported by a team of 10 HCAs. 	<p>Governance and improvement processes</p> <ul style="list-style-type: none"> Currently, CCGs in the area operate relatively independently. This leads to variation in ways of working and improvement processes. There are aims across the ICS to increase joined up working. While a number of initiatives are in progress in the area, there are no dedicated action plans or forums for tracking/managing them Local enhancement services have been used in some areas (e.g. Ox) in addition to QOF. These had variable results. 	<p>Reporting and business intelligence</p> <ul style="list-style-type: none"> Most PHC data is extracted by each CCG from GPs using automatic extraction with EMIS Enterprise. Some practices that use SystmOne still extract data manually. These practices align reports to QOF templates but there is some variation. Bucks and Ox CCGs have developed a PHC dashboard that is shared monthly with GPs and details PHC performance. This has had a positive response from GPs and could be rolled out across the ICS but requires analyst support. Oxford Health also use their own internal dashboard to track and drive PHCs
<p>Interoperability, communication and connected data</p> <ul style="list-style-type: none"> Often PHCs are completed in secondary but not shared or recorded in primary care. A mini-template has been created to share PHC outcomes using Docman. In some cases, MH providers can access EMIS notes via EMIS Clinical Services or a shared care record (Graphnet). Bucks CCG Digital Transformation programme is working on primary/secondary care interoperability, including developing a Shared Care Record to support data sharing. Shared care record is already available to OHFT in Bucks. In Oxfordshire, Ox Health are sharing a monthly excel with patients details to bridge the comms gap 	<p>Patient education and communication</p> <ul style="list-style-type: none"> GPs generally invite patients for their PHCs in their birthday month or combine it with annual medication review. If patients do not respond to initial letter, then there is a second push that often utilises 3rd sector support (e.g. Berkshire West Your Way). The ICS highlighted the need for more emphasis on patients owning their health e.g. through remote monitoring via the NHS app. 	<p>ICS STRENGTHS</p> <ul style="list-style-type: none"> PHC dashboards and BI Template for sharing PHC outcomes from secondary to primary care Dedicated resource for PHC SMI across the ICS e.g. OHFT 10 HCAs 	<p>ICS IMPROVEMENT INITIATIVES IN PROGRESS</p> <ul style="list-style-type: none"> Social Prescribers pilot in Berkshire West to support patient engagement Development and roll out of an ICS Shared Care Record New team in OHFT of 10 HCAs and a PH lead to drive PHC compliance

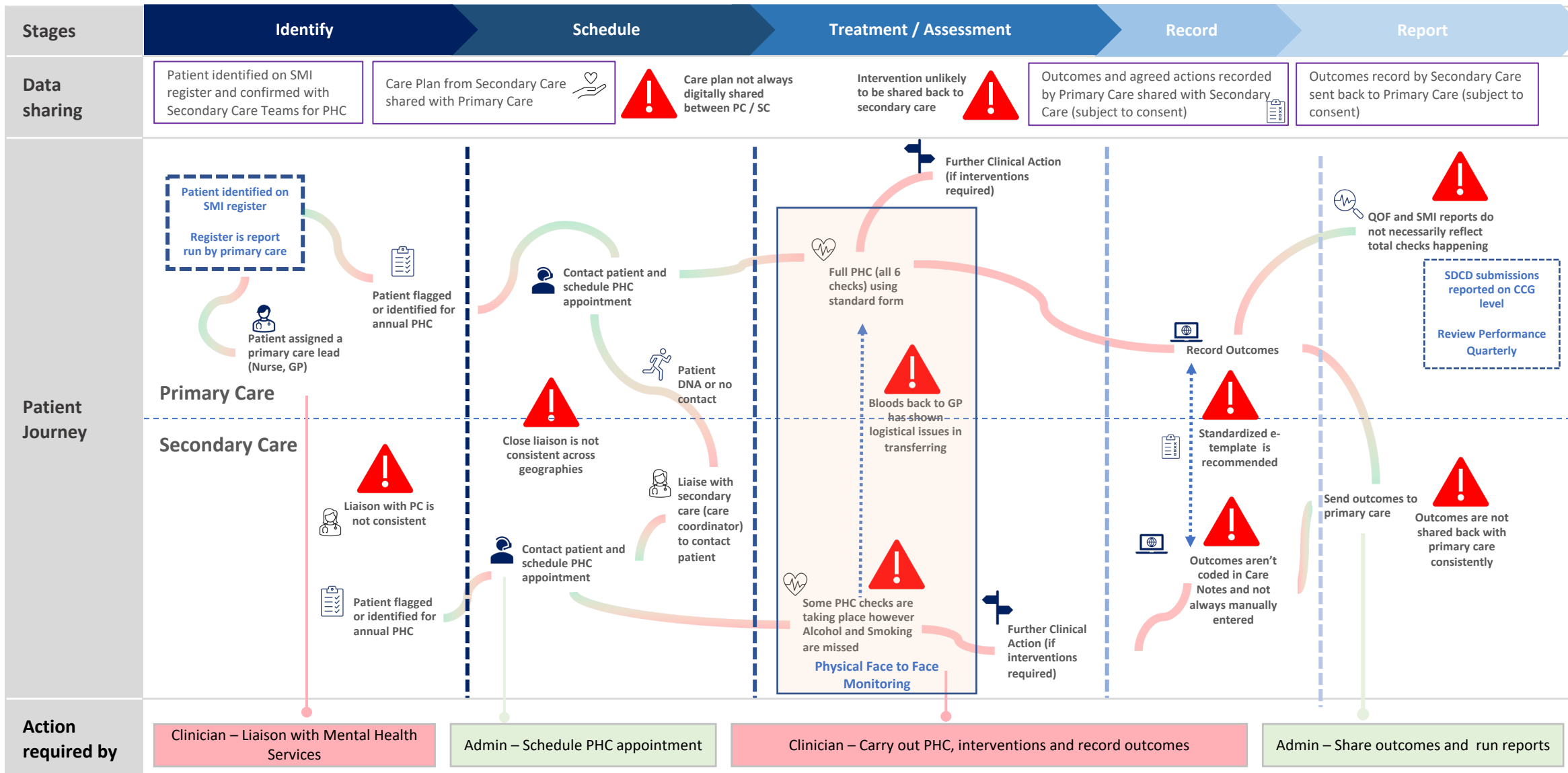
1. Executive summary | 2. Introduction | 3. Diagnostics | **4. System findings** | 5. Process mapping | 6. Roadmap | 7. Recommendations | 8. Next steps | 23



Process map: patient journey best practice



Process map: patient journey – example pain points

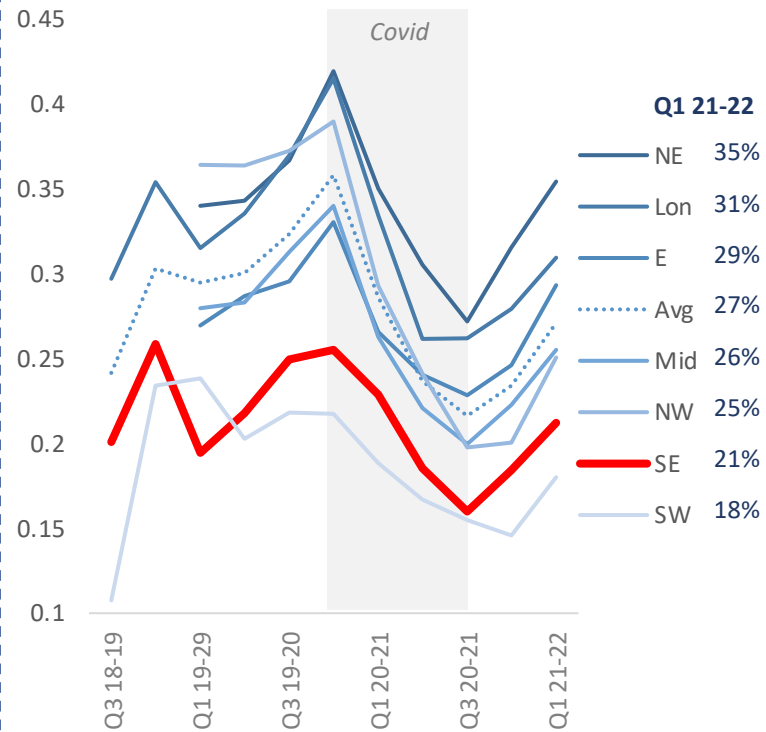


South East region data summary (1 of 2)



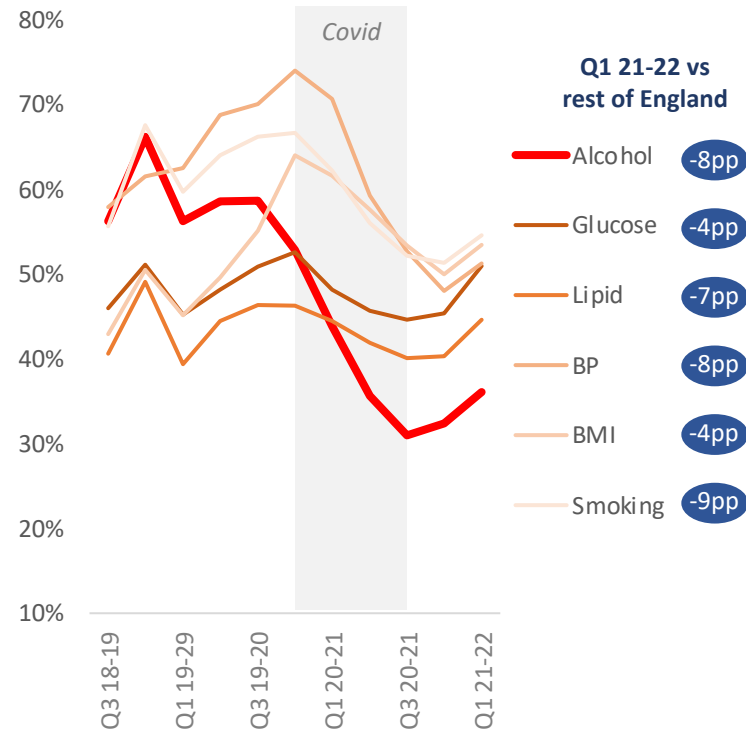
National performance fell in COVID and is recovering. The South East has followed the same trend but has been consistently below average

Proportion of SMI pts with all six PHCs



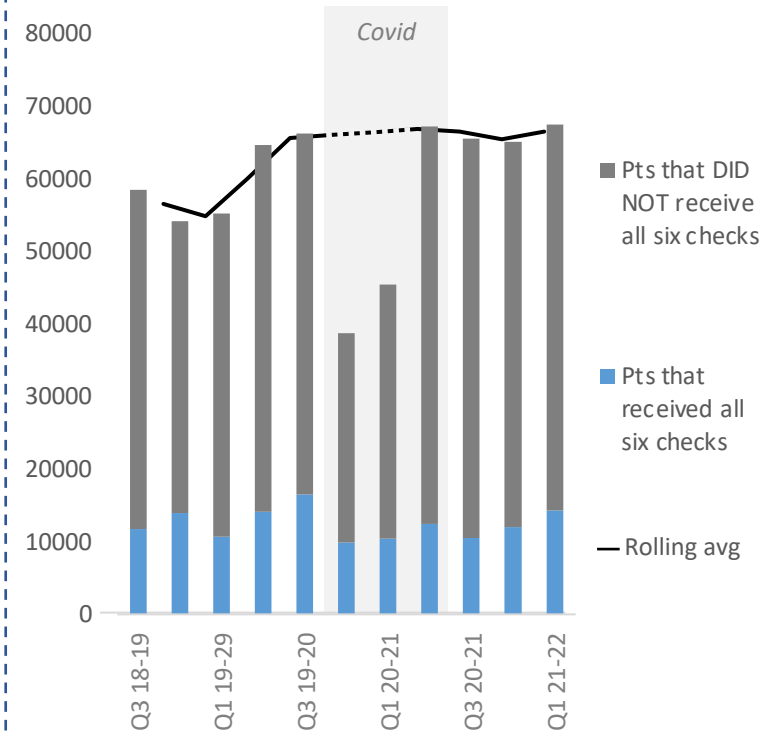
Some checks are performed more than others. Alcohol has declined while BMI has improved. The SE is below the rest of England in all checks

Proportion of SMI pts achieving individual PHCs



The size of the SMI register was growing prior to COVID but now is more stable

Number of SMI pts receiving all six PHCs

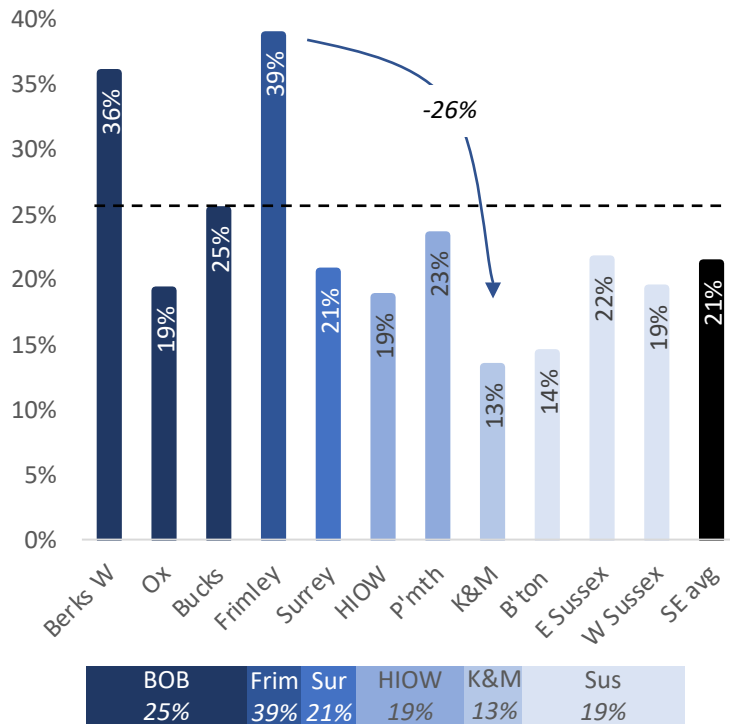


South East region data summary (2 of 2)



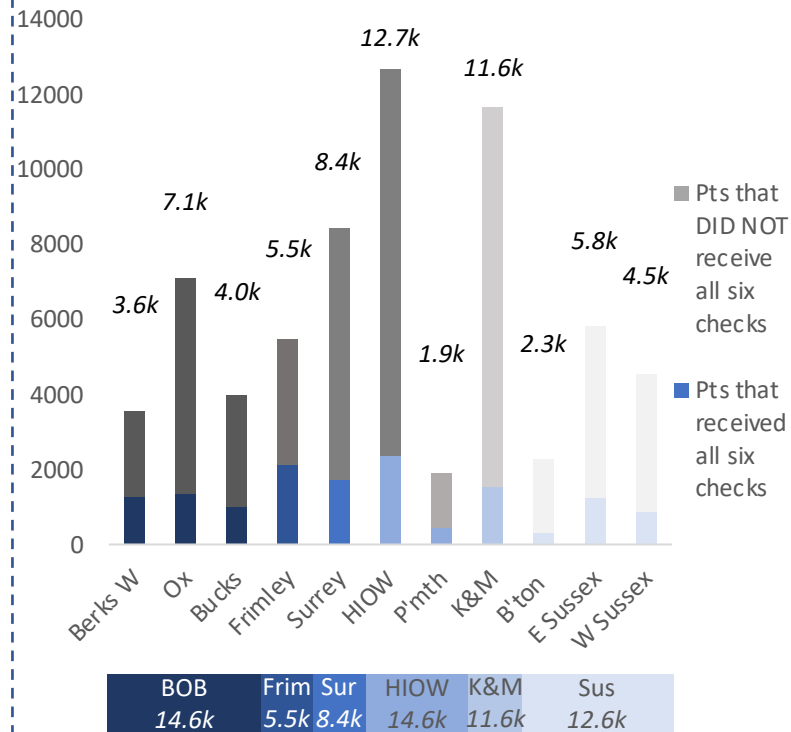
There is variation in performance across CCGs, with a 26% difference between Frimley (39%) and Kent & Medway (13%)

Proportion of pts with all six checks by CCG, Q1 21/22

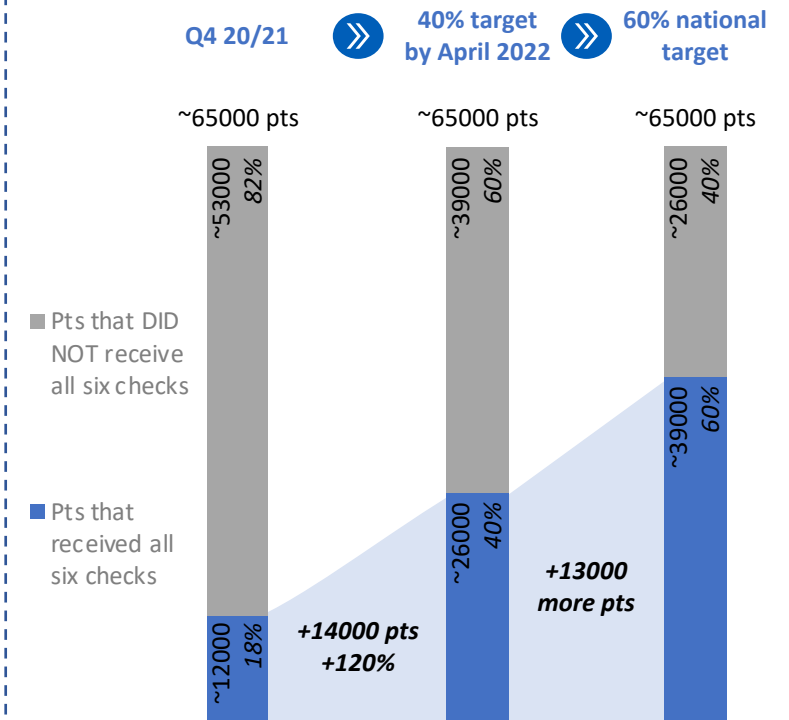


Performance on its own doesn't show the full picture, as the size of the CCGs also varies significantly

Number of pts with all six checks by CCG, Q1 20/21



The South East need to complete 14000 more PHCs to achieve the April 2022 target. This is 13000 patients below the national 60% target



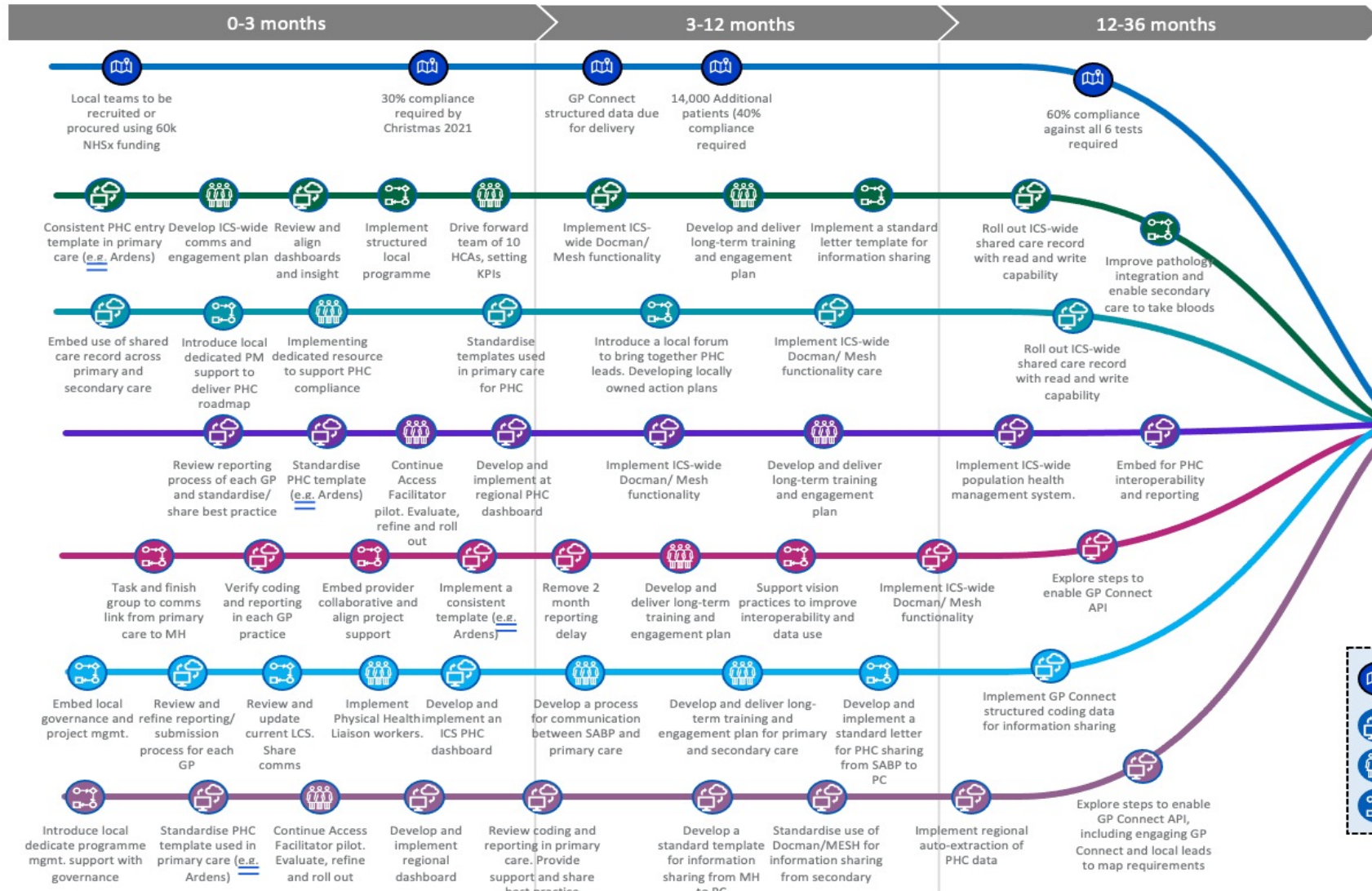
3. Roadmap and recommendations

Roadmap to success



Recommendations have been structured against known national and regional mandates and aims, as well as short, mid and long-term timeframes for each ICS. Recommendations are aligned to people, process and technology themes and are built from individual ICS plans

NHSE/I regional delivery commitments



>60% of all patients on an SMI register in SE region receiving all 6 Annual PHCs

- National Delivery
- Technology
- People
- Process

Regional menu of innovations and initiatives to improve patient engagement



Many areas have new and innovative practices in place or under implementation. These new models offer an an exciting selection of actions that the region could pick from.

	Easy – 0-3 Mths		Medium – 3-6 Mths		Hard – 6+ Mths
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<p>DROP-IN SMI CLINICS </p> <p>Flexible or drop-in sessions so patients can attend to suit their mood or needs. Drop-ins can take place in community venues or in secondary care settings where patients are already attending appointments with secondary care.</p>	<p>QUICK PHC INFO GATHER </p> <p>Gather PHC information that doesn't require physical procedures via quick touchpoints such as text, WhatsApp, receptionists asking when patients call in or through registration touch-screens. This can help to boost lower performing areas including Alcohol.</p>	<p>SPECIALIST SMI HCPs </p> <p>Recruit or train HCAs or nurses who specialise in working with SMI patients and are tasked with delivering SMI PHCs. This approach has been piloted across the country and anecdotally is proving effective at boosting performance.</p>	<p>MOMENTUM </p> <p>Use the opportunity of having a patient at a PHC appointment to engage them in ongoing wellbeing support, whether through VCOs, Health Coaches or other means. Also seek commitment they're happy to attend the check the following year.</p>
<p>PATIENT FRIENDLY </p> <p>Reduce number of DNAs by scheduling appointments for later in the day because of the effects of medication. Allow a quiet space in the waiting area and ensure appointments aren't too long.</p>	<p>STAFF TRAINING </p> <p>Increase staff confidence by ensuring they're trained in the importance of SMI PHCs and how to conduct them. This 32-minute training video from NHS England and NHS Improvement – South East, Health Education England and the Charlie Waller Trust also has supporting materials.</p>	<p>SELL THE BENEFITS </p> <p>For many patients there aren't immediate benefits for attending a PCH, so stating the benefits in their invite letter, using leaflets or proactively mentioning PHCs to all SMI patients during appointments throughout the year will help to increase those scheduling appointments.</p>	<p>COLLABORATE </p> <p>Work with local voluntary sector groups to promote the importance of physical health checks, giving information and promotional materials. Some MH providers, such as walking groups, can provide a way of bringing patients into surgeries for a coffee as well as their PHC.</p>
<p>SPECIALIST SERVICES </p> <p>Place SMI PHC practitioners inside specialist services. Having dedicated resources in ED, EIP, PD services allows you to more effectively meet and conduct PHCs with patients not typically in contact with their GPs.</p>	<p>REMOTE MONITORING </p> <p>Adopt use of remote monitoring devices, either by coding data from patients who are using them for comorbidity or by identifying patients who could benefit from a new device</p>	<p>TIE INTO MH SUPPORT </p> <p>Leverage support from GP Federations to support the delivery of SMI patient needs. GP Feds have successfully provided data analysis or overseen the operational management of HCAs alongside service clinical supervision. (Requires budget)</p>	<p>PATIENT OWNERSHIP </p> <p>Use publicly available SMI PHC guides, such as the Rethink Physical Health Guide, to share with SMI patients and encourage them to document their own physical health. They can bring this to their PHC to improve the conversation.</p>

Regional and ICS recommendations and initiatives



The roadmap is built from granular initiatives detailed at regional and ICS level. These have been informed by data analysis and regional and national engagement

Regional initiatives across the six engagement themes

Regional recommendations and best practice (4 of 4)
Initiatives to utilise in regional and ICS action plans to drive PHC improvement

Area	Recommendation/Initiative	Level	Owner	Time-frame	Ease of implementation	Potential Impact	Current ICS rating
	Introduce a region-wide PHC SMI forum attended by regional and ICS leads to manage action plans and hold to account	Regional	Local	Short	High	High	Low

Regional recommendations and best practice (3 of 4)
Initiatives to utilise in regional and ICS action plans to drive PHC improvement

Area	Recommendation/Initiative	Level	Owner	Time-frame	Ease of implementation	Potential Impact	Current ICS rating
	Develop and share content on the importance of PHCs to be shared with all relevant stakeholders. Aim to increase awareness and understanding of the need	IC levels, MH	Local	Short	Med	High	Low

Regional recommendations and best practice (2 of 4)
Initiatives to utilise in regional and ICS action plans to drive PHC improvement

Area	Recommendation/Initiative	Level	Owner	Time-frame	Ease of implementation	Potential Impact	Current ICS rating
	Use a consistent template for PHC completion by clinicians (Adverse recommendations). Where other templates are used (e.g. EAMH/VOCD) should be	IC levels, MH	Local	Short	High	High	Low

Regional recommendations and best practice (1 of 4)
Initiatives to utilise in regional and ICS action plans to drive PHC improvement

Area	Recommendation/Initiative	Level	Owner	Time-frame	Ease of implementation	Potential Impact	Current ICS rating
	Define a standard process for coding information in GP practices from letters received from secondary care. Share content and run training where required	IC levels	Local	Short	Med	High	Low

Regional menu of innovations and initiatives to improve patient engagement

Many areas have new and innovative practices in place or under implementation. These new models offer an exciting selection of actions that the region could pick from.

Category	Initiative	Impact
DROP-IN SMI CLINICS	Flexible or drop-in sessions so patients can attend to suit their mood or needs. Drop-ins can take place in community venues or in secondary care settings where patients are already attending appointments with secondary care.	Easy - 0-3 Mths
PATIENT FRIENDLY	Reduce number of DNAs by scheduling appointments for later in the day because of the effects of medication. Allow a quiet space in the waiting area and ensure appointments aren't too long.	Easy - 0-3 Mths
SPECIALIST SERVICES	Place SMI PHC practitioners inside specialist services. Having dedicated resources in ED, GP, ID services allows you to more effectively meet and conduct PHCs with patients not typically in contact with their GP.	Medium - 3-6 Mths
QUICK PHC INFO GATHER	Gather PHC information that doesn't require physical procedures via quick touchpoints such as text, WhatsApp, receptionists asking when patients call in or through registration touch-screens. This can help to boost lower performing areas including alcohol.	Easy - 0-3 Mths
STAFF TRAINING	Increase staff confidence by ensuring they're trained in the importance of SMI PHCs and how to conduct them. This 32-minute training video from NHS England and NHS Improvement - South East, Health Education England and the Humberside and Lincolnshire Local Health System also has supporting materials.	Easy - 0-3 Mths
REMOTE MONITORING	Adopt use of remote monitoring devices, either by coding data from patients who are using them for compliance or by identifying patients who could benefit from a new device.	Medium - 3-6 Mths
SPECIALIST SMI HCPS	Recruit or train HCAs or nurses who specialise in working with SMI patients and approach with delivered SMI PHCs. This approach has been piloted across the country and anecdotally is proving effective at boosting performance.	Medium - 3-6 Mths
SELL THE BENEFITS	For many patients there aren't immediate benefits for attending a PHC, so stating the benefits in their invite letter, using leaflets or proactively mentioning PHCs to all SMI patients during appointments throughout the year will help to increase those scheduling appointments.	Medium - 3-6 Mths
TIE INTO MH SUPPORT	Leverage support from GP Federations to support the delivery of SMI patient needs. GP Feds have successfully provided data analysis or overseen the operational management of HCAs alongside service clinical supervision. (Requires budget).	Medium - 3-6 Mths
MOMENTUM	Use the opportunity of having a patient at a PHC appointment to engage them in ongoing wellbeing support, whether through VCDs, Health Coaches or other means. Also seek confirmation they're happy to attend the check the following year.	Medium - 3-6 Mths
COLLABORATE	Work with local voluntary sector groups to promote the importance of physical health checks, giving information and promotional materials. Some MH providers, such as Mental Health Foundation , can provide a way of bringing services into surgeries for a coffee as well as their PHC.	Medium - 3-6 Mths
PATIENT OWNERSHIP	Use publicly available SMI PHC guides, such as the British Physical Health Guide , to share with SMI patients and encourage them to document their own physical health. They can bring this to their PHC to improve the conversation.	Easy - 0-3 Mths



ICS recommendations across people, process and technology

Example: Buckinghamshire, Oxfordshire, Berkshire West

ICS recommendations: BOB
Recommendations specific to ICS, in addition to regional recommendations

ICS FOCUS AREAS

- CCGs within BOB operate independently, with variable process and improvement plans in progress in each CCG for PHCs. Learnings and good practice need to be shared across areas and OHFT.
- New teams have recently been introduced to support PHC. The outputs of these need to be maximised
- Communication between OHFT and primary care is inconsistent and often limited across the ICS.

ICS PLANS IN PLACE

- Social Prescribers pilot in Berkshire West to support patient engagement (Jan 2021)
- Development and roll out of an ICS Shared Care Record
- New team in OHFT of 10 HCAs and a PH lead to drive PHC compliance

ICS SHORT TERM INITIATIVES

- Implementation of consistent PHC data entry templates used in primary care for PHCs, ensuring coding is aligned to SNOMED codes.
- Review PHC dashboards used across the three CCGs and OHFT. Align KPIs and reporting methodology. Develop plan for consistent insight generation, ICS-wide communication, and action plans informed by the dashboard.
- Utilise and drive forward efficacy of new OHFT PHC team 10 HCAs. Set clear KPIs and actions, and ensure the team operate effectively across the whole ICS
- Continue social prescriber pilot. Evaluate and role for potential ICS-wide roll out
- Develop consistent ICS-wide comms and engagement plan for raising PHC awareness within primary care (e.g. best practice process, focus on lipids and alcohol as low scoring checks)
- Engage with low scoring QOF GPs as potential areas pulling down ICS performance

ICS MID TERM INITIATIVES

- Implement ICS-wide Docman Connect/MESH functionality for data sharing between Care Notes (Advanced) to EMIS
- Review existing reporting within each GP and implement coding and extraction PHC data
- Develop and deliver a long-term training plan for stakeholders in each step of the pathway
- Implement a standard template for letters sharing the outcomes of PHCs from MH to primary care with summarised checks in a table at the top

ICS LONG TERM INITIATIVES

- Develop an ICS-wide Shared Care Record and embed use within primary care for PHCs
- Implement auto-extraction reporting of PHC data via EMIS Enterprise/Ardens
- Improve pathology integration, including enabling secondary care to undertake bloods and ensuring bloods results are shared across primary and secondary care.

ICS CHALLENGES AND RISKS TO DELIVERY

- Current BOB CCGs often operate in silo due to historic boundaries. This way of working is embedded in the region and will be challenging to overcome.
- Historic variation has led to different practices across the region which will be challenging to standardise.

BOB | Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

1. Executive summary 2. Introduction 3. Diagnostics 4. System findings 5. Process mapping 6. Roadmap 7. Recommendations 8. Next steps 57

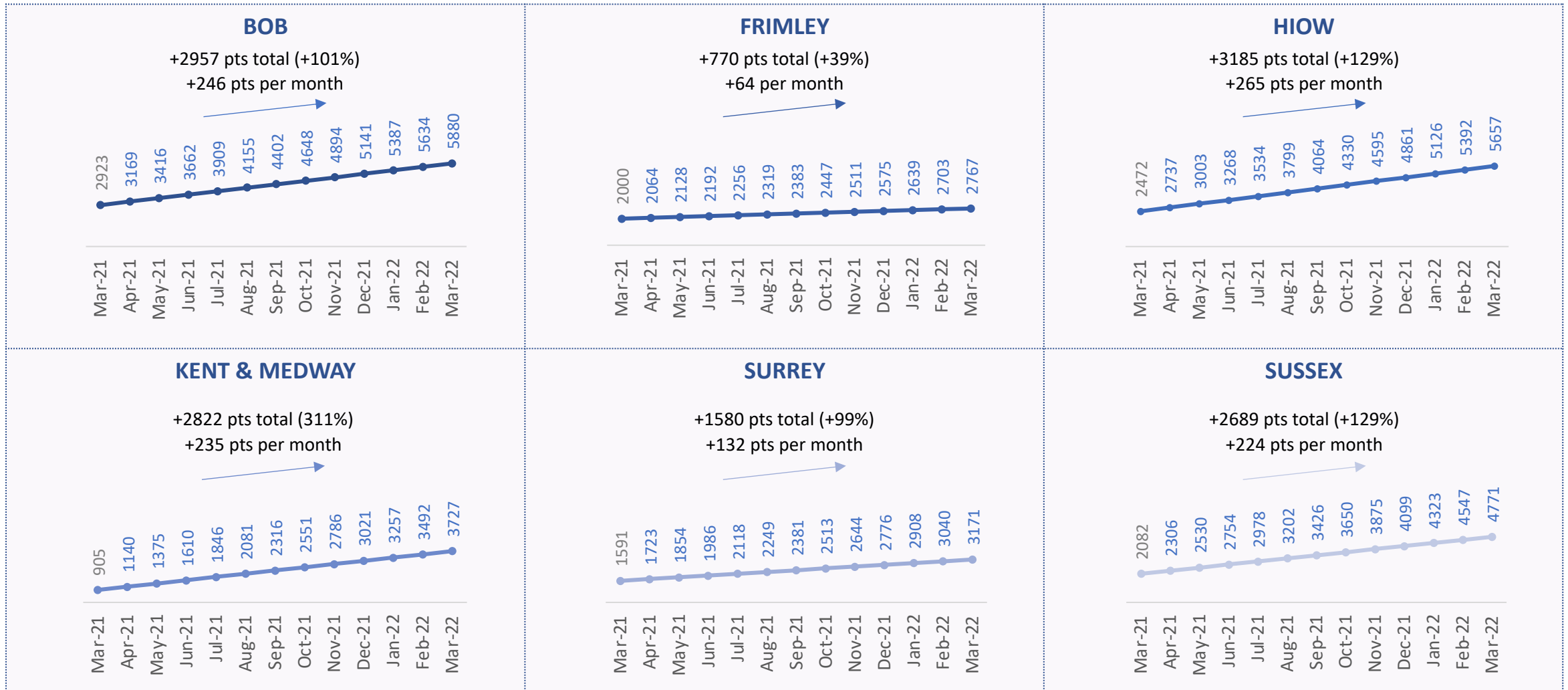


ICS improvement trajectories



Each ICS has an improvement target to achieve a share of the 14000 patient regional aim. Trajectories have been calculated using ICS size and current performance. Current regional reporting is quarterly, with the aim to move monthly to track progress of the programme.

Number of SMI patients that need to have received full PHCs in previous 12 months to end of month

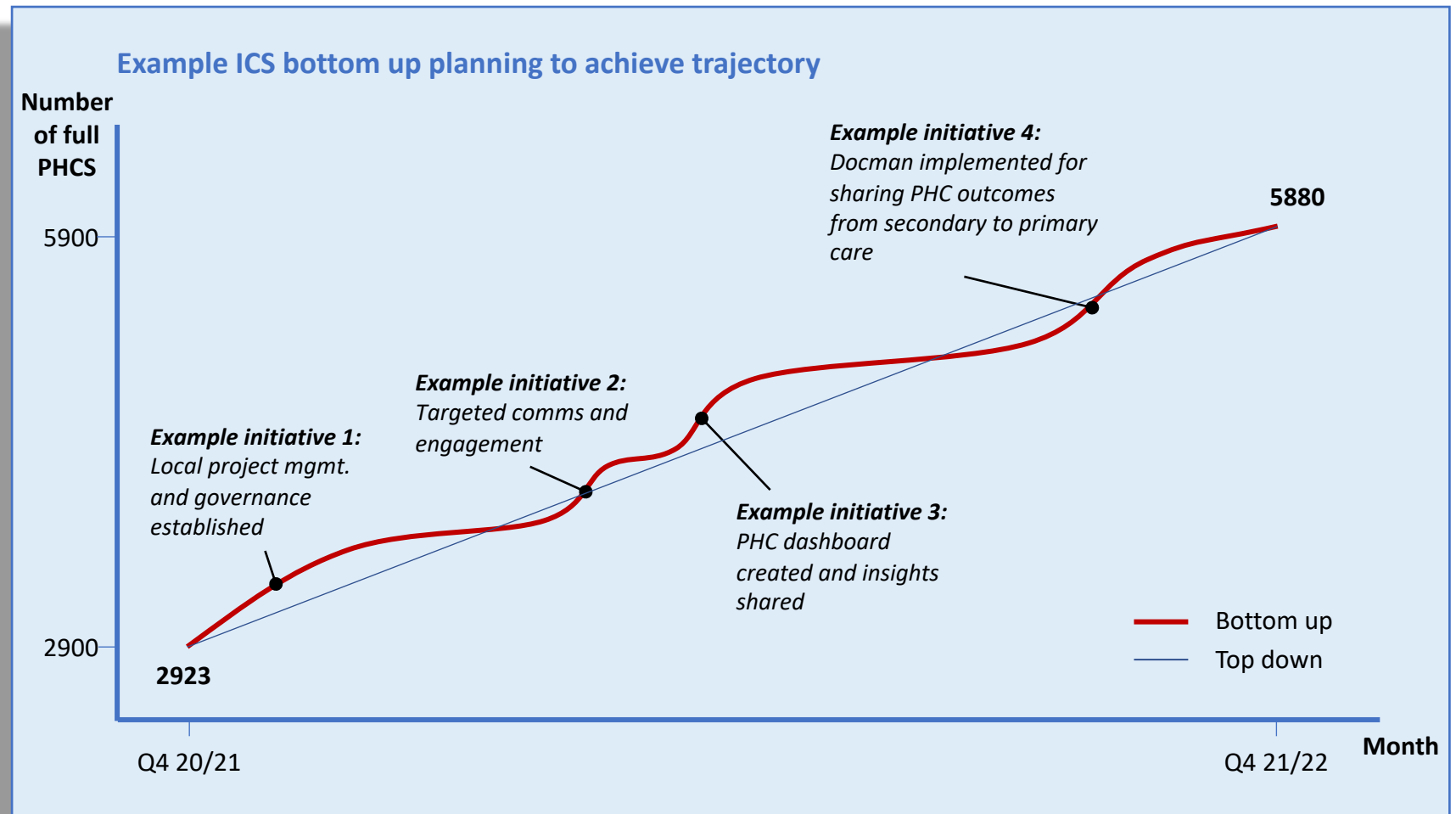
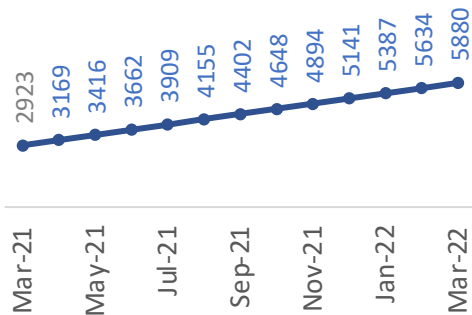


Combining trajectories with bottom up action plans

Each ICS can use their roadmap and recommendations to build action plans detailing initiatives, timeframes and expected impact. These can be used to build bottom up forecasts to achieve their trajectories

Example ICS trajectory

+2957 pts total (+101%)
+246 pts per month



4. Next steps

Moving into the delivery phase

The programme has completed the initial discovery phase and is moving at pace into delivery. This includes dedicated programme management support for each ICS to determine and drive forward improvement initiatives

DISCOVERY PHASE

July – Sep 2021

- ✓ Quantitative and qualitative analysis of current state in each ICS
- ✓ Process mapping and understanding of the drivers of performance
- ✓ Roadmapping and building ICS trajectories
- ✓ Regional and ICS level recommendations and initiatives
- ✓ Engagement with stakeholder nationally, regionally, and across each ICS

New focus going forwards

DELIVERY PHASE

Sep 2021 – April 2022

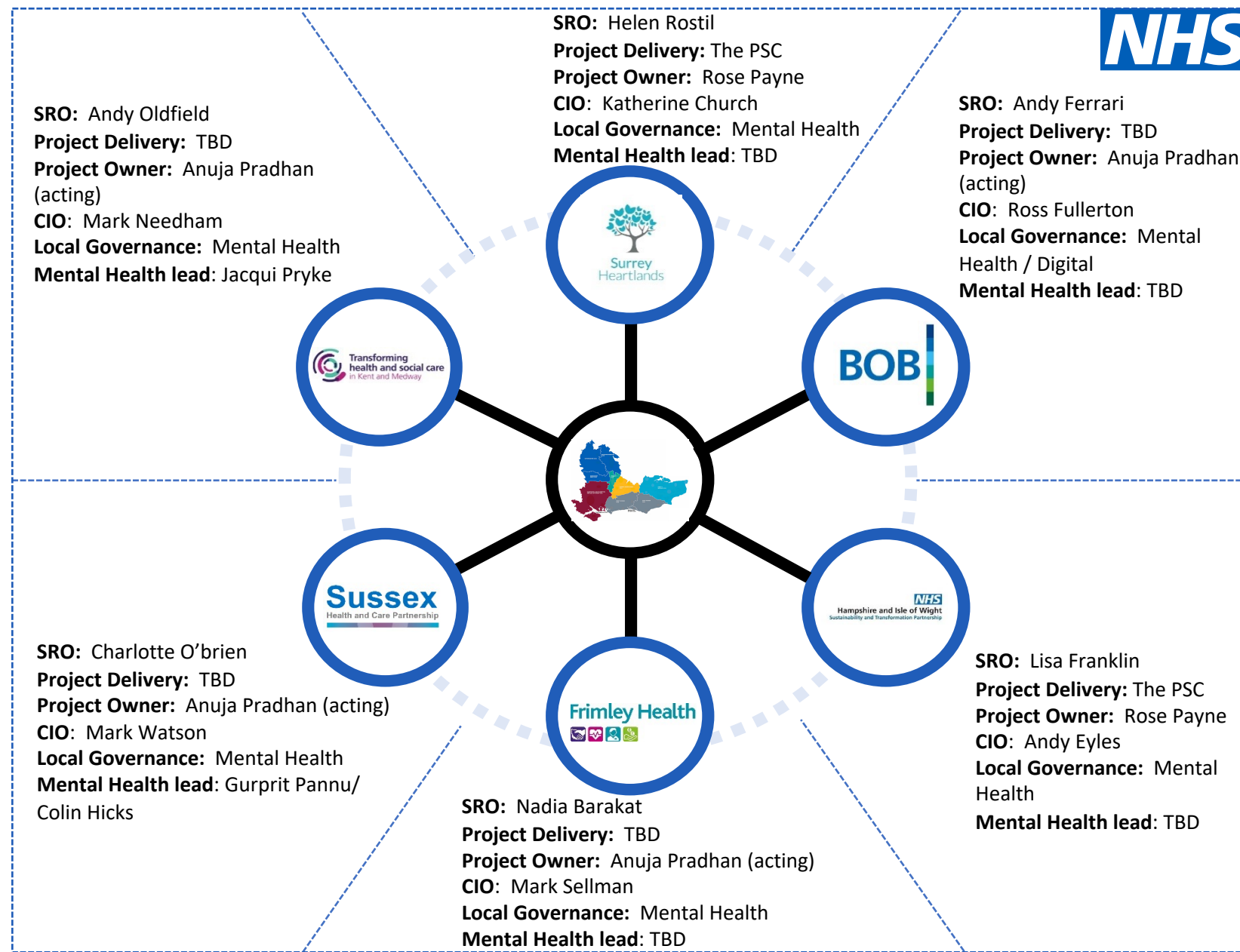
- Dedicated programme management in each ICS
- Defined roles and governance to drive forward progress at pace
- Local action plans, with tailored initiatives and deliverables
- Monthly reporting to track against improvement trajectories, with local BI where possible

Going forward through ICS teams

Each ICS has £60k for programme delivery of these initiatives between September and March 2022.

Project delivery should include:

1. Transferred local ownership of deliverables outlined in this report
2. Monthly reporting and exception reporting of progress against the outlined trajectory in this report
3. System interoperability workarounds, measures and vendor management to ensure technical objectives are achievable
4. Regional representation at monthly forums to share information on progress
5. Highlight report shared back to central Innovation Collaborative team



Regional governance going forward

In collaboration with the teams outlined in the previous section, governance regionally will be led through the Mental Health Programme:

SRO: Nick Broughton
Clinical Lead: Bikram Raychaudury

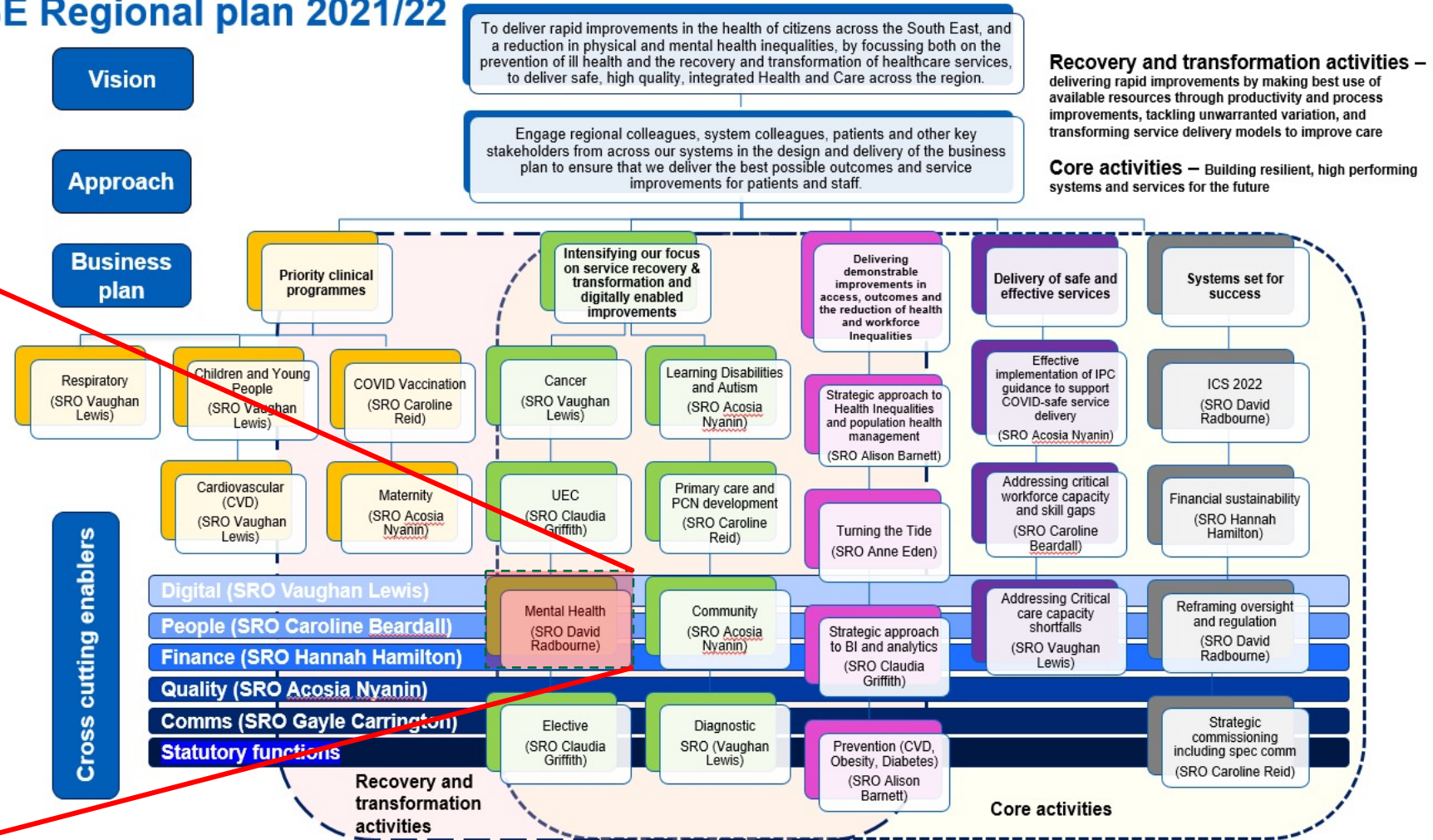
Mental Health Programme team:
 James Carter
 Nicolas Hanson-James
 Joanne Gavins

Regional Innovation Collaborative:
 Georgie Cole
 John Williams

Working Group Forums:
 MH Digital working group (bi-monthly)

Board governance
 Mental Health Delivery board

SE Regional plan 2021/22



5. Q&A

Q&A and feedback

1. Do you have any comments or feedback on ICS engagement themes or recommendations?
2. What are the barriers and requirements to actioning recommendations within your ICS?
3. Do you have any further questions or actions for this session?



Appendix

Appendix 1: ICS action lists

Appendix 2: Detailed data summary

Detailed ICS recommendations: Technology



0-3 months

- | | | | | | |
|--|---|---|--|--|---|
| <ul style="list-style-type: none"> Implementation of consistent PHC data entry templates used in primary care for PHCs, ensuring coding is aligned to SNOMED codes. Review PHC dashboards used across the three CCGs and OHFT. Align KPIs and reporting methodology. Develop plan for consistent insight generation, ICS-wide communication, and action plans informed by the dashboard. | <ul style="list-style-type: none"> Embed use of shared care record across MH and PC to support flagging and identification overdue/missing PHCs Standardisation of templates across the ICS through a roll out of Ardens (or similar specification) template across MH providers and Primary care practices. Expand use of dashboards building on level of detail already provisioned through the population health management tool. | <ul style="list-style-type: none"> Standardise PHC template used by primary care for PHC (e.g. Ardens) Review reporting practice of each GP to identify variation and it's drivers. Determine best practice method for manual extractions and share comms. Ensure standard set of clinical codes are used for reporting. Develop and implement a dashboard to GP level detailing trends and performance. Identify insights and engage GPs | <ul style="list-style-type: none"> Implement ICS-wide PHC template e.g. EMIS or Ardens. Reduce variation, ensure templates signpost PHCs, ensure correct coding against national. Work with 3rd party data providers to minimise delay in monthly figures Verify SNOMED coding in each PC provider for templates and reporting. Share comms to align to national requirement. Embed a process for developing and acting on insights from dashboard | <ul style="list-style-type: none"> Review reporting submission rates and process per GP to identify variation. Define best practice extraction process and share comes, focussing on areas of low submission Implement an ICS dashboard and associated process to identify insights and drive action Review PHC templates in place. Introduce consistent templates and ensure coding is correct, including in SABP | <ul style="list-style-type: none"> Implement a consistent template for executing PHCs within primary care (e.g. Ardens) Review codes used in primary care for PHC delivery and reporting. Align codes to national guidance and standardise process to CCG for manual extractions Develop and implement a monthly dashboard reporting to practice level. Embed a process for insight generation and action |
|--|---|---|--|--|---|

3-12 months

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| <ul style="list-style-type: none"> Implement ICS-wide Docman Connect/MESH functionality for data sharing between Care Notes (Advanced) to EMIS Review existing reporting within each GP and implement coding and extraction PHC data | <ul style="list-style-type: none"> Implement ICS-wide Docman Connect/MESH functionality for data sharing from secondary care | <ul style="list-style-type: none"> Implement ICS-wide Docman Connect/MESH functionality for electronic data sharing between secondary and primary care | <ul style="list-style-type: none"> Implement ICS-wide Docman Connect/MESH functionality for electronic sharing from secondary to primary care. Engage Servelec on next steps Provide dedicated support to Vision practices to improve interoperability | <ul style="list-style-type: none"> Expand and embed use of Docman/MESH to share information from secondary to primary care. Determine and execute steps required to prepare for GP Connect implementation in EMIS and SystemOne. | <ul style="list-style-type: none"> Review use of Docman/MESH across the region for information sharing from primary to secondary care. Identify gaps and improve uptake using action tracker Implement regional auto-extraction of data at CCG level for reporting and BI |
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12-36 months

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| <ul style="list-style-type: none"> Develop ICS-wide Shared Care Record and embed within primary care Implement auto-extraction via Enterprise/Ardens | <ul style="list-style-type: none"> Implement population management system. Utilise for interoperability and reporting for primary and secondary care. | | <ul style="list-style-type: none"> Explore steps required to enable GP Connect API, including engaging GP Connect and local leads to map ICS-wide needs | | <ul style="list-style-type: none"> Explore steps required to enable GP Connect API, including engaging GP Connect and local leads to map ICS-wide needs |
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Detailed ICS recommendations: People



0-3 months

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| <ul style="list-style-type: none"> Utilise and drive forward effectiveness of new OHFT PHC team 10 HCAs. Set clear KPIs and actions, and ensure the team operate effectively across the whole ICS Continue social prescriber pilot. Evaluate and role for potential ICS-wide roll out Develop consistent ICS-wide comms and engagement plan for raising PHC awareness within primary care (e.g. best practice process, focus on lipids and alcohol as low scoring checks) Engage with low scoring QOF GPs as potential areas pulling down ICS performance | <ul style="list-style-type: none"> Continue high levels of engagement and training across primary care. This is an ICS core strength that should be rolled out to support other ICS's improvement. Consider dedicated resource to support PHC compliance and identify PHC delays/pain points e.g. patients with 4/6 checks completed, focus alcohol consumption checks. This should be at the PCN level or higher (e.g. ICP) Contribute to a community of practice forum to share best practice across all ICS's | <ul style="list-style-type: none"> Continue Access Facilitator roll out in Southampton. Evaluate initiative and refine roles & responsibilities, and share best practice across the ICS. Develop an ICS-wide comms and engagement plan for increasing awareness of PHCs across MH and PC e.g. to share best practice and target particular areas for improvement such as alcohol PHC | <ul style="list-style-type: none"> Develop and execute an ICS-wide comms and engagement plan for increasing awareness of PHC process and best practice within primary care Establish additional resource for target ICPs. Reach out to GPs re-type/ timelines | <ul style="list-style-type: none"> Introduce targeted comms and engagement to primary care on best practice and focus areas e.g. tackling low rates of alcohol and blood pressure PHCs Continue implementation of Physical Health Liaison Workers. Evaluate initiative and refine role, sharing best practice and rolling out regionally if successful Develop a process for communication between SABP and primary care e.g. letter sharing following PHCS or implementing a primary care stop-gap HCA | <ul style="list-style-type: none"> Continue roll out of Access Facilitators. Evaluate initiative and refine role. Share best practice across ICS. Develop and execute an ICS-wide comms and engagement plan for increasing awareness of PHC process and best practice within primary care |
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3-12 months

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| <ul style="list-style-type: none"> Develop and deliver a long-term training plan for stakeholders in each step of the pathway | <ul style="list-style-type: none"> Develop and deliver a long-term training plan for stakeholders in each step of the pathway | <ul style="list-style-type: none"> Develop standard training required for staff across PHC pathway and implement across the ICS | <ul style="list-style-type: none"> Provide training in SMI check delivery through already available video tools developed Nationally and in use in North East Region. Roll out in next available comms through each ICP | <ul style="list-style-type: none"> Develop standard training required for staff across PHC pathway and implement across the ICS |
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Detailed ICS recommendations: Process



0-3 months

- Implement structured local **governance** to bring together leads within each CCGs to share best practice and develop and track improvement initiatives
- Improve **liaison between primary and secondary care**, ensuring dedicated leads within each GP
- Define and share the **expectations, role and responsibilities of providers** within the pathway e.g. secondary care patient ownership and proportion of PHCs to be delivered
- Introduce **dedicated programme support** to develop, manage and deliver PHC improvement plans (e.g. introduce a project manager utilising regional PHC funding)
- Bring together ICS PHC leads under a **single consistent improvement plan** (e.g. CCG commissioner and PC leads). Embed a regional forum for problem solving plans and sharing best practice.
- Engage **LCS** leads to identify and implement standardisation/optimisation opportunities across multiple LCS
- Create a task and finish group to implement a **communication channel from MH to PC** (physical or electronic). Utilise to develop a standard PHC letter template
- Embed **provider collaborative** and share as best practice across the South East
- Identify **variation in process** of each K&M ICP in patient and data flows. Identify best practice and standardise if possible.
- Review current **LCS** and ensure this reflects immediate priorities (6 checks) with flexibility built in to later be increased to 9. Share comms regionally
- Embed local **governance** and improvement processes introduced by PSC project management support. Develop local action plans and instil ownership with local leads
- Record **regional forums** for PHC SMI and align workstreams/reduce silos.
- Introduce **dedicated programme support** to develop, manage and deliver PHC improvement plans (e.g. introduce a project manager utilising regional PHC funding)
- Introduce **local PHC forums** to coordinate improvement and best practice across CCGs
- Target **liaison and comms** from PC and MH as a high impact improvement opportunity

3-12 months

- Implement a **standard template for letters** sharing the outcomes of PHCs from MH to primary care with summarised checks in a table at the top
- Embed a **local forum** bringing together different areas. Develop locally owned (leads, providers) targets and trajectories for PHC improvement to be held to account through the forum.
- Develop and implement a **letter template** for sharing information across primary and secondary care

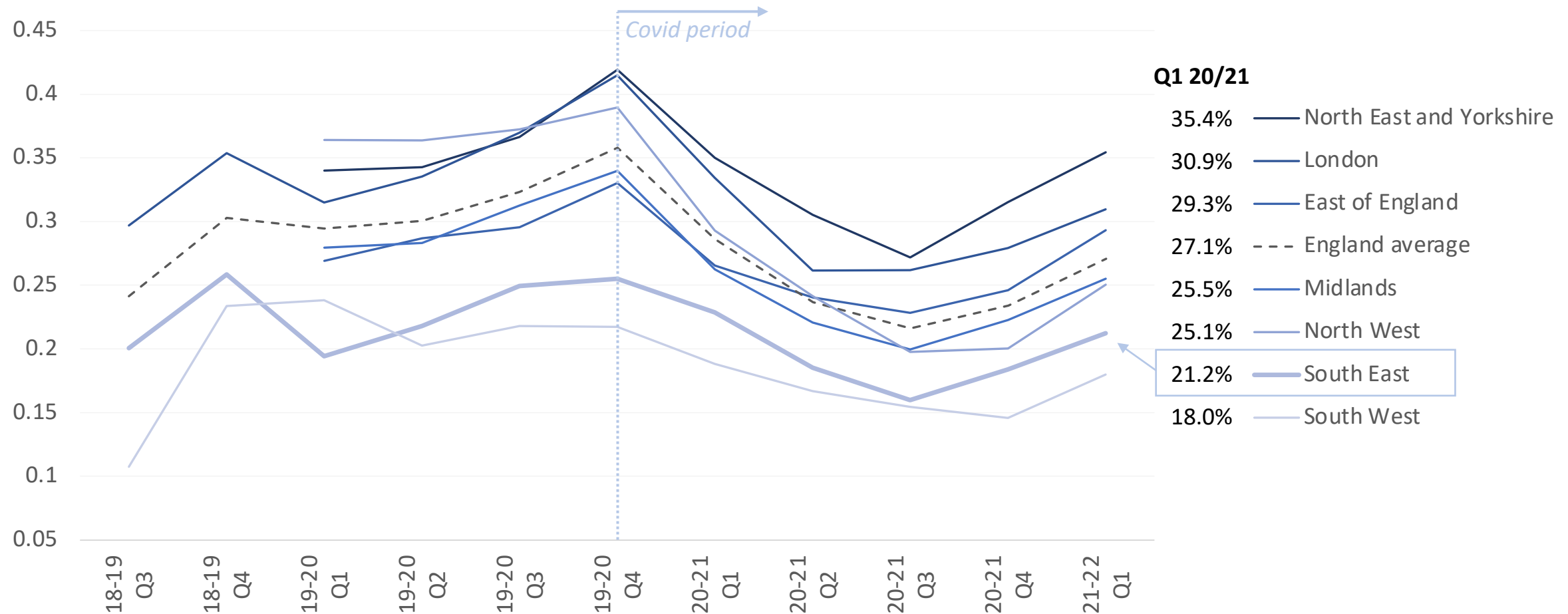
12-36 months

- Improve **pathology integration**, including enabling secondary care to undertake bloods and ensuring bloods results are shared across primary and secondary care.
- Improve **pathology integration**, including enabling secondary care to take bloods and ensuring results are shared across primary and secondary care

Over time, the South East has tracked below average and has followed broadly the same trend as other regions. Last quarter, the South East achieved 21.2%



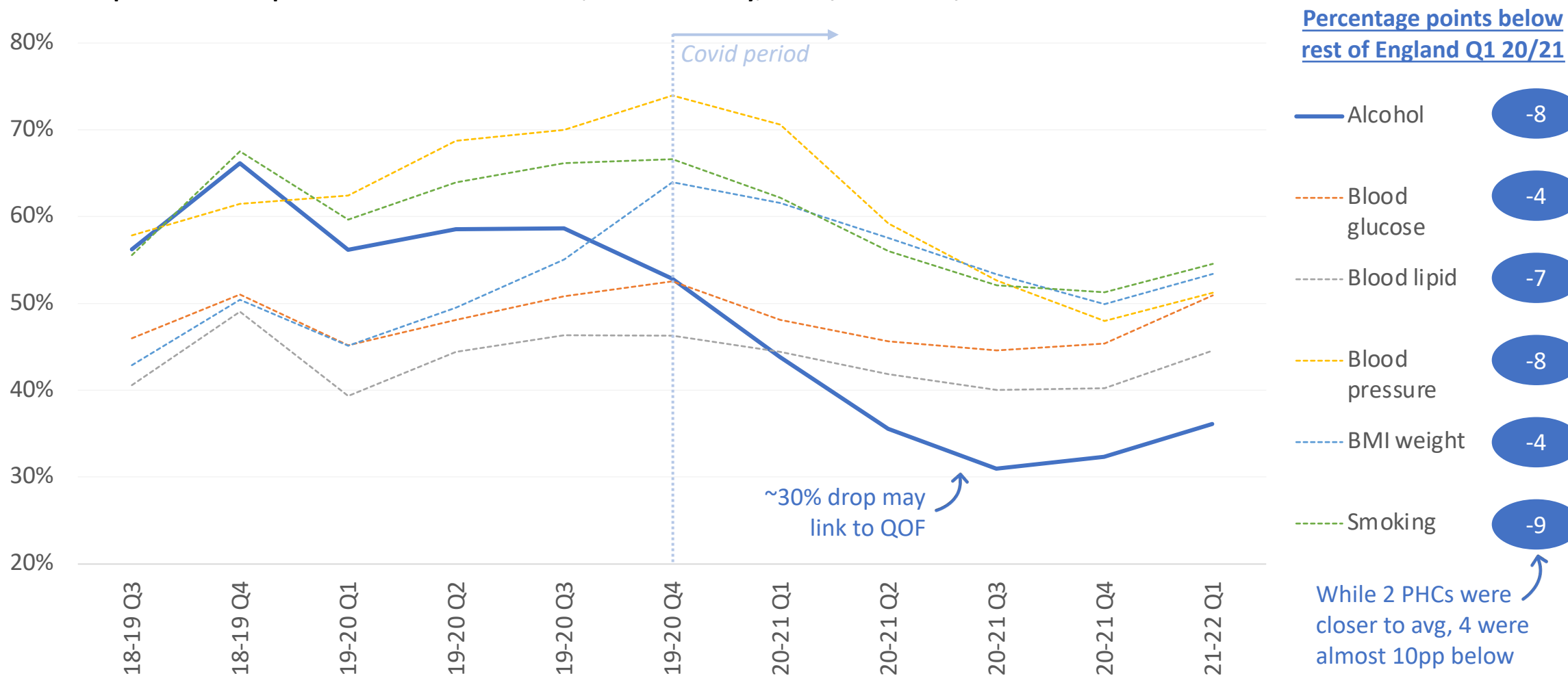
Proportion of SMI patients with all six PHCs completed in previous 12 months, Q3 18/19 – Q1 21/22





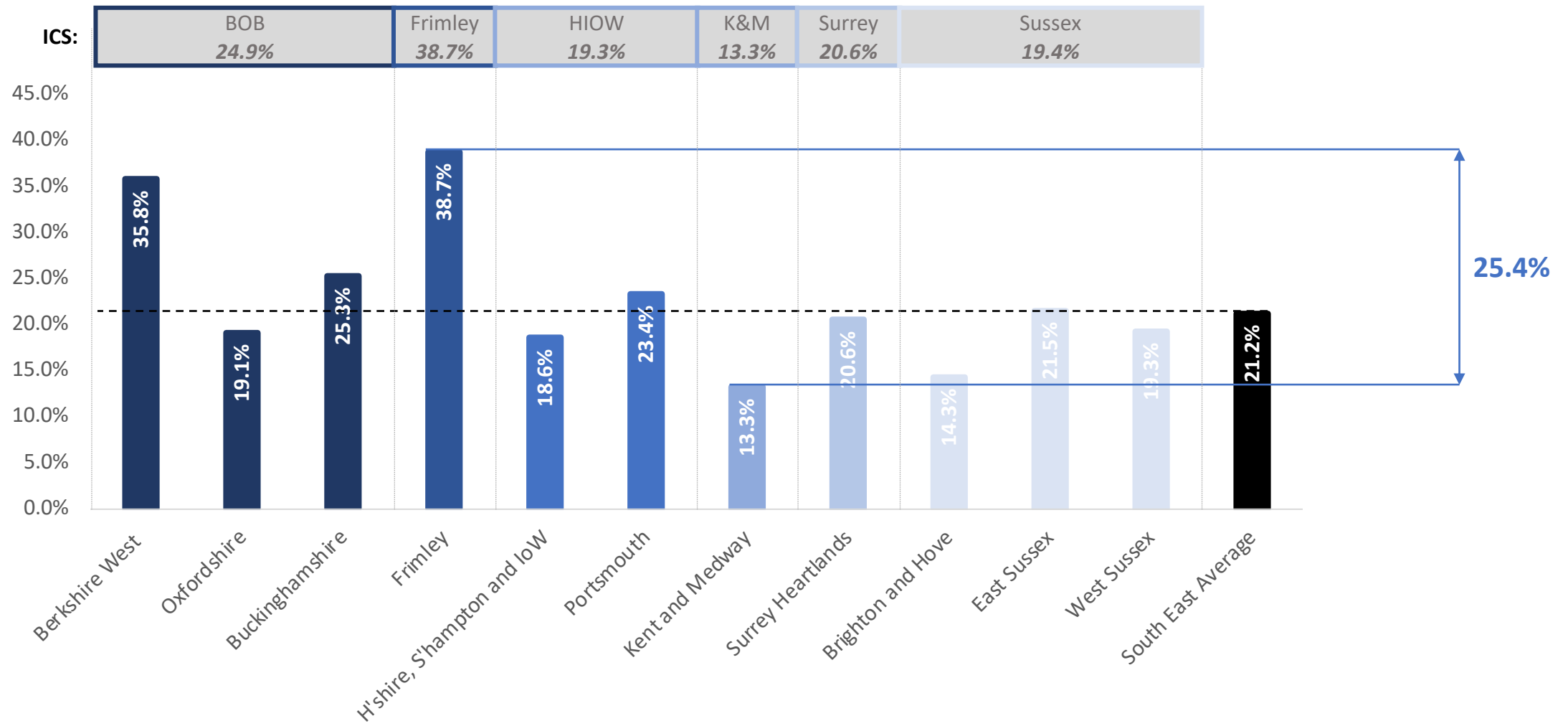
Alcohol PHC has declined ~30% since 2018. While the other checks have been more stable, all are completed less than the England average

Proportion of SMI patients with individual PHCs, South East only, Q3 18/19 – Q1 20/21



Last quarter there was a 25.4% difference between the South East's best and worst performing CCGs. The lower performers may be the ones with most opportunity...

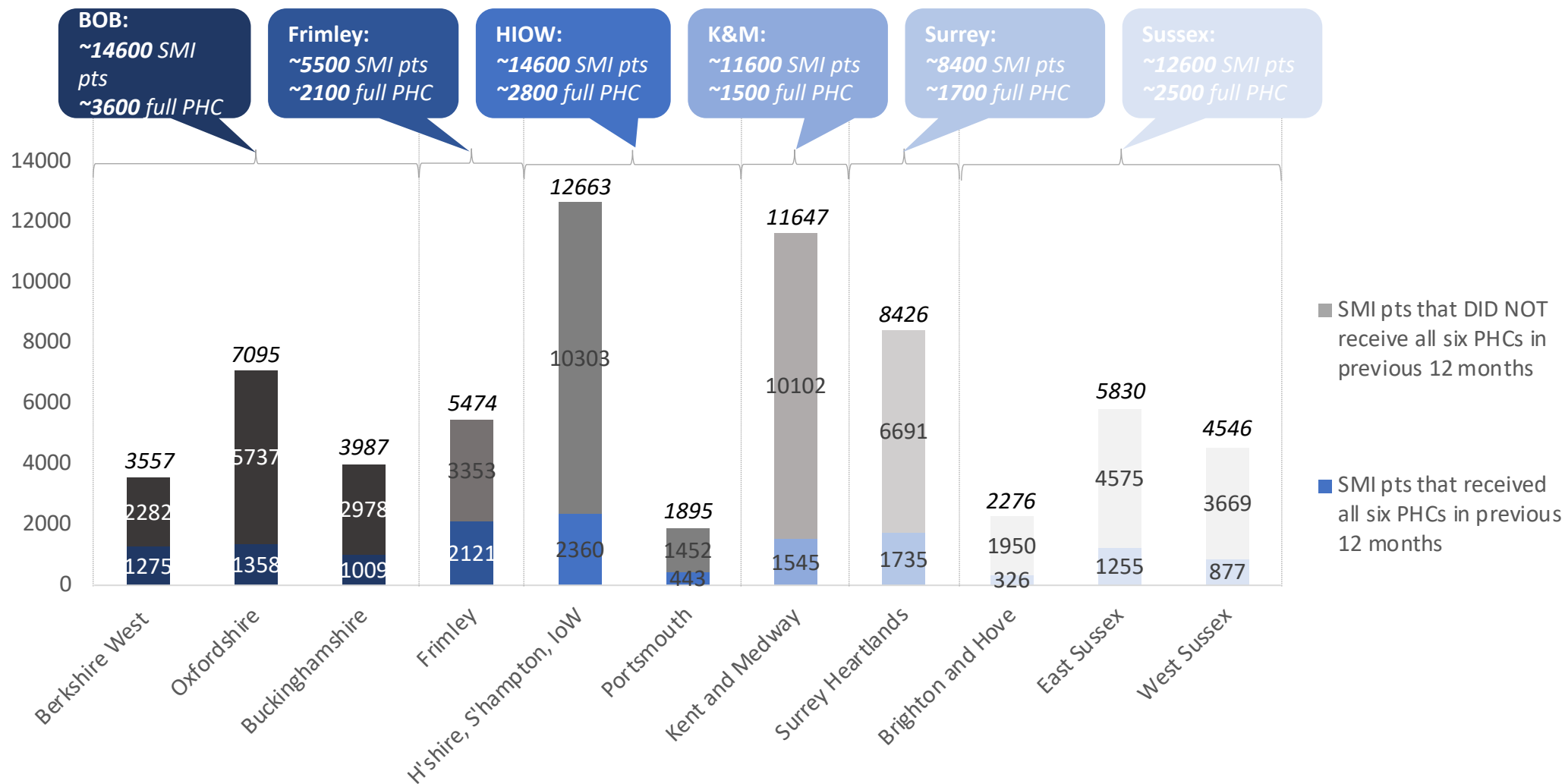
Proportion of SMI patients with all six PHCs completed in previous 12 months by South East CCG, Q1 21/22





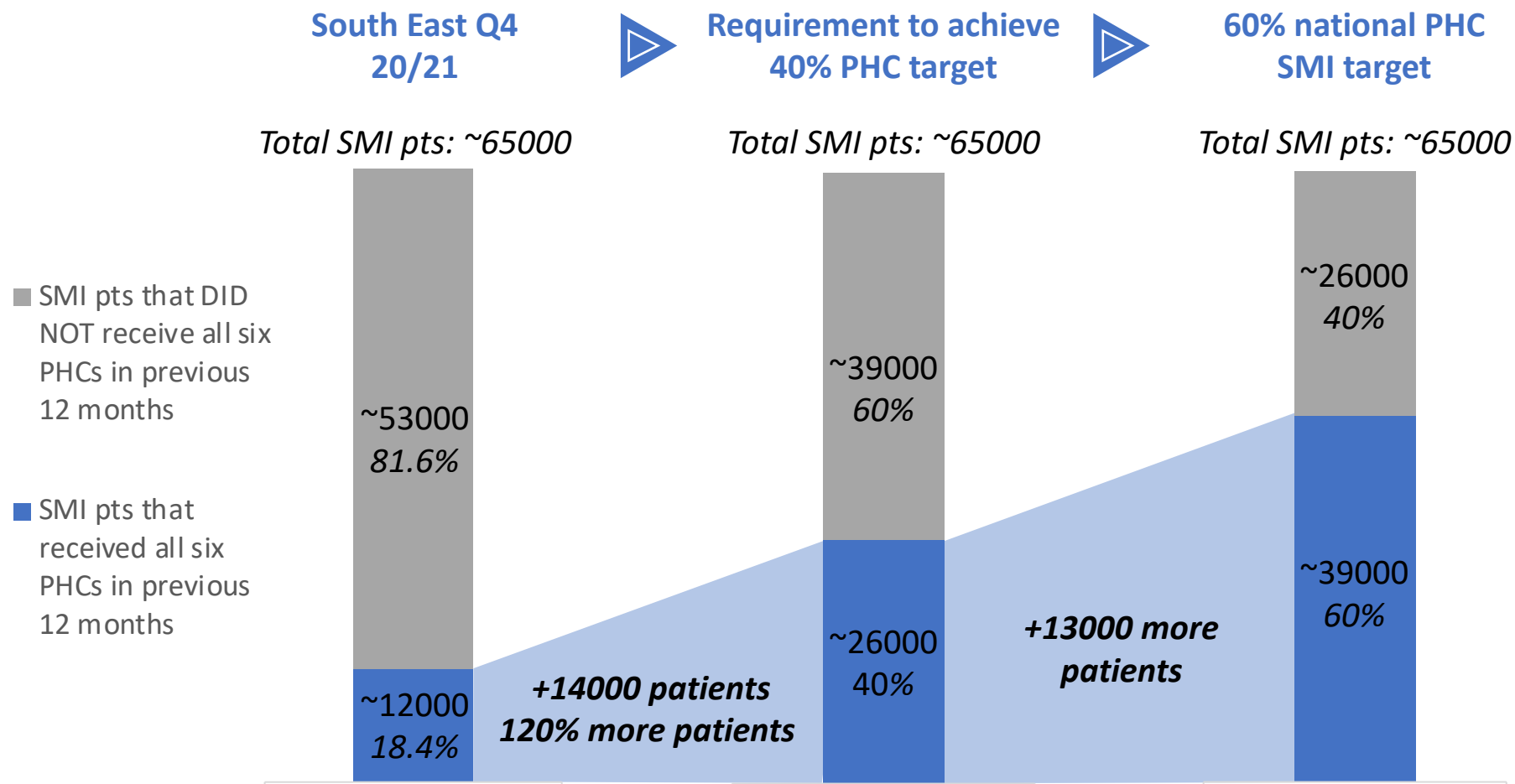
...however the CCGs have large differences in their number of SMI patients. This means larger CCGs have more to contribute to the whole region's performance

Number of SMI patients and proportion receiving all six PHCs in previous 12 months by South East CCG, Q1 21/22





The South East aims to achieve 40% of SMI patients receiving full PHCs by April 2022. In Q4 20/21, ~12000 of ~65000 patients in the South East had all six PHCs (18.4%). To achieve 40%, 14000 additional patients need full PHCs. This is still below the 60% target



Each ICS has an improvement trajectory to achieve the 14000 pt total based on their size and current performance