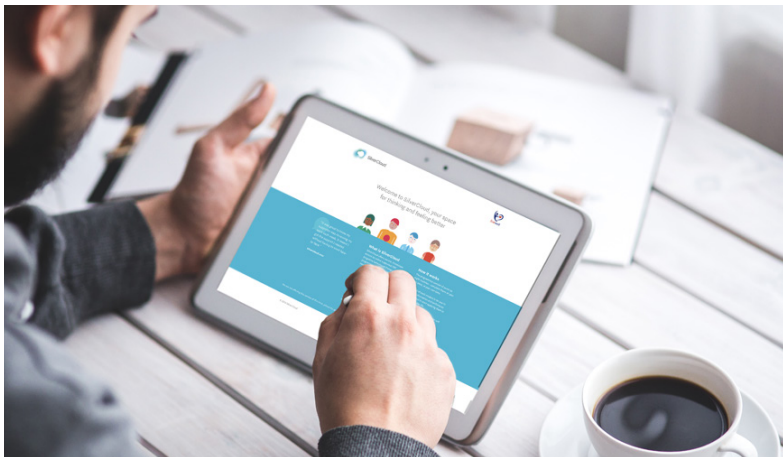
Primary Care

For Essex Health Overview and Scrutiny Committee (HOSC) June 2019







Introduction & Purpose

October Recap

In October 2018 the HOSC received a report on Primary Care that focused on the contractual framework for General Practice, the challenges faced within this sector in terms of workload, workforce and rising demand and articulated the approach that the five CCG's within the council boundaries were working on to transform General Practice to be fit for the future. This was presented within the context of the evolving STP landscape, and the movement towards Integrated Care Systems, but described how local implementation would vary dependent upon local needs

The key messages built upon in this paper are

- The long-term sustainability of General Practice is a priority for all systems, and there is national contract reform looking to address this
- General Practice in Essex is historically challenged in terms of workforce numbers, relating to traditional roles of Doctor and Nurse, and to manage this there is movement to GP Led as opposed to GP Delivered models of care and the wider diversification of the workforce
- Whilst General Practice is made up of independent contractors there is a view that both 'organisationally' and for the 'system' there is benefit from closer collaboration amongst practices. In October we called these localities and/or neighbourhoods and further progress has been made in this area

The HOSC have requested an update on progress made in delivering these new models of care and addressing practice sustainability/resilience as well as identify new local or national policy which may impact on this journey

What's in scope

The NHS landscape is a vast and complex one, and the transformation of General Practice cuts across several areas such as workforce and digital. This paper focuses on progress made in supporting the resilience and sustainability of General Practice as outlined above and discussed in October.

It provides this update in the context of an evolving landscape following release of two national strategic documents in January of this year. Namely the NHS Long-Term Plan, and 'Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan'.

What's out of scope

As the intended focus is transformation to date the paper does not cover General Practice Business as Usual issues (i.e. quality/CQC issues), individual practice performance or other Primary Care (Dentistry, Optometry of Pharmacy). In October we utilised the national General Practice patient survey as a means of assessing patient experience and access to services. The survey has not been re-implemented since October, and as such no further update is provided in this report.

Whilst the paper will touch on workforce developments within General Practice – in terms of additional staff and services commissioned to support General Practice - it does not go beyond this sphere of interest. It is understood HOSC have received separate updates covering workforce and workforce planning.

The paper does include extracts from NHS England's own high-level summary of the NHS Long-Term Plan for the purpose of understanding alignment of the transformation of General Practice as described in this and the previous paper with national policy. Each STP is tasked with developing its own local plan by the Autumn. These are currently in development through the partnerships in place between Local Government, the NHS and other key stakeholders including the public and is therefore out of scope.

Subsequent Policy Direction

Since October there have been two significant publications by NHS England that impact upon General Practice.

The first is the NHS Long-Term Plan, building on the Five Year Forward View and supporting documents including the GP Forward View (GPFV). Summarised below this was developed by Health and Care leaders and describes how the NHS will be fit for the future and get the most value for patients out of every pound of tax-payers' investment.

The second followed shortly after and was the announcement of a five-year reform programme for the GP Contract, agreed between NHS England and the BMA. The document sets out how the General Practice contract will evolve to be fit for the new systems that are emerging and be able to provide the foundations needed for the continued evolution of Integrated Care Systems.

National Policy Changes

Long Term Plan

NHS England state that the plan was drawn up by those who know the NHS best, including frontline health and care staff, patient groups and other experts. This group benefited from hearing a wide range of views, whether through the 200 events that have taken place, and or the 2,500 submissions we received from individuals and groups representing the opinions and interests of 3.5 million people.

The summary below, extracted from NHS England's own summary, sets out the key things they expect people to see and hear about over coming months and years, as local NHS organisations work with their partners to turn ambition into improvements.

The NHS Long Term Plan states that it will

- Making sure everyone gets the best start in life
- Deliver world class care for major health problems
- Support people to age well

Delivering the ambitions of the NHS Long Term Plan

To ensure that the NHS can achieve the ambitious improvements it intends to deliver for patients over the next ten years, the NHS Long Term Plan also sets out how to overcome the challenges that the NHS faces, such as staff shortages and growing demand for services, by:

1. Doing things differently: giving people more control over their own health and the care they receive, encourage more collaboration between GPs, their teams and community services, as

'primary care networks', to increase the services they can provide jointly, and increase the focus on NHS organisations working with their local partners, as 'Integrated Care Systems', to plan and deliver services which meet the needs of their communities.

2. Preventing illness and tackling health inequalities: the NHS will increase its contribution to tackling some of the most significant causes of ill health, including new action to help people stop smoking, overcome drinking problems and avoid Type 2 diabetes, with a particular focus on the communities and groups of people most affected by these problems.

3. Backing the workforce: continuing to increase the NHS workforce, training and recruiting more professionals – including thousands more clinical placements for undergraduate nurses, hundreds more medical school places, and more routes into the NHS such as apprenticeships. The NHS will become a better place to work, so more staff stay in the NHS and feel able to make better use of their skills and experience for patients.

4. Making better use of data and digital technology: providing more convenient access to services and health information for patients, with the new NHS App as a digital 'front door', better access to digital tools and patient records for staff, and improvements to the planning and delivery of services based on the analysis of patient and population data.

5. Getting the most out of taxpayers' investment in the NHS: working with doctors and other health professionals to identify ways to reduce duplication in how clinical services are delivered, make better use of the NHS' combined buying power to get commonly used products for cheaper, and reduce spend on administration.

What happens next

Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) are working together with each other, local councils and other partners, to develop and implement their own strategies for the next five years.

These strategies will set out how they intend to take the ambitions that the NHS Long Term Plan details, and work together to turn them into local action to improve services and the health and wellbeing of the communities they serve – building on the work they have already been doing.

STPs are responsible for delivering elements of the HWBBs priorities, as such, local authority officers are fully involved in the development of the STP strategy, and HWBBs will be engaged in this process. As noted above the Long-Term Plan announced the development of Primary Care Networks, further defined as a group of GP practices (and other providers) serving an identified network (geographical area). The success of Primary Care Networks is reliant on individual practices being resilient and sustainable enabling them to engage in what will be some of the most significant changes to the GP Contract in recent years.

GP Contract Reforms

GP Contracts in the main are nationally negotiated, outlining expectations on General Practice and the framework in which they operate. These core contracts are then 'built' upon through the utilisation of 'enhanced service agreements' or 'local improvement schemes' either nationally or locally set.

It was acknowledged in October that the nationally negotiated GP contractual arrangements made it difficult to progress some elements of required change, such as collaboration amongst practices, within the existing framework. The October paper described the differences in delegation arrangements, and therefore responsibility, across the five CCG's.

In January 2019, following publication of the Long-Term Plan, NHS England and the BMA's General Practitioners Committee England announced that they had agreed a five-year framework for the GP contract which confirms the direction for the next ten years[1]. In their words the new contract arrangements will deliver the most fundamental change to General Practice in decades. These changes start to align with the requirements previously identified as being challenging to the local system.

The contract reform focuses on two key elements.

1. the existing core contract, with changes being made to a number of areas including indemnity cover, investment in IT and digital technologies, changes to the Quality and Outcomes Framework and importantly a five-year contract settlement seeing practice funding increase each year until 2023/24
2. the announcement of the Network Agreement. A Directed Enhanced Service that all practices were to be offered, and all patients are to benefit from. It is this agreement that is being nationally identified as the vehicle to deliver collaboration amongst practices, as well as with the wider system

The Network Agreement, also being called a Primary Care Network Contract,

- will be introduced from 1 July 2019 as a Directed Enhanced Service (DES). It will ensure general practice plays a leading role in every PCN and mean much closer working between networks and their Integrated Care System. This will be supported by a PCN Development Programme which will be centrally funded and locally delivered. Details of this are still to be released.
- By 2023/24, the PCN contract is expected to invest £1.47 million per typical network covering 50,000 people. This will include funding for more health professionals including additional clinical pharmacists, physician associates, first contact physiotherapists, community paramedics and social prescribing link workers. Bigger teams of health professionals will work across PCNs, as part of community teams, providing tailored care for patients and will allow GPs to focus more on patients with complex needs.

The contract framework will see significant extra investment for improved access to family doctors, expanded services at local practices and longer appointments for patients who need them.

The development of PCN's, under the Network Agreement Directed Enhanced Service, sees the opportunity for significant investment into local services and is intended to be the bedrock of the health system moving forward. It is envisaged this becomes the vehicle to support the aims in the Long-Plan focusing on prevention, population health and health inequalities. The expectation is that PCNs deliver full population coverage.

[1] Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan

https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf

In October HOSC were advised that collaboration amongst practices was for the willing, and that the contract as it was then did not encourage joint working. The new contract reforms change that landscape. Through the Network DES practices are encouraged and incentivised to collaborate. The contract reforms make clear that new money into General Practice will in the main be through this vehicle.

The Network DES provides the foundation for collaborative working with key outcomes expected to include:

- Improved sustainability for GP practices, including improving the ability of practices to recruit and retain staff
- to provide a wider range of services to patients
- facilitate stronger collaboration with the wider health and care system to deliver the triple integration of
    - Primary and specialist care
    - Physical and mental health services
    - Health with social care

A maturity matrix for PCN's has been issued by NHS England and is attached in Appendix 1. This makes it clear that the expectation is that PCNs are more than just GP practices collaborating to deliver services in the way they have previously done, but are a vehicle that will require cross system working, and the delivery of services that go beyond ill-health and into population health management, supporting people to stay well and have an impact on health inequalities.

Local Strategy Changes

The previous paper summarised the local strategic direction across all five CCG's and the alignment to the three STP's.

In summary these described local strategies that focused on the sustainability of General Practice, and the movement towards models of care that looked at Practices collaborating with each other, and with other partners including Community Services, Social Care and the Third Sector across geographical areas known as localities or neighbourhoods.

These emerging collaborations would form the basis of Integrated Care Systems in North East and West Essex, and the integration of services outside of hospital within Mid and South Essex.

Given the context described above the strategic direction of Commissioners has not changed since October.

Update on Local Progress

Previously HOSC were informed of a movement to undertake two key actions to build practice resilience and support sustainability. The drive behind this is to both ensure general practice can cope with the demands placed upon it, improve patient experience, as well as where appropriate releasing time to care. These two actions were

a. To ensure practices became more resilient individually, and
b. To support practices to work closer together to achieve economies of scale

Practice Resilience

High Impact Changes

The GP Forward View contained a series of 10 high impact actions that aimed to release time for general practice staff.

These High Impact Actions (HIA) individually and collectively are aimed at improving practice sustainability through improving internal business process, and improving the offer to patients through alternative, and more appropriate, intervention – such as redirection to a diversified clinical workforce, or through social prescribing to more appropriate non-medical interventions.

1. Active signposting
   Provide patients with a first point of contact which directs them to the most appropriate source of help. Receptionists acting as care navigators can ensure the patient is booked with the right person first time.
2. New consultation types
   Introduce new communication methods for some consultations, such as phone and email. Where clinically appropriate, these can improve continuity and convenience for the patient, and reduce clinical time per contact.
3. Reduce DNAs
   Maximise the use of appointment slots and improve continuity by reducing DNAs.
4. Develop the team
   Broadening the workforce, to reduce demand for GP time and connect the patient more directly with the most appropriate professional.
5. Productive workflows
   New ways of working which enable staff to work smarter, not just harder. These can reduce wasted time, reduce queues, ensure more problems are dealt with first time and that uncomplicated follow-ups are less reliant on GPs consultations.
6. Personal productivity

Staff are the most valuable resource in the NHS. We have a duty to nurture them as well as providing resources and training to ensure they are able to work in the most efficient way possible. This may include improving the environment, reducing waste in routine processes, streamlining information systems and enhancing skills such as reading and typing speed.

7. Partnership working
   For a number of years, practices have been exploring the benefits of working and collaborating at greater scale. This offers benefits in terms of improved organisational resilience and efficiency and is essential for implementing many recent innovations in access and enhanced long-term conditions care.
8. Use social prescribing
   Refer or signpost patients to services which increase wellbeing and independence. These are non-medical activities, advice, advocacy and support, and are often provided by voluntary and community sector organisations or local authorities.
9. Support self-care and management
   Take every opportunity to support people to play a greater role in their own health and care.
10. Build QI expertise
    Develop a specialist team of facilitators to support service redesign and continuous quality improvement. Such a team will enable faster and more sustainable progress to be made on the other nine high impact changes.

All CCG's have been working with practices to ensure maximum uptake where appropriate of these high impact actions. Progress across Essex is identified in the table below. As should be expected progress is varied depending upon priority focus within each CCG, and more importantly, within individual practices. Appendix 2 provides detail of each of the HIA and the benefits that should be delivered for practices and their patients.

Number of Practices Engaged and Delivering the High Impact Action

HIA	Basildon & Brentwood	Castle Point & Rochford	Mid Essex	North East Essex	West Essex (i)
1 Active signposting	29	18	39	16	13
2 New consultation types	16	4	43	23	29
3 Reduce DNAs	32	20	43	20	28
4 Develop the team	29	22	41	20	20
5 Productive workflows	3	9	36	16	23
6 Personal productivity	0	0	0	4	25
7 Partnership working	35	23	10	23	31
8 Use social prescribing	35	23	29	9	23
9 Support self care and management	16	0	29	6	26
10 Build QI expertise	14	9	2	3	2
Total Number of Practices in CCG	35	23	43	32	32

(i) These are the practices who are actively delivering the HIA. A number of other practices are engaged and planning to deliver the HIA within this financial year, particularly in relation to Active signposting where another 17 practices have been trained and are planning for implementation, but these have not been included in the above.

Clerical and Administrator Training

As part of the GPFV there is a drive to upskill clerical and administration staff within practices, improving both personal and business processes. Whilst the numbers in the table above identify practice 'implementation' training of staff needs to be wide reaching within practices. The training is intended to cover topics such as Care Navigation and Clinical Correspondence and fall into HIA's 1 and 5.

Across Mid and South Essex Basildon & Brentwood have seen over 90 members of staff trained in Care Navigation, Castle Point & Rochford over 80 practice staff trained and over 100 in Mid Essex.

West Essex had over 150 individual staff members complete a full two-day training package.

In addition to the implementation of the High Impact Actions each area has a more bespoke programme of work to support practices and their local transformation requirements.

Mid and South Essex

The Mid and South Essex Primary Care Strategy outlined a model of care that focused on improving the resilience of General Practice. It described a model that moved to GP delivered to GP led services, and outcomes that put improved GP morale alongside improved patient experience.

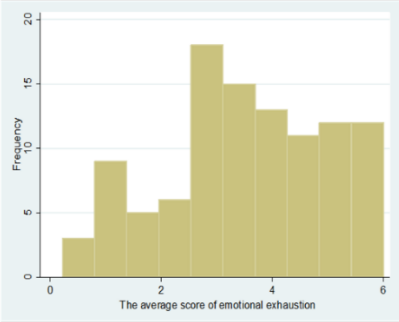
GP Burnout

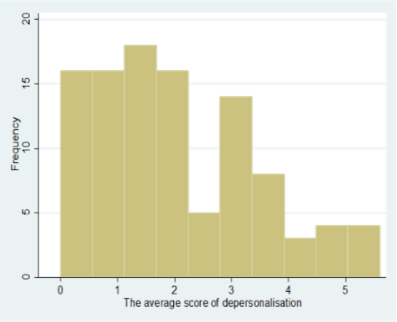
The strategy committed to assessing GP Burnout – as a way of improving recruitment, retention and morale - through the Maslach Burnout Inventory. The MBI is recognised as a leading measure of burnout, and extensive research has been conducted using this measure. The MBI-Human Services Survey for Medical Personnel has been specially adapted for medical personnel and addresses three scales:

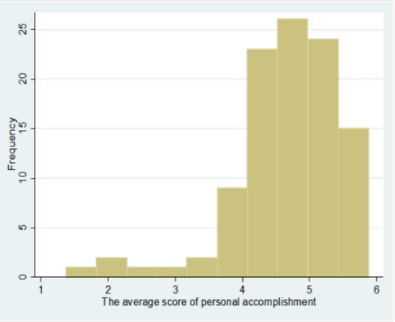
- Emotional Exhaustion,
- Depersonalisation, and
- Personal Accomplishment.

During February and March, we implemented the baseline assessment across the STP, inviting all GP's in the area to participate. 104 opted to engage in this baseline exercise, with over 75% of these coming from the three CCG's that fall within Essex CC boundaries. It will be rerun in six and twelve months. The detailed results have been collated and published by Anglia Ruskin University which in summary show

- The average GP experiences emotional exhaustion between 'A few times a month' and 'Once a week'
- Whilst at the same time they
- have a good attitude towards their patients, which should not have a detrimental effect of their care, and
- feel a positive attitude towards their accomplishments and achievements.







Delivery of the strategic vision is expected to improve these scores over the coming months, with an improvement expected to be seen through future surveys.

Workforce Diversification

Aligning with HIA 4 the strategy focuses on the utilisation of a diversified workforce. Across the STP the key focus has been to enable this diversification at the most appropriate level, and through the most appropriate vehicle. For example, with Mid Essex investment has been through individual practices, whilst in Basildon & Brentwood and Castle Point & Rochford this has been through the commissioning of increased capacity through GP Federations or Alliances covering groups of practices.

Castle Point and Rochford have commissioned an Enhanced Access service through their localities, creating additional capacity during core hours, and into the evenings. The total value of this service enhancement is circa £1.2m and equates to an increase in funding in General Practice of circa 5%. This is an investment in service provision that is expected to increase capacity of General Practice and has seen the appointment of staff including Clinical Pharmacists, Emergency Care Practitioners and Advanced Nurse Practitioners.

Basildon & Brentwood have also looked to diversify the workforce though the commissioning of services across practices, this has included an Acute Home Visiting service, improving the capacity through additional GP and Advanced Nurse Practitioners across practices to see housebound patients.

Mid Essex have seen over 100 new staff, equating to nearly 60 wte, funded within General Practice as part of their foundations programme as described in the October paper.

Reducing 'Did Not Attend's'

Given pressures within General Practice it is important that available appointments are utilised effectively. Missed appointments had previously been raised as an issue amongst General Practice, with the process for patients to follow to cancel being identified as a reason for people not formally notifying practices of their intention to not attend. These DNA's result in patients missing out on accessing help when they need it.

In Mid and South Essex this has started to be addressed through the implementation of a text-based solution that links into GP booking systems, enabling patients to easily cancel their appointment. This has started to see a reduction in DNA's.

In addition to these improvements there are also several pilots underway to look at new ways of working, and upskilling the workforce, that are being tested in pockets of the STP prior to wider adoption. These include

- Fifteen-minute appointments,
- New roles such as First Contact Physio therapists
- Utilising digital access solutions as opposed to traditional face to face contacts, and
- Quality Improvement methodology for practice staff

West Essex

Workforce Diversification

Many of the neighbourhood projects focused on trialling new ways of working in primary care, building on the national initiative within the GP Forward View and 10 high impact changes. 2 neighbourhoods in West Essex, trialled physiotherapists working as part of the general practice team, being the first point of contact for patients with musculoskeletal conditions. 3 neighbourhoods also trialled Emergency Care Practitioners working alongside GPs to support patients who require an urgent on the day home visit. These pilots have been very successful in reducing GP workload and supporting practices to consider recruiting different professionals to address GP recruitment challenges. The CCG is funding these posts in all Primary Care Networks across West Essex in 2019/20.

Transformation Projects

The primary care transformation projects enabled neighbourhoods to piloting new ways of working to meet workforce and workload challenges. Projects were designed and led by neighbourhood leaders generating ownership and energy for effective delivery. The CCG also commissioned proactive support to patients identified as moderate frailty and schemes to tackle variation in primary care. £6 per head was invested as a result of recycled primary care funds. All services have been evaluated at 9 months and informed commissioning arrangements for 2019/20.

	Neighbourhood Primary care transformation projects in West Essex	**Summary Description**	North Harlow	Central Harlow	South Harlow	North Uttlesford	South Uttlesford	Epping & Ongar	Waltham Abbey	Loughton	Buck'st Hill & Chigwell	**Summary Commissioning Plan**	**Service continuing**
Positive evaluation & continuing / spread across CCG	Moderate frailty	Virtual review and f2f proactive care										Commission as a LES across CCG	9
	Emergency Care Practitioner	Home visiting service for housebound patients	RIS									Commission across CCG at £1.70 per head	3
	First Contact Physiotherapist	Alternative to GP and early mngt of MSK										Commission across CCG as part of MSK	3
	Enhanced community team	Admin support for community matrons										Commission across CCG - EPUT contract	1
	Breathlessness pathway	Enhanced service for breathless patients										Build into Complex patients LES	1
Pilot yet to complete	Proactive care: temporary housing	Target residents of special accomodation										March Eval'n - part year funding 19/20	1
	Proactive care for severely frail	Enhanced review for severely frail										March Eval'n - part year funding 19/20	1
	Extended appt - one stop shop	Proactive care for LTC/mental health patients										Feb Eval'n - part year funding 19/20 possible	1
	Pooled on the day appointments	Hub model for nursing appts across practices											1
	Advanced Care Practitioner Coordinator	streamline EOL coordination across practices										May eval'n - part year funding 19/20	1
Other funding	Community builder/social prescriber	Improve patient access to vol. sector										Continue through other funding sources	1
At practice discretion Not commissioned	Pooled on the day appointments	hub model for nursing appts across practices										Core funding - for practices to consider	1
	Shared Prevention Adminstrator	primary care prevention coordination										Core funding - for practices to consider	1
	Health check monitors	in practice kit enables patient to self report										Core funding - for practices to consider	1
Stopped - not effective	Neighbourhood practice nurse	shared nurse resource (project stopped)											1
	Extended appt for mild frail	mild frail extra support											1
	Community GP for vulnerable patients	enhanced visiting for frail patients											1
Complete	IT/recall	IT systems to increase LTC recall											1
	QOF variation reduction	N'hood targets for QOF/screening variation										Develop a new approach	9
											Summary	Number definitely continuing	17
												Number possibly continuing	9
												Number not continuing	13
												Total projects	**39**

Services continuing to be commissioned in 2019/20 are as follows:

- proactive support to complex patients and moderately frail.
- Emergency care practitioners in general practice to support GP home visits
- Physiotherapists in general practice, being the first point of contact for patients with musculoskeletal conditions

North East Essex

Workforce Diversification

Within North East Essex we are actively looking to improve the holistic environment of the GP practice. We have wrapped round a test pilot looking to all kinds of workforce and social interventions, which has decreased the workload and increased the quality and employee experience. NEE has a historic relationship of using a wide range of clinicians as part of its offer to patients. As an STP, we have already exceeded our target through the introduction of roles such as Medical Assistants, Physician Associates, Social Prescribers, Care Navigators and First Contact Practitioners. As these roles have been key in reducing workload it will in turn help recruitment and retention.

Practice Collaboration

All recent guidance has emphasised the benefits of collaborative working between practices and with other providers in the local health and care system.

Over recent years practices had started to become more open to collaboration, potentially as a response to identifying ways to improve General practice workload and become more efficient and in October a few formal and informal arrangements had started to form, as summarised in the table below. These formal collaboration arrangements were generally through vehicles known as Federations or Alliances – GP owned entities developed to support their member practices or provide an alternative vehicle for providing non-core services. They were collaborations of the willing, and by those with a similar vision.

The lack of Federations or Alliances in some areas should not be seen as putting local development at risk or areas at a disadvantage. The creation of the Network Agreement, and movement towards Primary Care Networks, introduced in this paper will result in the delivery of General Practice at Scale, with practices currently working through their arrangements for collaborative working. Whilst there could be a role in service delivery for federations and alliances this is not essential and will be at the discretion of the emerging Primary Care Networks.

The Network Agreement, as part of the nationally negotiated GP Contract, is changing the approach to collaboration and provides a contractual vehicle to commission population wide services.

For practices at its heart the offer is simple - sign up to a network agreement with practices in a geographical footprint to enable delivery of population wide services. If as a practice you do not choose to sign up your patients will be aligned to an appropriate Network and have access to the enhanced service offer through that Network.

This has resulted in a current dual approach to collaboration between practices.

1. Collaborate with those with similar minds
2. Collaborate with those serving the same population

The table below summarises the landscape as it was in October in relation to the development of Federations and Alliances.

GP Practice Collaboration (Federations/Alliances)

Basildon & Brentwood	Castle Point & Rochford	Mid Essex	North East Essex	West Essex
Two established federations.	Two local GP Alliances.	Mid Essex does not have any established alliances/federations.	Three local GP Alliances.	Two local GP Provider Companies.

Primary Care Networks (PCN)

National direction is that the PCNs become a key provider within local landscapes. At present PCN arrangements in the main are newly evolving relationships between practices, that will develop and mature over coming months and years. To date the only formal ask of them is to identify the Networks they wish to form (practices that wish to work together), identify a Clinical Director and the recipient of the funds.

On the 15th May practices were due to submit to commissioners their proposed configuration for Primary Care Networks, or more explicitly the proposals for sign-up to the Network Agreement DES. Following submission, it was anticipated that where key criteria had been met – full population coverage, practice coverage and minimum size (30,000 population coverage for a PCN) – that these would be signed off by CCG's/NHS England by the 31st May. Where criteria have not been met it is expected that this is resolved during June. All CCG's across Essex are working with practices and the Local Medical Committee to achieve full coverage.

All practices within a Network need to sign-up to a Network Agreement that describes how they will work together. This is not due for completion until the end of June after which the first stage of the Network Contract goes live which includes full population coverage for the extended hours service offer.

Whilst there is some discrepancy between the arrangements that were forming as Localities & Neighbourhoods introduced in October, and proposals received from Practices regarding PCN arrangements, irrespective of how practices collaborate the principle around patient care is the same. Access necessary services through your own practice, with the additional offerings and wider collaborations seen as an extension to the core service and experienced as though part of the practices service offer. There is however likely to be a period of transition once PCN arrangements are finalised due to this discrepancy.

Financial Sustainability

a. There have been concerns around the financial sustainability of general practice, and the removal of funding from core contracts. In this context it is important to note the following. Previous exercises that resulted in some practices losing core funding was a result of national policy to ensure practices providing the same service offer were being reimbursed at a similar level. The new Contract Reforms guarantee that core contracts will increase in value over the next five years.
b. Investments made by CCG's into services above and beyond core requirements are still at the discretion of CCG's, although the development of the Network Agreement does provide a vehicle to

    a. Standardise the offer to patients where traditionally practice sign-up or delivery has been variable, and
    b. For local commissioners – health and social care – to purchase further services through general practice at scale that meet the specific needs of the population served by a PCN
c. The Network DES, and the financial entitlements that accompany it, is a nationally negotiated offer. It is not for local CCGs to amend and is an expected minimum offer to emerging PCN's
d. Current financial entitlements under the DES makes available up to 70% of staff costs in line with the stated development programme – 100% for social prescribing link workers. Networks will need to identify where the other 30% of costs, and non-pay costs, will come from. Where Networks do not take up the offer this will be a Network decision, not a commissioner decision.

Early Feedback

As noted in October performance is difficult to measure contractually due to the framework that is in place. Previously the HOSC were presented with the latest results of the GP Patient Survey as indicators of performance, satisfaction and feedback. The results as included in October are the most recent published, as such no update is included in this paper.

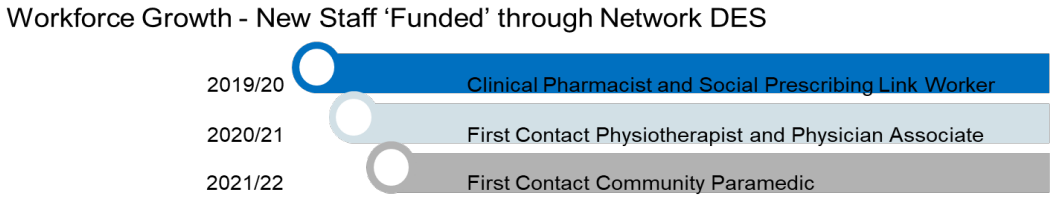
Whilst the programme of change is in its early stages, we are starting to identify examples of improved patient experience through this way of working, particularly around the diversified workforce. It is expected over time this sees positive improvements in indicators included in the GP Patient Survey.

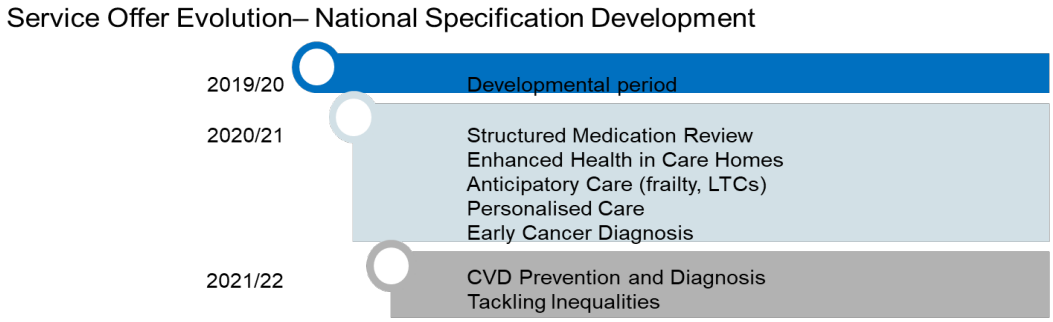
Next Steps

Nationally directed

The development of PCN's is being driven through the national process. Over the next three years PCN's will be able to access funding to contribute to the staffing costs associated with a diversified workforce to be accessible through General Practice under an additional roles' reimbursement scheme.

PCN's will also be expected to deliver seven new services detailed in yet unpublished nationally negotiated specifications, and from 2021/22 provide a new, and simpler, access offer to patients bringing together the currently disparate range of service offers for both physical and digital access for patients. This development timeline is illustrated below.





These enhancements are expected to remove some of the variability of provision that occur under current arrangements and start to impact on health inequalities and improve population health outcomes. By 2020 NHSE will publish a Network Dashboard that will set out progress on network metrics, covering amongst other things population health.

Local next steps

The transformation of General Practice is a long-term piece of work. The new contract reforms outline an evolution over five years, and as noted above builds the foundations for the next ten.

As such it is important to recognise that this will continue to evolve over time, with requirements changing in response to local need. The next steps locally are not new actions, they are the continuation of work that has already been started, such as further roll out of the High Impact Actions, the continued evolution and support of Primary Care Networks and the journey to closer collaboration between General Practice and the rest of the system. It also includes continued engagement with the public to understand the changes that are being seen within General Practice, particularly the understanding that they will have their needs met by the most appropriate person, and not necessarily a GP.

Collaboration

Areas continue to progress collaborative working between General Practice and the wider system, including Community Health Care services, Social Care, the Third Sector and the populations they serve.

Most of these developments are being driven through local partnerships and forums that include representation from key stakeholders, including within

a. Mid and South Essex
    a. South East Essex Partnership covering Castle Point and Rochford
    b. Basildon and Brentwood Integration and Partnership Forum
    c. Mid Essex Integrated Community Health & Social Care Programme Board
b. West Essex's Integrated Care Partnership

With PCNs being seen as important partners in, and a foundation for, future service delivery each area is currently working through how they are represented at the most appropriate forum.

Through this collaboration between General Practice and the wider system we are already seeing Community Nursing Teams, and Social Care Teams, aligned to General Practice, making a real movement towards collaborative working across the system, and access to a wider range of professionals through General Practice. This continued movement is seen as essential for the long-term success of PCN's and is supported by contractual requirements included within the NHS Standard Contract for Community Services. A key focus within all systems over coming months will be how this is operationally delivered.

The focus on collaboration is also supported by the continued focus on individual practice resilience as noted above.

GP Forward View Funding

Following a successful national pilot within Mid and South Essex funding available through NHSE to support four programmes of work – Practice Resilience, Online Consultations, GP Recruitment and Clerical and Admin Training – is being made available through STP's to support delivery of the GPFV and practice resilience. The specific requirements for these four areas – for STPs and CCGs - include

- *ensure that the delegated budgets received are used to support the development of all practices in the context of PCN development*;
- *ensure that the local practice development plans continue to identify those practices who need more intensive and immediate support to stabilise, build their resilience and become sustainable*;
- *maximise retention of experienced, effective staff (doctors, nurses and other health professionals);*
- *CCGs are expected to work with their practices to ensure that by March 2020, 75% of practices are offering online consultations to their patients*

As part of the arrangements all STPs, and CCG's, will have a local plan for the delivery of these requirements. In addition to this all CCGs continue to work with Practices to increase uptake and implementation of the High Impact Actions identified earlier in the paper.

This funding previously flowed through CCGs and as such work in these areas will build upon progress to date.

Recruitment & Retention of GP Workforce

Whilst there is a focus on workforce diversification, and utilisation of other roles, it remains a priority to attract GPs to the area and retain the GP workforce already in the area. Projects have been initiated in previous years and they continue to be an area of focus, including

- International GP recruitment - All CCGs are participating in IGPR. Recruitment is undertaken by third party recruitment companies. Recruitment of potential IGP recruits for Hertfordshire and West Essex commenced in January 2019, with interviews x 10 and practice visits scheduled for June 2019.

  In MSE 16 GPs have been recruited thus far through the programme. Four candidates withdrew from the scheme, six are currently on the induction programme and a further six have

completed the scheme and are working as a salaried GP. The MSE recruitment provider is currently working with a number of candidates to commence the recruitment process.

In North East Essex two candidates have been recruited to a practice in Clacton. One is on the performers list with no conditions and the second is going through the Induction and Refresher scheme phase.

- Post CCT GP Fellowship scheme - All STPs are working on implementing these schemes. In the Mid and South Essex STP there is funding for 11 fellows. West Essex CCG have 3 Fellows, part of 11 across their STP. This is a full or part-time development programme for qualified GPs which will facilitate both an individual's career development and local health service needs through the provision of extended skills and experience. The additional professional roles will support STP plans and the programme will support GP recruitment in areas of need. In addition, the programme offers service commissioners the opportunity to develop shared posts between employers (for example across primary and secondary care or between practices and a CCG).
- GP Retention Scheme - Another area of focus for all CCGs. As an example in West Essex a Task and Finish Group set up to survey their needs, their scheme seeks to support GPs to work a minimum of five sessions in general practice per week (equating to a participation rate of 56%) however regions may tailor this approach to the needs of their local workforce.
- GP Retainer Scheme - West Essex have 2 retained GPs. This scheme is intended as short-term support for GPs who have family commitments or health problems which restrict them from working in General Practice in the usual way as partners or salaried GPs. The MSE STP is an intensive support site for GP Recruitment and Retention and through the workforce initiatives have 4 retained GPs. The scheme offers flexibility and educational support.
- GP Portfolio Roles - Systems are looking at creating clinical lead roles to enable GPs to adopt a portfolio career, with interests outside of General Practice. Examples include Diabetes and AF Clinical lead roles in Mid and South Essex and First5 network lead roles in both MSE and West Essex who will develop the establishment of a First5 network in their geographical footprint to contribute to the ongoing GP recruitment and retention agenda across the STP.

Digital Transformation

It is important to recognise that transformation to date has generally focused on the sustainability of the workforce, mainly through diversification and the increase in numbers of staff, and this paper has focused heavily on workforce solutions, and collaboration, as a way of increasing capacity. Moving forward the transformation of General Practice will start to look more at opportunities available through the use of new technologies, and the movement to digital solutions, to manage demand and increase capacity. Whilst there are examples of innovation and progress in this area moving forward the widespread adoption of digital solutions will be a significant contributor to the long-term sustainability of General Practice. Examples of work to date include

- WIFI - providing Wi-Fi for both patients and staff across all practices
- E-Consult - All areas must work towards the delivery of online consultations as noted under the GP Forward View funding section. West Essex have just published their ITT to look at solutions available for video Consultation for their practices, and in Mid and South Essex a process is being followed which should see solutions available for practices from December 2019.
- Integrated Care Records - A single clinical record should improve patient care. My Care Record is being used as the brand to support further interoperability initiatives across the Herts and West Essex STP which now hosts over 150 organisations with all 3 Acute's accessing a digital GP record and in Mid and South Essex a programme of work to implement a single Local Health and Care Record is already well developed.

Appendix

1 – Primary Care Network Maturity Matrix

Element	Foundations for transformation	Level 1 (least mature)	Level 2	Level 3 (most mature)
Right Scale	**Plan** : There is a plan in place articulating a clear end state vision and steps to getting there, including actions required at team, network and system level.	Practices identify partners for **network-level working** and develop shared plan for realisation	Practices have **defined future business model** and have early components in place.	**Network** business model fully operational.
Integrated Working	**Engagement** : GPs, local primary care leaders and other stakeholders believe the vision and the plan to get there	**Integrated teams**, which may not yet include social care, are working in parts of the system.	**Integrated teams** formalised to include social care, the voluntary sector and easy access to secondary care expertise in at least some sites. **Functioning interoperability** between practices, including read/write access to records. Data sharing agreements in place.	**Fully functioning integrated team. Workforce shared** across network Rationalisation of primary care with **optimum estate usage**. **Interoperable systems** Integrated clinical records
Targeted care	**Time :** Primary care, in particular general practice, has the headroom to make change	**Analysis on variation** between practices is readily available and acted upon. **Basic population segmentation** is in place, with understanding of needs of key groups and their resource use. Standardised end state **models of care** defined for all population groups, with clear gap analysis to achieve them. Protoypes in place for highest risk groups.	The system can **track data in real time**, including visibility of patient movement across the system and between segments, and information on variability **New models of care** in place for most population segments, including both proactive and reactive models, with standardised protocols in use across the system. Evidence of active sign posting to community assets.	Systematic population segmentation including risk stratification with in depth understanding of needs of each population segment. Routine peer review of metrics in and between networks. New models of care in place to meet needs of all population segments. Internal referral processes in place. Routine peer review of metrics per hub.
Managing resources	Transformation resource : There are people available with the right stills to make change happen	Steps taken to ensure **operational efficiency** of primary care delivery.	**Networks have sight of resource use** for their patients, and can pilot new incentive schemes.	Primary care networks take **collective responsibility for available funding**. Data being used at individual clinical level to make best use of resources.
Empowered primary care		**Primary care** has a seat at the table for all system-level decision making.		**Primary care network** full decision making member of ICS leadership.

2 – HIA Benefits Practice and Patients

HIA	Benefits for practice	Benefits for patients
1 Active signposting	Frees GP time. Makes more appropriate use of each team member's skills. Reduces internal referrals.	Improves appointment availability. Reduces low-value consultations and onward referrals. Shorter wait to get to see the most appropriate person.
2 New consultation types	Shorter appointments (eg phone consultation average 50% shorter, 66% dealt with entirely on phone). More opportunities to support self care with e-consultations, text message follow-ups and group consultations.	Greater convenience, often no longer requiring time off work/caring duties. Improves availability of appointments. More opportunities to build knowledge, skills and confidence for self care.
3 Reduce DNAs	Free GP time. Easier to avoid queues developing, through more accurate matching of capacity with demand.	Improves appointment availability.
4 Develop the team	Frees GP time. Makes more appropriate use of each team member's skills. Reduces internal referrals. Improved job satisfaction for administrative staff undertaking enhanced roles.	Improves appointment availability. Reduces low-value consultations and onward referrals. Shorter wait to get to see the most appropriate person.
5 Productive work flows	Frees time for staff throughout the practice. Reduces errors and rework. Improves appointment availability and patient experience.	Improves appointment availability and customer service.
6 Personal productivity	Frees clinicians to do more in each consultation, with fewer distractions and frustrations. Improves staff wellbeing and job satisfaction.	Improved quality of consultations, with more achieved. Reduced absence of staff.
7 Partnership working	Frees GP time, makes best use of the specific expertise of staff in the practice. Creates economies of scale and opportunies for new services and organisational models.	Access to expanded range of services wrapped around the patient in the community. Reduces delays introduced by referrals to different providers.
8 Use social prescribing	Frees GP time, makes best use of their specific medical expertise.	Improved quality of life. Improved ability to live an independent life.
9 Support self care and management	Frees GP time, makes best use of their specific medical expertise.	Improved ability to live an independent life.
10 Build QI expertise	Improved ability to achieve rapid, safe and sustainable improvements to any aspect of care. Increased staff morale and sense of control.	Assurance of continuous improvement in patient safety, efficiency and quality of care.