Report: To provide an overview of East Sussex Better Together CCGs strategies for ensuring accessible and sustainable GP services for our local populations

To: East Sussex Health Overview and Scrutiny Committee

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1. Introduction

East Sussex Better Together (ESBT) is our whole system transformation programme to tackle the challenges of improving quality and experience and delivering a sustainable health and care system locally.

Our shared vision is the establishment of a fully integrated health and social care economy in East Sussex that makes sure people receive proactive, joined up care, supporting them to live as independently as possible. The delivery of strong and resilient primary care services is central to the delivery of our vision. It is evident that workforce and workload pressures continue to pose a significant challenge to our primary care services both locally and nationally.

The purpose of this report is therefore to provide an update on:

- **The sustainability of GP services** across the ESBT footprint, particularly in relation to workforce and workload challenges as a consequence of recruitment and retention difficulties and population growth resulting in rising demand.
- **Practice closures:** The reasons why closures occur, the process for managing these and the impact on patients and other local practices.
- **Accessibility of GP services** including availability of appointments, use of digital technology to improve access and the physical accessibility of premises.

2. Background

Primary Care covers healthcare provided in the community by General Practitioners (GPs), Community Pharmacists, Dental Practitioners and Optometrists. In total these services account for around 90% of all patient interaction with health services.

This paper focuses on services provided by GP practices within Eastbourne, Hailsham and Seaford (EHS) and Hastings and Rother (H&R) for which the CCGs have delegated responsibility for commissioning from NHS England (NHSE) as of 01.04.2015 and 01.04.2016 respectively. The responsibility for commissioning Pharmacists, Dental Services and Optometry remains with NHSE.

Within EHS CCG there are currently 20 practices serving a total CCG population of 196,135. Practice list sizes range from 3,600 patients to a large multi-partner practice with a list size of 17,800.

Within H&R CCG there are currently 25 practices serving a total CCG population of 188,457. Practices range from a single handed practice with a list size of 2,650 to a larger multi-partner practice with a list size of 16,000.

3. Strategy Development

As CCGs, we are embarking on a refresh of our primary care strategy. This outlines our strategic intentions around the future of primary care and its transformation in relation to our overarching ESBT vision and national General Practice Forward View (GPFV) requirements and priorities.

This is based around the development of a primary care system that revolves around the needs of the individual, supporting people to get the care they need, as directly as possible, delivered by the right person. Set in the context of managing increasing demand and reducing resources, this focuses on resilience and sustainability, addressing workforce and workload issues, delivering high quality services to improve outcomes and experience, and introducing systems and processes to support working at scale. A copy of a presentation outlining our high level strategy is provided in **annex 1**.

To support this, the ESBT CCGs have committed to investing in primary and community based services as part of our strategic investment plan to reduce reliance, where appropriate, on higher cost settings of care.

4. Primary Care Sustainability

4.1. Workforce

4.1.1. Workforce objectives

Workforce is recognised as a significant challenge and risk to delivering a sustainable primary care service and therefore features as one of the four key priority areas underpinning our emerging strategy. The overarching aim is to increase capacity in order to meet growing demand through the introduction of new roles and innovative ways of working whereby Primary Care becomes truly multi-disciplinary, and patients are supported and navigated towards the person best placed to deal with their condition, at the right time, in the right place.

In order to support delivery of this, we have developed a focused primary care workforce plan with the following aims:

- To make our practices attractive places to work;
- To reduce workload on practices;
- To develop the skills of our practice staff;
- To build the workforce of the future;
- To lengthen medical and nursing careers;
- To find new ways to recruit medical and nursing staff into our CCGs.

Our workforce plan will aim to ensure that EHS and H&R are in the best position to recruit and retain our staff, ensure they are well placed and have the right skills to deliver the care needed by our local populations.

4.1.2. Current position / Vacancies

A number of workforce pressures are evident across both CCGs, in particular GP and practice nurse vacancies:

- In H&R there are approximately 16 WTE GP vacancies based on the UK average number of 0.58 WTE GPs per 1,000 patients.
- In H&R, practices themselves have reported 12.05 WTE GP vacancies and 4.8 WTE practice nurses vacancies;
- In EHS there are approximately 11 WTE GP vacancies based on the UK average number of 0.58 WTE GPs per 1,000 patients.
- In EHS, practices themselves have reported 10.03 WTE GPs absent and 1 WTE practice nurse absent.

It should be noted that self-reporting on vacancies is voluntary and may not capture the full position.

As identified in **annex 2**, there is an additional risk that this position will be exacerbated by the number of GPs and practice nurses reaching retirement age in the near future. This is considered particularly acute in Hastings and St Leonards for both professional groups, with the added challenge for nursing in the Hailsham and Bexhill localities.

This position is potentially further challenged due to:

- difficulties filling GP training places both nationally and locally plus the implications of Brexit and tougher immigration rules for overseas recruits;
- the younger and newly qualified workforce seeking more flexible work options and being less keen to take on the responsibility of a partnership;

Practices manage any vacancies in the way that best works for them including the use of locums and implementing new ways of working across their practice teams.

As part of the work to support delivery of our strategic direction of travel and GPFV priorities, we have developed or are in the process of implementing a number of initiatives to attract, train, support and retain colleagues as outlined below.

4.1.3. Recruitment and retention

The CCGs have established and supported a number of initiatives to support recruitment of GPs and practice nurses. Examples include:

- **International Recruitment:** ESBT fully participated in the successful STP wide bid led by High Weald Lewes Havens (HWLH) CCG for inclusion in the 2018 NHSE International Recruitment of GPs initiative for which 12 practices have expressed an interest, representing a spread across both CCGs;

- **Nurse Apprentices:** The CCGs are actively supporting the development of apprentices at levels 2, 3 and 4;
- **Locum Medical Bank:** The CCGs are subsidising the cost of locums managed through a federated approach to enable practices to focus on long term workforce planning.

In addition, GPFV monies have been made available to ensure ESBT can participate in key career fairs and maximise opportunities for attracting the future primary care workforce.

However, recognising the severe national workforce supply issues, much time has been spent in conjunction with our Community Education Provider Network (CEPN) to develop and implement initiatives to invest in the development and retention of primary care staff in East Sussex. Initiatives include:

Medical Staff:

- **GP Portfolio Fellowship scheme:** This has provided an opportunity for joint working across our ESBT Alliance with our GP fellows working on an integrated project in partner organisations (one each in Sussex Partnership Foundation Trust (SPFT), East Sussex Healthcare NHS Trust (ESHT) and East Sussex County Council (ESCC)) whilst also being placed in primary care two days per week;
- **GP Bursary scheme:** This scheme makes £5,000 available to newly qualified and those within the first years post-qualification to support them to continue with their career development whilst also encouraging them to remain working within East Sussex.
- **GP Career Plus scheme:** This scheme is targeted at GPs wishing to leave the profession by offering sessions in GP mentoring and clinical leadership alongside clinical sessions to support a more challenged GP practice. An e-platform is in place, allowing practices to advertise their vacancies to the growing pool;
- **Developing Physician Associates (PAs) in East Sussex:** General practice trainers have been supported to host a number of PAs whilst they undertake training. The CEPN is now working to develop a PA portfolio role to include a community rotation as well as primary care, aiming to make this an attractive career opportunity for qualified PAs and help retain them within primary care.

Nursing staff:

- **Leadership development:** This has entailed working with the Leadership Academy to develop leadership competencies within our nursing workforce, and in particular, increasing the numbers of mentors and educators to support the new nurse associate roles. This has also involved the development of Advanced Clinical Practitioner roles using the credentialing framework for existing nurse practitioners and supporting new trainees;
- **General Practice Nursing:** The development and the delivery of a nationally developed General Practice Nursing ten point action plan across the ESBT footprint;
- **Bursaries:** Continuation of investment in nursing bursaries to support academic development and in turn assist with staff retention;

- **Continuing Professional Development**: ESBT has been instrumental in supporting the development of a clinical skill bundle across our STP area with a view to ensure standardisation of a mobile workforce. We are also recruiting a development nurse to work across the CCG areas and support new staff.

In addition to the above, we are reviewing **ways** to retain experienced doctors and nurses reaching the end of their career; examples include offering more part time options, mentoring and speciality work.

4.1.4. Service redesign and Primary Care Workforce development

Whilst the CCGs have clearly developed plans to both recruit and retain our primary care workforce, it is recognised that this, in isolation, will not address the workforce and workload issues facing general practice in particular.

Therefore, as part of our GPFV plans, we have established a Primary Care Service Redesign Fund which encourages federations or groups of practices to work together to introduce new models of care and broader workforce opportunities. 25 practices have signed up to the scheme during 2017/18 with multiple bids approved. The return on investment will see several examples of extending the primary care team with new roles, creating greater capacity and an improved service for patients. Examples include:

- On the day primary care mental health therapist appointments, including substance misuse service;
- First contact advanced physiotherapy offering on the day appointments for patients with common MSK complaints;
- GP led health coaching service offering one to one and group activities for service users with long-term conditions;
- Paramedic Practitioner home visiting service and in-practice urgent clinics;
- Care navigation to seamlessly enable patients to access the wider range of primary care appointments.

These will be subject to a robust evaluation to assess the level of benefits realisation and scalability during the course of 2018/19.

4.1.5. Sustainability - Primary Care at Scale

There is an increasing recognition that the traditional practice led / small GP partnership model of delivery of primary care is often too small to respond to the demographic and financial challenges facing the NHS. Central to our emerging strategy is to support GP practices and other professionals, such as clinical pharmacists, to work together in a more integrated, collaborative partnership approach (or networks) to deliver more sustainable services. This should result in a number of benefits including access to a wider range of local services for patients within the local community, increased staff resilience, improved staff satisfaction, work life balance and learning opportunities, and improved financial sustainability. The CCGs are therefore working with the four GP Federations within our ESBT footprint to encourage and facilitate collaboration and joint working between groups

and clusters of practices where this will support primary care and deliver improvements to our local populations.

5. Practice Closures

Across the ESBT footprint, there has been one practice closure due to partner resignation which took place in October 2017. This was the Cornwallis Plaza practice in Hastings.

The CCG supported the managed closure of Cornwallis Plaza surgery following the resignation of the contract holder and the managed list dispersal of c17,000 patients to three local practices. All affected patients were written to in advance of the changes to advise them of their new surgeries or, in the case of a small cohort living out of area, with advice on how to find a new GP surgery.

A number of face to face registration sessions were held by the CCG primary care team to assist patients in registering with alternative surgeries. All vulnerable patients were flagged prior to transfer and the team regularly monitored this list to ensure all vulnerable patients were re-registered.

We are currently finalising a lessons learned report from the Cornwallis Plaza dispersal and will be sharing the lessons from this widely with practices and other colleagues. This information will be used to inform our action plan and how we work collaboratively with our practices to identify any where there may be challenges. In addition, the CCGs are introducing a more targeted, risk-based approach to practice support visits.

6. Accessibility

6.1. Overview

The CCGs are committed to providing patients with improved access to primary care across the ESBT footprint that is joined up, easy to navigate and provided locally. Our approach is being informed by the views of local people as we work with practices, patients and providers to design our long-term models of care including the implementation and roll out of care navigation and our approach to Social Prescribing (social prescribing, sometimes referred to as community referral, is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services). These initiatives are aimed at helping practices to manage demand and support people accessing the right services at the right time including, non-medical services to improve their well-being and access sources of community and social support.

6.2. Access and availability of appointments, including extended access

All GP practices across EHS and H&R CCGs deliver core general medical services between 08.00 – 18.30 hours. In addition, 13 out of 20 and 17 out of 25 practices provide the extended hours Directly Enhanced Service in EHS and H&R CCGs respectively. This is a national, optional service that practices can choose to

deliver, commissioned by NHS England whereby practices extend their opening hours according the needs and wishes expressed by patients,

In addition, there is now a national requirement for CCGs to commission extended access to primary care, which can be provided by practices, localities or from central locations. The requirements include providing access to pre-bookable and on the day appointments for primary care including additional weekday hours from 6.30pm – 8pm, and on Saturdays and Sundays according to local need.

CCGs are required to provide an extra 30 minutes per 1000 population from October 2018. For H&R CCG, with a population of 188,457 patients, this is equal to 95 extra hours per week. For EHS CCG, with a population of 196,135 patients this is equal to 97.75 extra hours per week. If there is patient demand NHSE have indicated an aspiration of 45 minutes per 1000 population.

Soft market testing has been undertaken via a request for information and the options for the procurement approach to be followed are due to be considered by the ESBT CCGs in March 2018 with a procurement process to follow ready for implementation in October.

In order to inform our approach, a public engagement activity via an online and paper based survey to seek the views of local people on the their preferences on the time of day they would wish to be able to access extended primary care services has recently been undertaken. A total of 1,271 people responded. These results are currently being analysed and will inform discussions with potential providers going forward and shape the service we commission locally.The results of this survey will inform the final design and service specification.

It should be noted that, as well as delivering additional appointments, CCGs are required to ensure that this extended access service is procured and delivered alongside the redesign and integration of urgent primary care. Urgent care redesign forms part of a separate report to this committee. As part of this, the CCGs must ensure these services are also delivering or working towards the direct booking of routine appointments (pre-bookable and same day) into extended access evening and weekend GP services.

6.3. The use of Digital technology to improve access and support

As part of our digital strategy, a number of significant initiatives have been agreed and have or are in the process of being implemented across the ESBT footprint with the aim of supporting sustainability and / or improving access to services. In particular, all practices are now on the same clinical system and we have a programme that encourages practices to trial new technologies with a view to rolling out those that are most successful. Examples of initiatives being trialled include:

- **Intelligent messaging / enhanced SMS:** this provides patient messaging services and has been rolled out to all practices. Early indications are that this has been very successful.
- **Online consultations:** A selection of practices will be piloting two alternative suppliers of on-line consultation software. The expectation is that following evaluation a preferred supplier will be selected and the software rolled out across all practices by March 2019.
- **Skype Consultations:** Skype consultations have been piloted in one Hastings practice and have been popular with patients. Depending on the results of the evaluation the CCGs will consider the appropriate approach for further roll out.
- **Roll out of NHS e-referrals:** The CCGs are working very closely with our local provider and supporting practices to ensure early adoption of NHS electronic referrals system which includes prompt access to advice and guidance.
- **Mobile Working:** The CCGs have supported general practice staff to adopt mobile working by introducing a variety of approaches to enable remote access and working off site.
- **Telephony:** The CCGs are working with practices to consider options for a major telephone upgrade across all practices that will be able to offer fully integrated communications systems including flexible models of call handling.

6.4. Investment in premises and estates to ensure modern facilitates that are fit for purpose

The CCGs are working with ESBT alliance partners on an ESBT wide estates strategy recognising the importance of the estate as a key enabler to support clinical services. This builds on the ESBT Strategic Estates Plan, produced in 2016/17 by NHS Property Services (NHS PS) in conjunction with ESBT which focused on the NHS PS property portfolio the CCGs operate from and GP primary care estate.

The strategy will promote the flexible use of space and the co-location of primary, community, voluntary and secondary care services where appropriate to meet the needs of the local population.

In the meantime, the CCGs are making significant investment to support the development of an improved estate that is fit for purpose and will assist the recruitment and retention of primary care workforce. Across both CCGs, there are 16 premises proposals at various stages of development.

7. Conclusion

The committee is asked to note the plans and progress made in supporting the delivery of a sustainability of primary care in Eastbourne, Hailsham and Seaford (EHS) CCG and Hastings and Rother (H&R) CCGs.

Annex 1

The Future of Primary Care Across ESBT

Building and developing our strategy

What is Primary Care?

- Primary Care (PC) is first-contact, accessible, continued, comprehensive and coordinated care.
    - First-contact care is *accessible* at the time of need;
    - *Continued* care focuses on the long-term health and well-being of a person;
    - *Comprehensive* care is a range of services appropriate to peoples' problems in the community;
    - *Coordination* is the role by which primary care acts to coordinate other specialists that the patient may need.

Primary care is provided by a number of different services including General Practice, Dentistry (which is currently commissioned by NHSE), Pharmacies, Community Services, Charitable and Voluntary Organisations, Physiotherapists, Mental Healthcare Workers and Opticians.

The National Context

- Economic and workforce constraints, coupled with an ageing population are putting Primary Care in England under significant strain.
- Nationally, Primary Care organisations are responding to pressures by forming new structures to allow care provision at greater scale e.g. federations, networks, super partnerships.
- General Practice Five Forward View – a national 5 year programme which aims to boost Primary Care by encouraging a step change in the level of investment and support into General Practice. It includes help for struggling practices, plans to reduce workload, expansion of a wider workforce, investment in technology and estates and a national development programme to accelerate transformation of services.
- GP Forward View link: https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

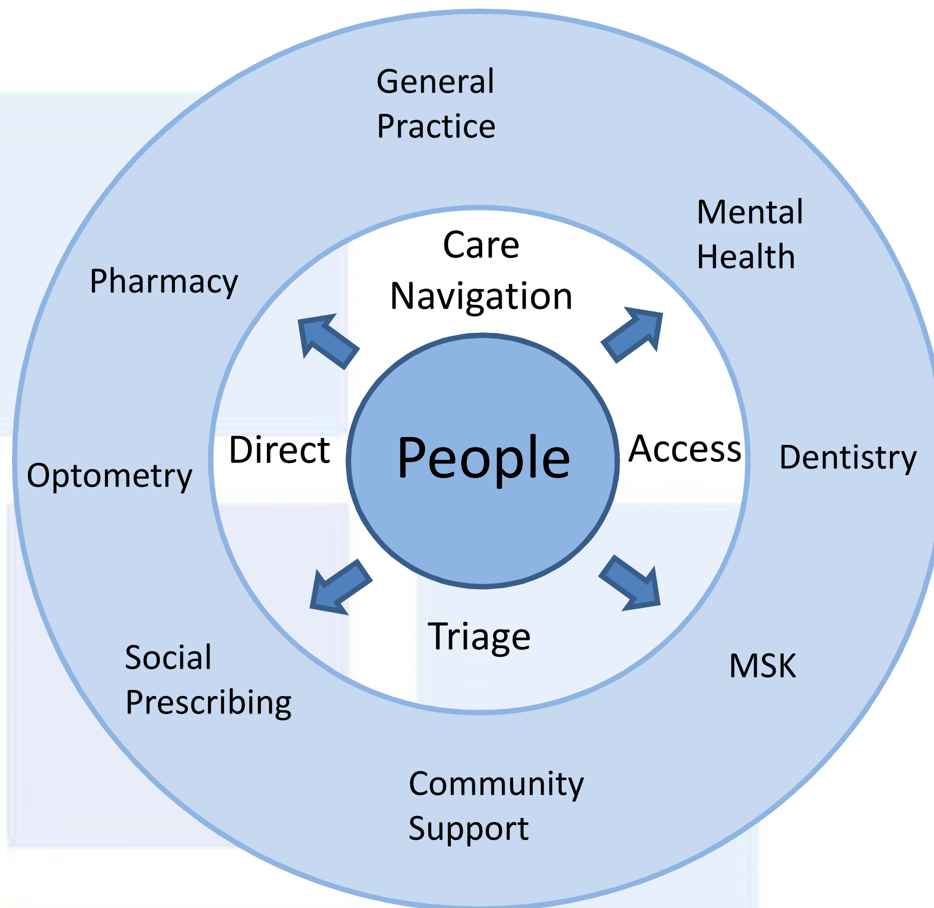
The Local Context

- Our population is growing and people are living longer, so demand for health and social care is growing faster than our budget.
- ESBT is our whole system transformation programme to tackle the challenges of quality and funding.
- Our shared vision is that by 2020/21, there will be an integrated, sustainable health and care economy in East Sussex that ensures people receive proactive, joined up care, supporting them to live as well and as independently as possible which:
  - ✓ Focuses on prevention and early intervention;
  - ✓ Provides high quality seamless care as close to home as possible;
  - ✓ Reduces inequality and improves outcomes across the population.
- In order to support this vision, there is a firm commitment to continue investing in Primary Care.
- ESBT recognises the value of a strong general practice base which can be a network of partnership-led, GMS/PMS practices alongside other models where needed.

The Development of a Primary Care Strategy

- Members of the local Primary Care team, the CCGs, LMC, GP Federations and representatives of GP practices have met to create this version of the strategy.
- Concepts have been drawn from Vanguard sites and other examples of good practice locally and around the country.
- Comments have been invited from across the local health community and the strategy adapted.
- A public and stakeholder engagement process is on-going.
- The aim is to have a clear strategy underpinned by a detailed roadmap arrived at by widespread consensus.

ESBT - A New Model for Primary Care



We intend to foster a Primary Care system that revolves around the needs of the individual and can get them the care they need, as directly as possible, delivered by the most appropriate person.

Our Strategic Intent

Current State

- Practice led primary care
- Unstable Workforce
- Multiple processes and approaches
- Allocated / awarded contracts
- Data used to evidence and trigger payment by results
- Isolated, practice varying/patient varying access into care
- Care can be predominately reactive and there is system-wide inequality

Future State

- Integrated, collaborative working
- Adequately resourced with succession plans
- Standardised systems, processes and approaches with locality focus
- Co-designing pathways and delivering local services at scale
- Data used to develop understanding of patients and localities and manage business
- Integrated, seamless care based around the practice list and at scale, patient accessible primary care
- MDT Primary Care teams resulting in reduction in health inequalities via prevention and self-management.

Detailing our Strategic Intent

In order to implement our strategy, we will invest and transform in several areas:

- Workforce - retain, attract and diversify the workforce;
- Resilience - creating sustainable, responsive, shared resources;
- Quality - having the highest clinical and quality outcomes;
- Processes - centralised work flow and interface.

Through centralising some activities, individual General Practices can focus on how to best respond to the particular needs of their population. Harmonising some functions can support appropriate diversity and is not a threat to practices continuing as individual entities.

Primary Care Workforce

Our Challenge: Too few key people to comprehensively staff a traditional primary care service.

Our Vision: Primary Care becomes truly multi-disciplinary. Patients are navigated towards the person best placed to deal with their condition, at the right time, in the right place.

Our Roadmap:

- We will support the training and development of the Primary Care Multi-Disciplinary Team (MDT).
- We will help to embed new ways of working in Primary Care.
- We will encourage centralised employment of key staff who can be seconded to or shared by practices.
- We will attract and retain colleagues.

Resilience in Primary Care

Our Challenge: We have a system of individual practices that rely on key individuals, both clinical and administrative. It only takes small changes for systems to struggle.

Our Vision: Greater centralisation of administrative and clinical functions enabling work and clinical resources to flow from areas that are overwhelmed to areas that have capacity through an embedded and sustainable network.

Our Roadmap:

- We will encourage the standardisation of procedures to allow the centralisation of high quality administrative functions, policies and procedures.
- We will create a system that allows a practices' patients to receive help when the practice itself is no longer able to manage their demand.
- We will promote self-care and encourage people to find their own solutions to their problems.
- We will support the development of premises and facilities that support the Primary Care strategy and are fit for purpose.

Quality of Primary Care

Our Challenge: There are too many inconsistencies in the quality, accessibility and type of care provided with no minimum standard, no consistent, governance and clinical support mechanism.

Our Vision: People can expect to get a good consistent standard of care no matter where it is accessed.

Our Roadmap:

- We will develop communication networks for clinical expertise to rapidly flow where it is needed.
- We will blur traditional primary and secondary boundaries through the sharing of knowledge and skills.
- We will support the development of standardised and centralised systems, tools, protocols, resources and processes.
- We will foster an effective shared governance and safeguarding framework.
- We will invest in clinical leadership and development.
- We will support change that ensures people get good care wherever they access it.

Systems and Processes

Our Challenge: Work is often not done by the most appropriate part of the system and frequently duplicated or delivered in silo.

Our Vision: The Primary Care work force will work in a truly integrated way and take responsibility for their part of the system, manage it and deliver it well.

Our Roadmap:

- We will foster a first-point-of-contact triage service that directs people appropriately so that GPs do not always need to be the centre of a person's care.
- We will encourage the fluidity of resources and new models of employment designed to work across Primary Care.
- We will develop systems (including IT and comms), procurement and other systems-related resources to enable Primary Care to evolve.
- We will move from payment based purely on activity to payment based on measurable outcomes where possible.
- We will continue to implement and develop ESBT pathways supporting care closer to home.

Primary Care Interfaces

- Primary Care can only be effective in the context of effective Secondary Care, Mental Health Care, Social Care and the Voluntary and Community sector.
- The interfaces between these different segments of the overall Alliance structure are crucial.
- Work is underway to create protocols for how work (and the resulting funding) is passed between different organisations within the Alliance.
- We will engage with the public to help them get the best from Primary Care. We will have fair, honest and open discussions about the strategy and the challenges. We will aim to make it easiest to get help from the best place to get that help.

Next Steps

The aim is to have a clear strategy underpinned by a detailed roadmap arrived at by widespread consensus. This will be achieved through:

- Extensive engagement across General Practice – presentation outlining high level strategy to be shared at both Membership and Learning Events (MELEs) in March 2018.
- The development of a detailed roadmap underpinned by clear milestones and an associated investment plan by 31st March
- Sign off via CCG GPFV Steering Group – April 2018

EAST SUSSEX
BETTER TOGETHER

Appendix 1

GP age by locality

Annex 2

Locality	No of patients	No of GP excluding others	% GP age under 45	% GP age 45 to 54	% GP age 55 and over
Rural Rother	40,677	28	50	35.7	14.3
Bexhill	47,460	31	61.3	19.4	19.4
St Leonards	41,102	20	35	30	35
Hastings	33,281	18	27.8	27.8	44.4
Eastbourne	135,914	88	43.2	38.6	18.2
Hailsham	31,093	19	42.1	47.4	10.5
Seaford	27,793	21	61.9	19	19

Please note number of GP refers to GP headcount. It includes GP partners and Salaried GPs only.

Rural Rother

Hastings

St Leonards

Hailsham

Bexhill

Eastbourne

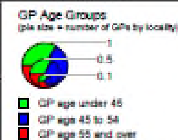
Seaford

0 5 10
kilometres

NHS Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG

GP Workforce: Age Profile by Commissioning Locality
(Based on NHS Digital: wMDS, March 2017 dataset)

GP Age Groups
(pie size = number of GPs by locality)



GP age under 45
GP age 45 to 54
GP age 55 and over

CCG boundary
Locality boundary

South, Central and West Commissioning Support Unit
NHS

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Nurse age by locality

Locality	No of patients	No of Nurse	% Nurse age <55	% Nurse age 55 and over
Rural Rother	36,584	18	72.2	27.8
Bexhill	47,460	22	36.4	63.6
St Leonards	41,102	21	42.9	57.1
Hastings	33,281	18	55.6	44.4
Eastbourne	135,914	57	61.4	38.6
Hailsham	31,093	13	46.2	53.8
Seaford	27,793	10	80	20

Nurse data for Fairfield Surgery within Rural Rother locality is not available

Rural Rother

Hastings

St Leonards

Bexhill

Hailsham

Eastbourne

Seaford

0 5 10
kilometres

NHS Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG

Nurse Workforce: Age Profile by Commissioning Locality
(Based on NHS Digital: wMDS, March 2017 dataset)

Nurse age groups
(Pie size = number of nurses by locality)

Nurse age under 55

Nurse age 55 and over

CCG boundary

Locality boundary

South, Central and West Commissioning Support Unit

NHS

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