NHS Basildon and Brentwood Clinical Commissioning Group

NHS Castle Point and Rochford Clinical Commissioning Group

NHS Mid Essex Clinical Commissioning Group

NHS Southend Clinical Commissioning Group

NHS Thurrock Clinical Commissioning Group

INVESTING IN OUR FUTURE

MID & SOUTH ESSEX STP PRIMARY CARE STRATEGY

GENERAL PRACTICE

JUNE 2018

FINAL

CONTENTS

EXECUTIVE SUMMARY

General practice in mid and south Essex is at a crossroads. We know that if we carry on as we are, with some of the lowest staffing levels in England, poor morale, excessive workload and difficulty recruiting the staff we need, practices – and individual GPs - will collapse and the quality and safety of the service we provide to local people will deteriorate.

This is not a future anyone wants. That is why, working with practices and the LMCs across our STP, we have developed this strategy and our supporting *narrative*. We believe our plan has the potential to regenerate and revitalise primary care locally, reducing workload, especially for GPs, improving the service we offer to patients and making mid and south Essex a place where staff want to come and work.

Three key themes lie at the heart of our strategy. Firstly, to expand and change the primary care workforce so that we move from a service that is GP delivered to one that is GP led. We want to recruit more GPs and nurses, but also a wide range of other professionals so that we have vibrant, multi-disciplinary teams in general practice.

Secondly, we want practices to accelerate progress in coming together to form localities covering populations of roughly 30-50,000 people. By working together in localities that they own and control, practices will be able to support one another, benefit from economies of scale, improve access for patients and provide a strong foundation for locally integrating a wide range of services.

Thirdly, we plan to do all we can to quickly support practices to manage demand and reduce workload. Our plans include more systematic deployment of proven methods of triage and care navigation, as well as widespread use of digital technology to promote and enable new models of care delivery and reduce bureaucracy.

Our strategy will help us to build that the solid local foundations that are essential for the further expansion of, and integration with, a wide range of out of hospital services, including community nursing, social care and voluntary organisations.

We know that we need to increase investment in general practice to deliver our future model of care. We estimate that fully implementing this strategy will require additional recurrent investment of £35m a year by 2020/21, as a result of significantly increased investment in workforce, estate and digital solutions. We also know that we need to invest in estate; this plan sets out the 'pipeline' that each CCG has developed.

We have already made progress in many areas. What we set out in this plan is not new or unique. What we have lacked until now, however, is a unified strategy that sets a clear direction for all parts of our STP.

This plan has been developed by the five CCGs in our STP working in partnership, as well as with local practices and the LMCs. We will build on this partnership and the momentum we have generated as we implement this plan; doing some things once across the STP where it makes sense to do so, and co-ordinating and sharing our local delivery plans.

1. INTRODUCTION

This strategy has been developed by the five CCGs within the mid and south Essex, working alongside practices and the LMCs. It was initiated by the Joint Committee of the CCGs, who recognised that while our STP now has a clear plan for the future of hospital services, we do not have plans of equivalent depth and rigour for primary care.

Its purpose is not to recreate or supersede work already underway in CCGs; rather it is intended to provide a single unifying vision and strategy that can be shared and owned by practices, LMCs, CCG Boards and external partners.

Although the strategy is set at STP level, the drive and energy required to implement it must come locally, from CCGs working together with practices, patients, councils and local organisations.

It is important to clarify terminology at the outset. Although in this document we regularly refer to 'primary care', our scope is limited to general practice; we do not consider in any detail other primary care services such as dentistry or optometry.

We also recognise that general practice is only part of a much wider local care system; providing effective, patient-centred care involves close integration with a wide range of other services, including social care, housing, mental health, community nursing and colleagues in hospital. We have not attempted to address this wider out of hospital picture here: our approach is to focus on re-establishing strong general practice first, as we believe this is a prerequisite for effective local integration.

We have also endeavoured to keep this document reasonably short so it is as accessible as possible. Further detail on the work that supports our strategy is available in both the *narrative* that has been developed in partnership with practices, and the *detailed technical appendix* that supports this paper.

The document is organised in eight main sections:

- Case for change
- Future model of care
- Workforce
- Digital
- Estates
- Finance
- Communications and engagement
- Implementation

This strategy will be finalised by early May 2018. It is then our intention to ask the Boards of each of the five CCGs to formally agree it, together with their local implementation and investment plan.

2. CASE FOR CHANGE

About this section

In this section we set out why we believe we need to take a new approach if we are to create a secure and stable future for general practice. We show how our STP has exceptionally low staffing levels, how this is likely to worsen in the future, and the impact this has on workload, morale, recruitment and our ability to provide consistently high quality services for patients.

There is a powerful case for change for general practice across our STP:

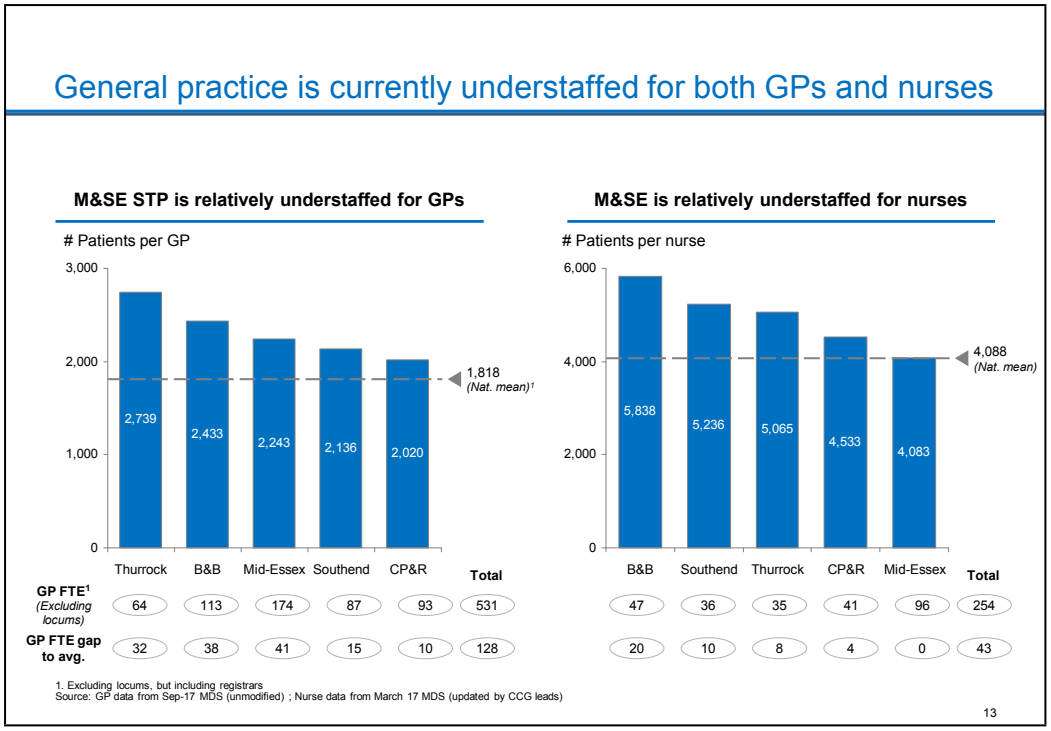
- General practice is understaffed, resulting in high workload
- Retirements will further reduce staffing levels
- Morale is low and we face long running recruitment challenges
- There is insufficient capacity to meet current demand
- The gap between demand and capacity will widen in future
- The service experienced by our patients is variable

General practice is understaffed, resulting in high workload

We know that against most of the key measures, primary care in mid and south Essex has significantly fewer clinical staff than the national average. This is the biggest challenge we face, and risks creating a downward spiral that is difficult to escape from:

- Low staffing levels increase workload, making staff in general practice vulnerable to burnout and, in extreme cases, possibly jeopardising safety
- High workload in turn negatively affects morale and makes mid and south Essex a relatively unattractive place for people to come and work in
- The resulting turnover and difficulties in recruitment lead to overall staffing levels reducing further – adding to the workload of those that remain.

On two of the key measures, the number of GPs per head of population and the number of practice nurses, our STP had significantly fewer staff per head of population than average. In the case of GPs, all five CCGs are below average, with Thurrock and Basildon & Brentwood having particularly low staff numbers. The overall pattern for practices nurses is similar, four of the five CCGs having significantly fewer staff than average.

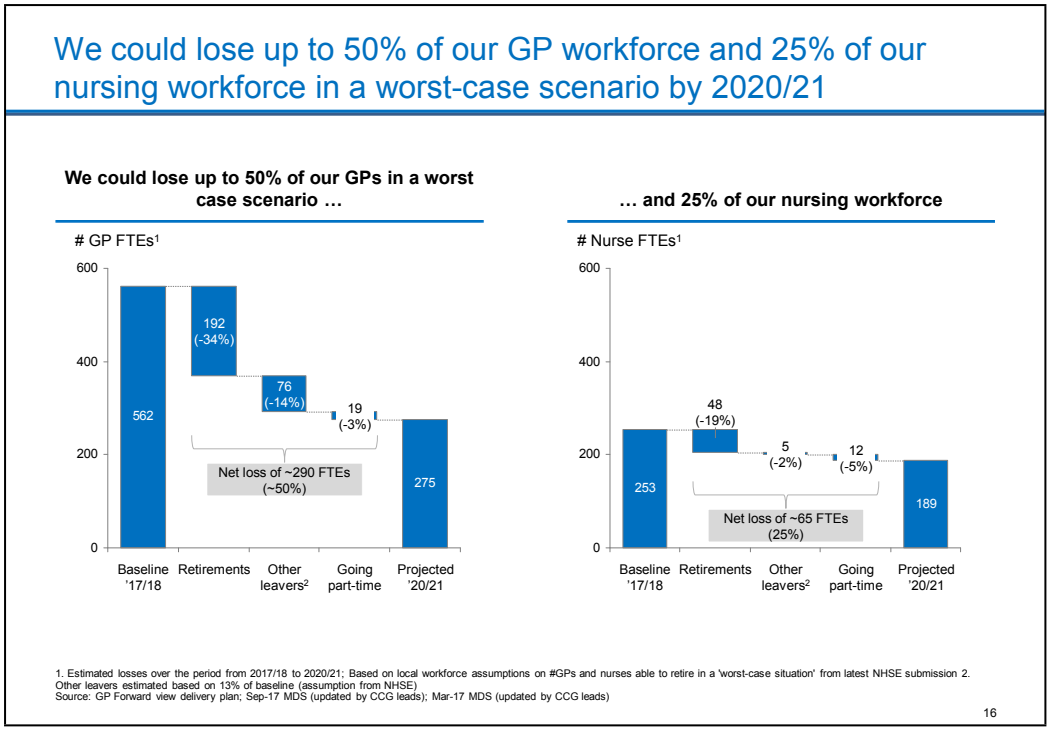


One consequence of the low level of 'core' staffing in general practice is that our STP relies much more heavily on locums and temporary staff than other areas. As well as being expensive, this can negatively impact on some patients by reducing continuity of care. This issue is considered further in the section on Workforce.

Workforce shortages in primary care are further compounded by staffing shortfalls in other local community services. Although we do not yet have STP level data, we do know that in many parts of our area there are significant vacancy rates in key services, such as community nursing.

Retirements will further reduce staffing levels

A further challenge for our STP is that the profile of our primary care workforce is relatively old, meaning that there is the potential for significant levels of retirement in the years to come. Health Education England has concluded that that this challenge is more significant in our STP than in any other part of England. Without mitigating action, this will further reduce staffing levels in general practice, exacerbating the problems outlined above.



Morale is low and we face long-running recruitment challenges

One consequence of the low staffing levels and high workload is a negative impact on morale. There is no uniform measure of morale or wider staff satisfaction in general practice (an anomaly that we are keen to address, as set out in the following section of this document), but we know from anecdotal evidence, as well as from high levels of turnover and early retirements, that morale in general practice in our STP is at a very low level.

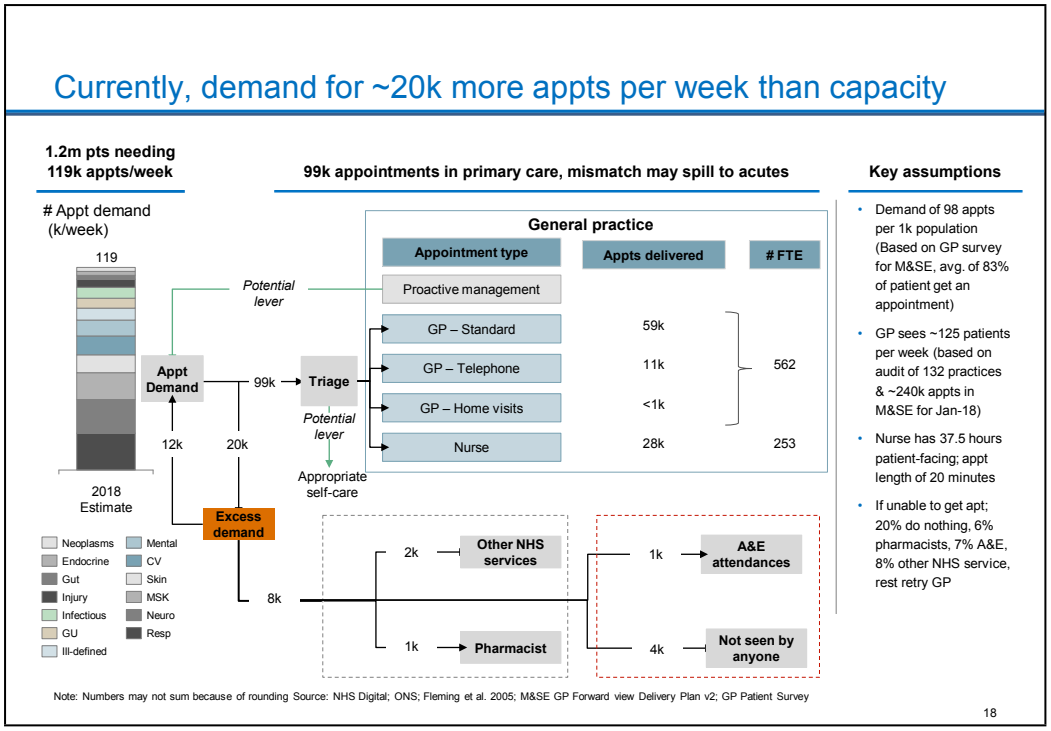
This challenge is compounded by the difficulty we experience in recruiting new, permanent staff. This affects all staff groups, but is more pronounced for GPs – a number of practices across our STP have vacancies that they have been unable to recruit to for a long period of time.

There is insufficient capacity to meet current levels of demand

As a result of the low level of staffing in our STP, we know that demand for care in our STP exceeds capacity. However, until now we have not been able to quantify this gap.

We have for the first time calculated the balance between demand (as expressed by patients seeking an appointment in primary care) and capacity (measured as appointment slots available). We carried out this exercise across the whole STP in early 2018.

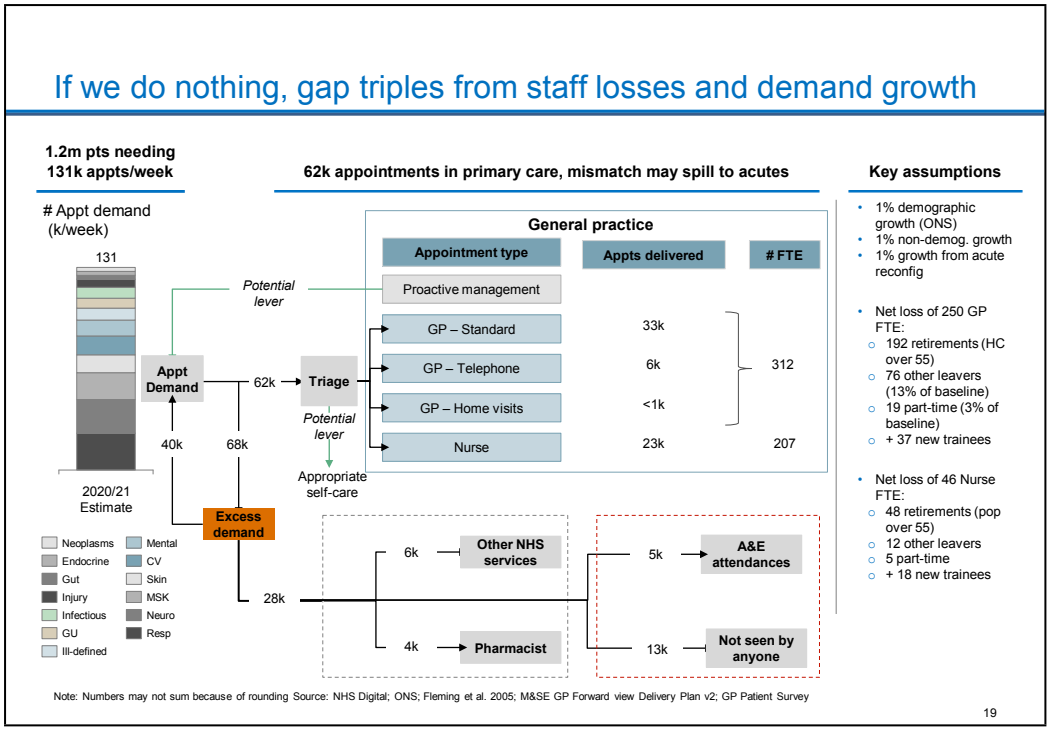
The results show that we have a very significant imbalance at present, with demand for appointments outstripping the available capacity by 20,000 a week. Taking data from the national patient survey, we estimate that in an average week there is demand for approximately 119,000 appointments in general practice. By reviewing data held by each practice, we know that on average there are 99,000 appointment slots available, largely split between GPs and practice nurses.



We do not know what the 20,000 patients per week who are unable to get an appointment do next. However, it is reasonable to assume that a significant proportion will attend A&E, increasing pressure on that service. This hypothesis is supported by survey evidence, which frequently highlights 'could not get an appointment with my GP' as a reason given by patients for attending A&E. In addition, it is also plausible that there are some people who do not get an appointment who really need medical attention – and in those cases their condition may deteriorate markedly before they are able to access treatment.

The gap between demand and capacity will widen in future

It is also clear that, without action, this gap will widen in future years. This is driven by two main factors. Firstly, demand will grow, as a result of population growth, demographic change and the impact of some services shifting from a hospital setting into primary and community care. Secondly, capacity will reduce, as the impact of losing clinical staff (partially to retirements) feeds through. We estimate that if we carry on as we are by 2020/21 in a 'worse case' scenario the gap between the demand for appointments and the capacity available could have widened from 20,000 to over 60,000.



Prior to the development of this strategy, we agreed plans to address the capacity shortfall in general practice, with a particular focus on increasing staffing levels. This includes a detailed plan to recruit more GPs, as part of our local response to the national *GP Forward View* strategy.

However, we know that there are significant risks associated with this element of the plan, not least the fact that we are relying heavily on overseas recruitment to find the additional GPs we need, and that we are in effect in competition with other areas to attract staff whose skills are in short supply. For this reason, out new model of care (set out in the following section) emphasises the importance of creating a much broader workforce in primary care.

The service experienced by patients is variable

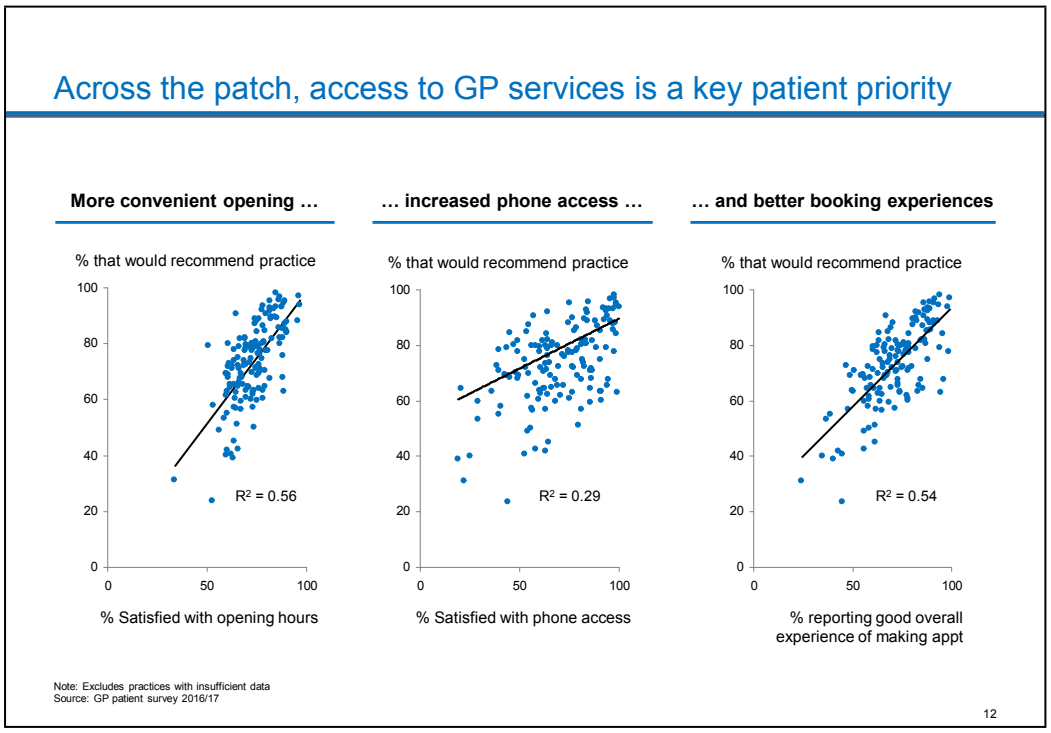
As a result of the challenges set out above – low staffing levels, high levels of retirement, low morale and problems recruiting – we know that the service currently experienced by patients is highly variable.

For example, patient surveys show that all five CCGs are below the national average in the percentage of patients who would recommend their practice; only one CCG is higher than the average for the percentage of patients who are happy with opening hours; and one CCG – Basildon – is below the national average on all of the key measures.

Metric	Mid Essex	Basildon	Thurrock	Southend	CP&R	STP Avg.	National Avg.
% Who would recommend the practice	76	71	67	72	76	72	77
% Satisfied with phone access	65	70	72	72	70	70	71
% Satisfied with opening hours	72	71	71	73	77	73	76
% Who saw/spoke to nurse or GP same or next day	52	46	48	48	54	50	50
% Reporting good overall experience of making appointment	71	68	69	72	76	71	73

We know that one of the key drivers of patient satisfaction is access to services. As set out in the following exhibit, there is a clear correlation between three of the key measures of patient access – satisfaction with opening hours, with phone access and with experience of making an appointment – and how likely a patient is to recommend their practice to others.

This is a particular challenge in our STP, where there is a significant – and widening – gap between demand for services and capacity.



Although many factors affect overall health outcomes - and at an aggregate level our STP has better than average outcomes - there is considerable variation at CCG level. For example, Southend has significantly worse mortality rates for liver disease than average, and Thurrock and Basildon both have higher mortality rates for cancer.

Metric	Mid Essex	Basildon	Thurrock	Southend	CP&R	STP Avg.	National Avg.
Potential years of life lost from amenable causes per 100k pop - Female	1,567	2,009	2,186	1,782	1,801	1,825	1,869
Potential years of life lost from healthcare amenable causes per 100k pop - Male	1,780	2,265	2,207	2,307	2,204	2,099	2,266
Under 75 mortality rates from cancer per 100k pop	107	127	130	116	112	117	120
Under 75 mortality rates from CV disease per 100k pop	50	59	76	65	62	60	64
Under 75 mortality rates from liver disease per 100k pop	11	11	15	21	9	13	16
Health related QOL for people with long term conditions	0.77	0.74	0.75	0.74	0.76	0.76	0.74

This variability, together with other the factors set out above, led us to conclude that we needed to go further and develop a different model of care for general practice. Our conclusions are set out in the following section.

3. FUTURE MODEL OF CARE

About this section

This section sets out the key elements of our future model of care; the detail behind this overview is contained in the *strategic narrative* which complements this document.

We describe how we plan to move to a GP led, rather than GP delivered, service, and to encourage practices to increasingly work 'at scale' by coming together in localities. We detail and quantify our plans to reduce workload and close the demand-capacity gap by expanding the workforce on primary care, managing demand and eliminating bureaucracy.

Overall approach

We have developed our future model of care in discussion with practices from across mid and south Essex, and have also tested our thinking with a wide range of partners including the LMCs. We have captured the detailed thinking **in our strategic narrative for general practice** which accompanies this document.

Our approach to transforming primary care seeks to protect and build on the strengths of general practice that are greatly valued by patients, whilst also ensuring that practices are resilient, flourishing and an integral part of a wider network of health and care services.

There are two key proposals at the heart of our future model:

- Moving away from a system in which services are principally GP delivered to one where services are GP led
- Encouraging and enabling practices to come together to form and lead localities serving populations of approximately 30 - 50,000 people

From GP delivered to GP led services

Although many practices have for some time employed a range of clinical staff (such as practice nurses and health care assistants), in many instances the norm remains for almost all care to be delivered by a GP, often in quite traditional ways – for example, with almost all consultations being face to face and in undifferentiated appointment slots.

Given the imbalance between demand and capacity and the recruitment challenges outlined in the previous section, it is clear that this model will be difficult, if not impossible, to sustain. There are also other reasons to think it could and should change:

- A model where the default is for patients to directly access a GP (and usually for a standard amount of time) is not tailored to an individual patient's need or circumstances
- When GP capacity is outstripped by demand, as it has been locally for some time, then it is important that highly skilled GPs are able to focus their time on the patients with the most complex needs, such as those with long term conditions
- A range of studies have demonstrated that having improved or direct access to a wider range of clinical skills such as nurses, physiotherapists and mental health workers can improve patient care and reduce pressure on GPs
- Most practices are, on their own, too small to be able to integrate effectively with other statutory services, such as social care

Our new model would see practices employing, or having direct access to, a much wider range of disciplines than is presently the case, including nurses, support workers, physiotherapists, clinical pharmacists and mental health specialists. While GPs would remain accountable for the care delivered to the patients on their list, only patients who really need the 'specialist generalist' skills of a GP would be directly seen by them; many other patients would be triaged and directed to another member of the team.

We recognise that changing the care model in this way may require other developments to make it as effective as possible; for example, building in opportunities for trust to be built within new teams, and enabling members of the extended team to refer patients where appropriate.

Under this model, we envisage that a range of new ways of seeing patients would develop, including telephone consultations, increased use of e-consult systems and remote monitoring.

Over time, we also envisage that GPs could play a wider leadership role in integrating local services, for example bringing together council led services like social care, as well as those provided by the voluntary sector.

Developing hubs/localities

The second key aspect of the future model we have developed is to encourage practices to come together and form hubs or localities serving a population of roughly 30,000 to 50,000 people. This is already happening in many areas across the STP, but progress is variable and lacks a common framework.

In our discussions with practices, we have emphasised that a key aspect of a successful locality will be to serve the practices that are within it; we believe this will be key if our new model is to be successful. Equally, we have been clear that joining or forming a locality is voluntary for practices – we think it is essential that practices *want* to join.

We anticipate that practices will in general lead and make the key decisions about their locality. One core function will be to ensure that the locality supports individual practices, for example by reducing workload or taking on some work on its behalf where this is appropriate.

Localities will have a key role in:

- Managing and reducing demand, for example through common triage processes and the deployment of Care Navigators
- Providing a common 'building block' for integration of other services, such as community, mental health and social care
- Ensuring that at a locality level there is consistent modelling of demand and capacity
- Providing tools to help practices manage workload
- Supporting practices with the recruitment of staff, potentially building on the existing expertise built up through the EPIC programme
- Creating the critical mass that will enable some services that have traditionally been provided in a hospital setting to be redesigned and re-provided in the community
- Supporting practices to reduce bureaucracy by, for example, sharing back office functions and implementing digital solutions
- Leading patient education on accessing services and self care

Localities could take many forms, however to be effective they will need to have some core features, including:

- Coherent geographical coverage
- Clear governance and decision making processes, such as a memorandum of understanding
- Strong and credible leadership and an enthusiasm for working with partners
- Demonstrable practice sign up

We anticipate that localities will operate differently in different localities, and we will encourage them to innovate, develop new models and evolve. We believe that having thriving will localities help us to unlock the potential offered by integrating health, care and voluntary services locally.

Over time, some localities could, in discussion with their CCGs and local partners, take on a range of additional budgets and functions. More detail on how localities might over time progress through several 'levels' is set out in our overall STP plan.

Reducing practices' workload

In discussions with practices, we have emphasised the need to move quickly to reduce workload. Over the medium term, this will largely be achieved by increased recruitment, the development of the wider workforce and working together in localities, as set out above.

We know we cannot wait until new staff are in place, however, particularly given the skills shortages that currently exist and that slow recruitment to vacant or new posts. Therefore, we want to move quickly to help practices reduce pressure in the coming months, for example by:

- More consistent triage
- Clearer navigation of patients to alternative services
- Reductions in bureaucracy
- Quicker access to the wider support team, such as district nurses
- Enabling emerging localities to share resources
- Seeking opportunities for improving integration with and access to key services, such as social care.

We anticipate that addressing this issue will be a key element of CCG's Implementation and Investment Plans (see Section 9).

Closing the demand – capacity gap

The Case for Change identified that at present there is a gap of almost 20,000 appointments a week between demand for care in general practice and its current capacity, and that this is likely to widen considerably in the future. Closing this gap is one of the key drivers for developing this strategy.

In developing our future model, we have identified four main ways in which we can close this gap:

- Manage the demand for primary care more effectively
- Recruitment of additional GPs and a range of other clinicians to significantly create capacity
- Work together in localities to enable the benefits of operating at scale to be realised
- Harness the opportunities that digital solutions could offer

The following exhibit sets out, at a high level, both the key elements of each of the four main 'solutions' and where relevant the possible impact on closing the capacity gap that we face. More detail on each of these areas, and the supporting evidence we have drawn on, is available in the appendix.

'Solution'		What solutions could we offer to practices in a locality?	Potential impact
Manage demand	Improved front-door triage	• Training for reception care navigators and social prescribers • Training for nurse/GP-led telephone triage systems • Access to free/subsidised e-consult and AI triage systems • Opportunity for shared triage in community hubs/via NHS 111	• 3–15% reduction in appointment demand 0 — 50
	Proactive management and risk-stratified care	• Enhanced care home services, with support from acutes • Improved EOL care in the community, with support from acutes • Self-care tools and Apps proven to drive behavioural change • Targeted outreach calls reduce primary & secondary care activity	• Up to 4% reduction in appointment demand • Future benefit from improved LTC case finding 0 — 50 (0, 4)
Create capacity	Improved use of the wider workforce	• Pump-priming to hire wider workforce roles, with minimum effective uptake req. per role (e.g., no less than 0.5 FTE/practice) • Tailored needs analysis and skills audit per locality • Training to up-skill existing staff	• Up to 24–40% reduction in GP clinical appointments based on model used 0 — 50 (24, 40)
	Reduced GP admin burden	• Pump-priming to hire GP admin assistants • Access to free/subsidised personal productivity tools and training • Opportunity for shared back-office functions in locality hub	• Up to 3–16% reduction in GP workload 0 — 50 (3, 16)
Operate at scale	Locality hub model of working	• Infrastructure to support working in virtual or physical hubs • Community hub estates and co-location of services to support MDT working	• Demand redistribution and reduced locum use • Increased staff satisfaction and retention
Digital opportunities	Harness new technology to improve efficiency	• Use of technology to enable and promote self care • Automated systems to extract key data enabling reduced bureaucracy	• Reduced demand for appointments • Reduced bureaucracy

We think that practices, by working together in the locality model and with appropriate support, could reduce the pressure by managing demand for care more effectively. This has two main components: improving the 'front door' triage so that patients access services (and the professional) that is right for them and their needs; and by making more systematic use of existing tools such as predictive modelling and care planning to improve care for people with complex needs such as long term conditions. There is good evidence from elsewhere in the country that a systematic approach to this area is effective in managing demand in general practice.

The second and by far the most significant 'solution' is to expand capacity, principally by increasing the workforce – both of GPs and other clinical staff. As set out below, to close the capacity gap we need to recruit another 120 GPs (in line with our STP's *Forward View* target), as well as more clinical practitioners, physiotherapists, mental health and social care professionals and a range of other support staff.

The staffing mix outlined below has been built up by modelling the additional staff required to close the gap, and testing this model against the projections made previously as part of our response to the *GP Forward View*, as well as with localities that have already begun to implement this model.

			Essex draft strategy (2020/21)[1]	
Skill mix	**Baseline** *(2017/18)*	**Est. cost per FTE (£K)**	**FTE Δ to baseline**	**Additional cost (£M)**
GP	562	101	120	12.2
Clinical practitioner	256	48	69	3.4
Physical	0	48	42	2.0
Mental	0	48	20	1.0
Social	0	48	12	0.6
HCA	77	27	29	0.8
Other DPC	63	27	13	0.3
Admin	990	23	87[2]	2.0
Total	1.9k		0.4k	22

Mapping of roles to skill mix

- Social —Social prescribing; VS support; Social worker
- Clinical practitioner— ANP, Practice nurse; Physician Associate; ECP; Pharmacist
- Physical — Physio
- Mental —MH Therapist; CPN

A further strand in creating capacity is to support practices to reduce bureaucracy in order free up clinical capacity. This includes streamlining back office processes by operating at scale across localities; working with other partner such as hospitals to reduce demands on practices; and increased use of administrative assistants to release clinical time.

The third broad 'solution' we have identified are a range of benefits that we believe will flow as a result of practices operating at scale in localities. Although we have not at this point attempted to quantify the benefit of these measures, we think it is likely to be considerable; key aspects include:

- Sharing capacity at time of peak demand
- Rolling our common technologies and approaches to risk stratification
- Developing physical hubs to accommodate wider professional teams

Finally, we consider there to be considerable opportunity to improve efficiency by taking a more systematic approach to the adoption and spread of digital technology. Once again, in order to be prudent we have not counted on a direct benefit of these changes, but key aspects include:

- Care navigation tools
- Self-care and community support
- Shared care records
- Process and productively improvement tools

Taken together, we believe the four 'solutions' outlined above – managing demand, creating capacity, operating at scale and digital opportunities - could close the capacity gap identified in the previous chapter.

However, we recognise that whilst we need to expand capacity now, we also need to support practices to manage and where possible reduce the existing workload. We set out in Section 3 some of the steps we believe we can take quickly in order to help practices, including more consistent triage, better care navigation and reducing bureaucracy.

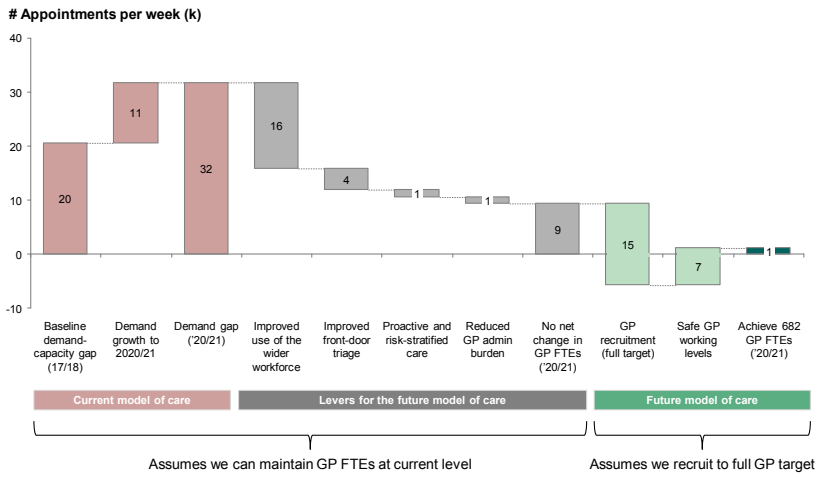
The following exhibit shows our predicted demand-capacity gap of 32,000 appointments a week by 2020/21, made up of our current estimated gap (20,000 appointments) and the projected increase in demand (11,000 appointments). We then factor in the positive impact of key aspects of the four solutions outlined above by 2020/21:

- Increases to the non-GP workforce and the development of a wider mix of staff – resulting in 16,000 more appointments available
- Better demand management though more effective front-door triage – results in a predicted gain of 4,000 appointments
- Consistent use of risk stratification and proactive care - results in a capacity gain of 1,000 appointment
- Reductions in bureaucracy - result in freeing up capacity of about 1,000 appointments.

Taken together, these measures result in a remaining gap of about 9,000 appointments. This residual gap is addressed recruiting the additional GPs that we need to implement our future model of care. If we then hit our *Forward View* target for GP recruitment, we will have an excess of capacity over demand, which would then enable us to reduce GP workload to BMA safe working standards (see below).

Closing the gap between demand and appointments

We can close the est. 32k appointment gap, and achieve safer GP working levels by 2020/21



Key assumptions

- Demand of 98 appts per 1k population in '17/18; growth of 3% p.a. to '20/21
- Safe working GP levels of 115 appts per week
- Uptake of 50% of the wider workforce model across M&SE
- Front-door triage reduces apt demand by 3%
- Proactive care reduces apt demand by 1%
- Reduced GP admin burden increases apt capacity by 2%

Source: NHS Digital; ONS; Fleming et al. 2005; M&SE GP Forward view Delivery Plan v2

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Safe working in general practice

One of our main objectives in rebalancing demand for care and capacity in primary care is to enable us to move towards safe working levels for GPs. At present, due to our historically low levels of staffing, we believe many GPs are working above the levels recommended by the BMA with most GPs seeing well over 30 patients per working day. By fully implementing our new model, we think this will enable a full time GP to see approximately 23 patients per day, in line with BMA guidance.

Measuring outcomes

At present, we do not systematically track outcomes in primary care at either an individual practice or locality level. This means that the priorities and targets we are aiming for are not always clear, and it is difficult to track and understand levels of progress.

However, we are clear that it would not make sense to try and set a single 'binding' set of outcome measures on all localities. To do so would risk alienating some areas and would also fail to capture the legitimate differing priorities across the footprint. Therefore, our emerging approach is to develop a menu of outcomes that localities can choose from (and that can be added to if necessary), together with a small set of core indicators that we will agree across our STP.

Types of outcome measure

In developing this work, we have identifying three main categories of outcomes that we think each locality should use: patient impact; practice level impact; and system impact. There is a wide range of indicators that it may be appropriate to use in each of these categories; some examples are set out below:

In measuring patient impact, we anticipate drawing primarily on the data that is available from the national survey, as this is a robust data set on how patients view their local practice. Over time, as we expand capacity in general practice and introduce the new model of care set out in this section, we would anticipate improvements in most or all of these measures. We are also keen to work with localities to develop further metrics that 'build out' from measures of access and capture other aspects of the patient experience.

We are also very keen to measure practice level impact, with a particular focus on staff satisfaction and morale. General practice is an anomaly in the NHS, in that there are at present no routine staff surveys in place. We are keen to correct this anomaly, and have identified one tool – the Maslach Inventory – that we are keen to pilot using across our STP. The Local Medical Committees are supportive of this approach and we plan to work with them to run a baseline assessment in the summer of 2018.

Our third category – system impact – seeks to determine how effective practices and localities are in supporting the overall effectiveness of the wider health and care system. There are several measures that could be used here, but we are particularly keen to focus on those that consider rates of hospital utilisation. In general, we would expect that increased investment in, and the improving capacity of, primary care will lead to a narrowing in the present variation in acute utilisation.

Clinical outcomes

As localities develop, we are keen that they obtain the expert advice of their local Director of Public Health to take advice on and set appropriate clinical outcome indicators. We anticipate that by focusing on a small number of clinical outcome indicators, rooted in a thorough needs assessment, localities will be able to focus their services and interventions on meeting specific local needs. Discussions to date suggest that the most fruitful measures are likely to be those that focus on the effective management of long term conditions such as diabetes or heart disease.

Developing our approach to outcomes

As we work with existing and emerging localities to complete a self-assessment and then subsequently agree a development plan (see section on implementation), one of the areas for discussion will be outcomes measurement. In any final agreement between a locality and its CCG, we would expect to see clear statement on the outcomes that have been selected as local priorities, together with target level of achievement and how they will be reviewed.

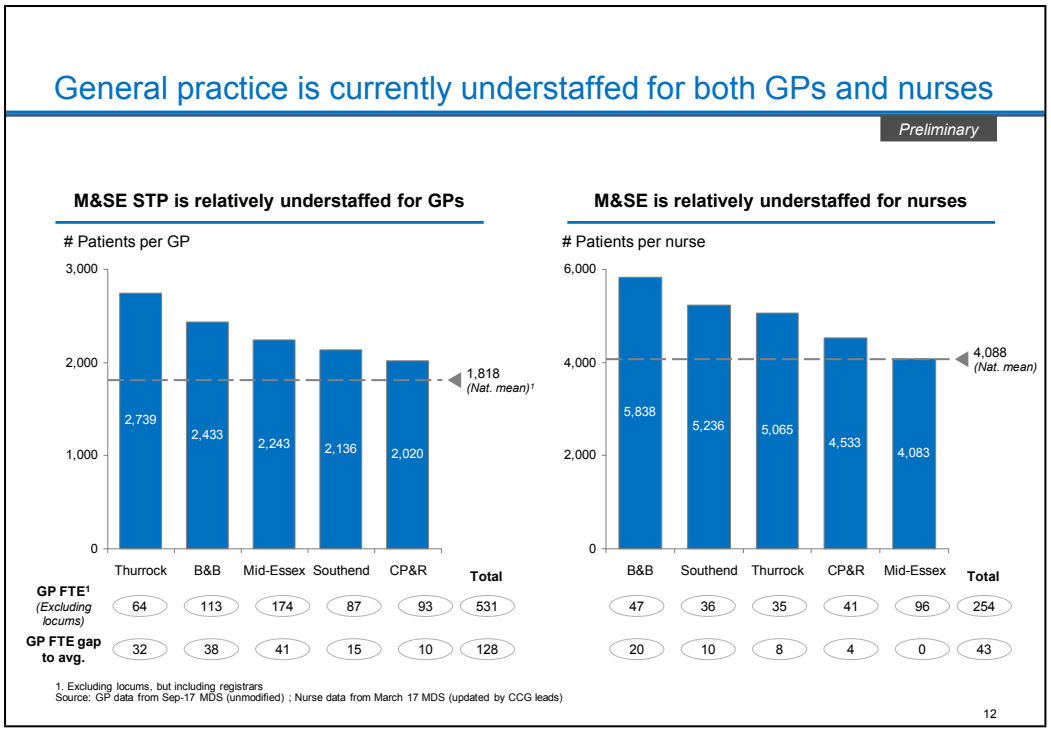
4. WORKFORCE

About this section

This section sets out our plans to expand and change the workforce in primary care. It outlines the challenge posed by our starting point, together with the importance of developing and implementing our new approach to workforce in order to differentiate our STP from others and make mid and south Essex an attractive place for staff to come and work in.

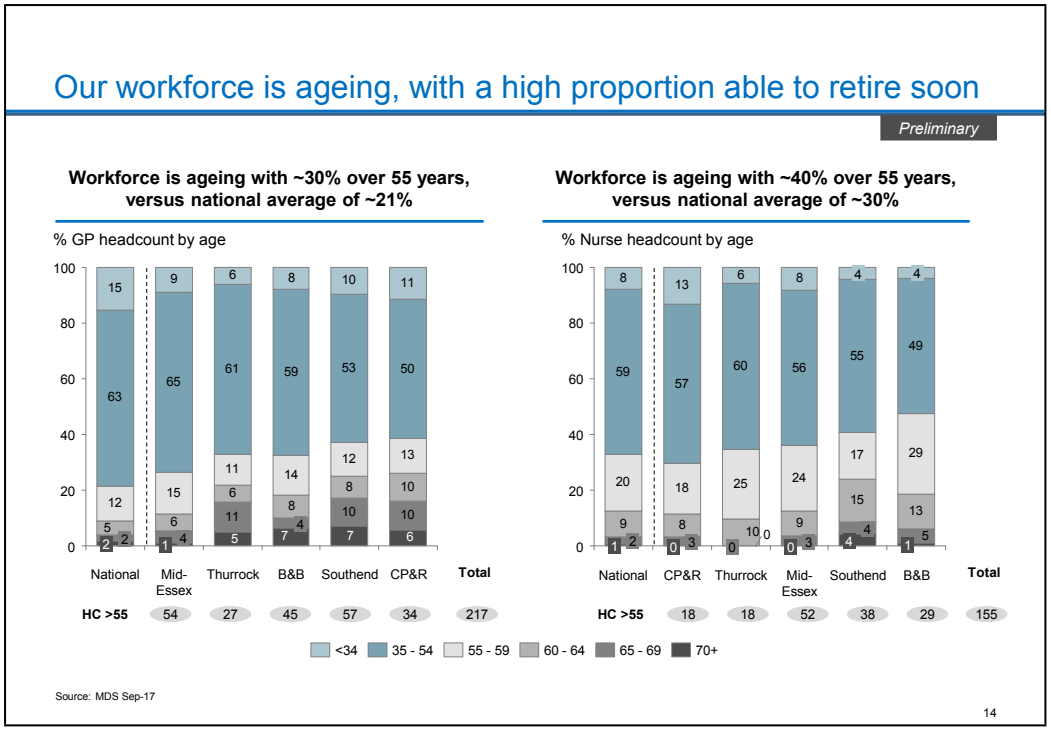
The Challenge

One of the main reasons we have developed this strategy is because we face a workforce crisis in primary care. One of the underlying – and longstanding – factors is that we have significantly fewer doctors and nurses per head than the national average:

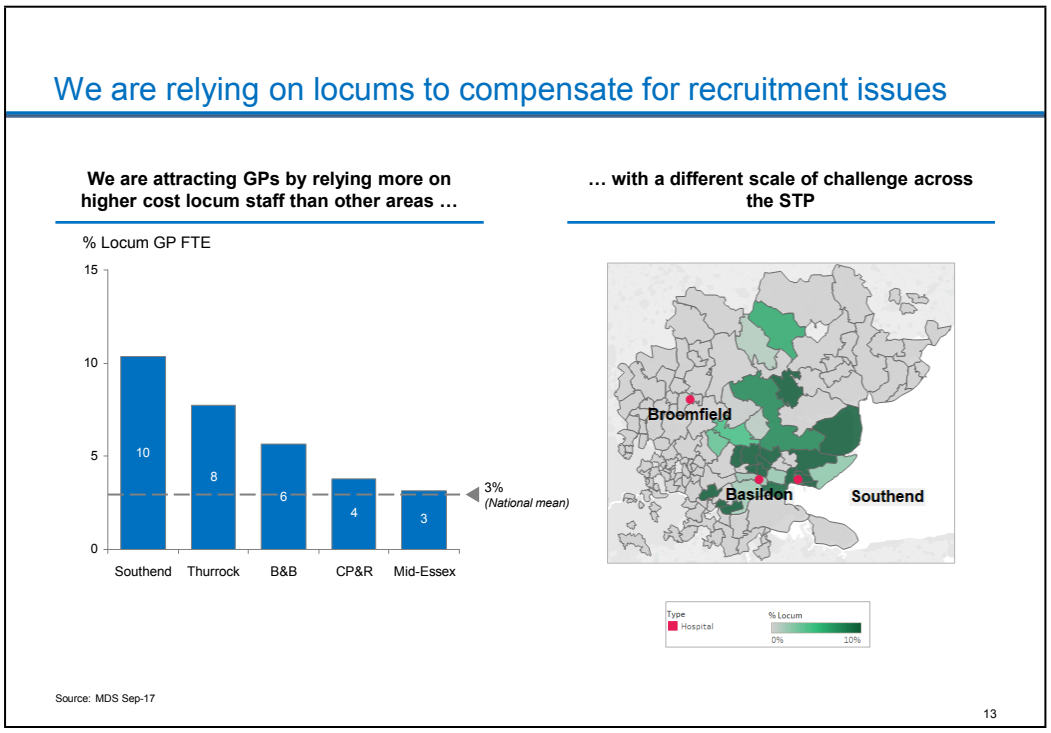


This clearly exacerbates the demand-capacity gap that we outlined in the case for change, as well as increasing the workload of and pressure on existing staff.

In addition, this position is likely to get worse in the coming years due to the age profile of our primary care workforce, which results in exceptionally high levels of predicted retirement. In fact, Health Education England recently identified that the retirement challenge in mid and south Essex as the greatest in England.



As a result of these pressures, as an STP we are heavily reliant on locums, with the challenge most pronounced in the south of the patch. As well as being expensive, this affects continuity of care for patients and potentially impacts on the quality of consultations.



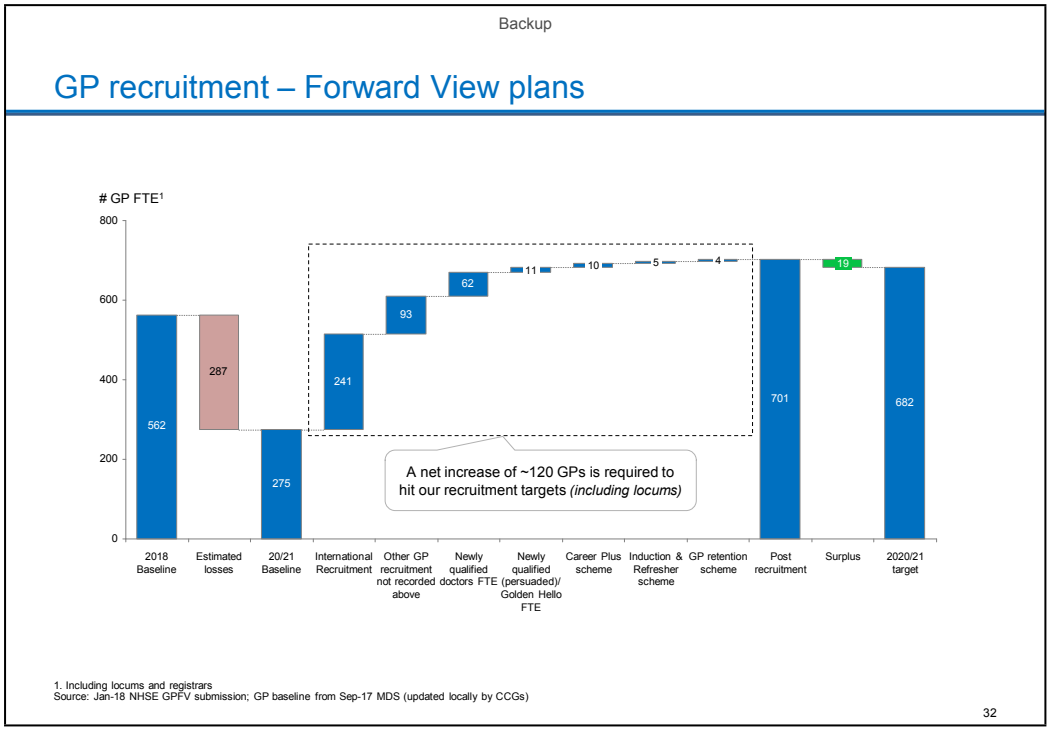
New model of care – workforce implications

As set out in the previous chapter, our new model of care has three key implications for our future workforce:

- Firstly, we need to recruit and retain significantly more GPs and practice nurses, building on our *GP Forward View* plans
- Secondly, we need to develop new roles and recruit a wider set of skills and disciplines into primary care, including pharmacists, GP assistants and mental health specialists, as well as think more creatively about possible new roles, particularly at the boundary of health and social care
- Thirdly, we need to reduce workload and make current roles more attractive, so that we have a competitive advantage in recruitment.

GP Forward View

As part of our pre-existing plans, we are aiming to recruit significantly more GPs across mid and south Essex. If successful, these plans will enable us to hit our national target of having 682 Full Time Equivalent (FTE) GPs in post by 2020.



However, it can be seen that we are heavily reliant on international recruitment in order to achieve our target and, although we have experience of running successful local programmes in the past, we recognise that this is a considerable risk. This is one of the reasons why, in this strategy, we advocate moving away from a service that is predominantly GP delivered to one that is GP led, building up a primary care workforce that includes a much wider range of professional disciplines.

Wider primary care workforce

At an STP level, in addition to recruiting additional GPs, to fully implement the new model of care we know we need to recruit or redeploy almost 200 additional staff, drawn from a wide range of professional disciplines:

Skill mix	Baseline *(2017/18)*	Essex draft strategy (2020/21)[1] FTE Δ to baseline
GP	562	120
Clinical practitioner	256	69
Physical	0	42
Mental	0	20
Social	0	12
HCA	77	29
Other DPC	63	13
Admin	990	87

Mapping of roles to skill mix

- Social —Social prescribing; VS support; Social worker
- Clinical practitioner— ANP, Practice nurse; Physician Associate; ECP; Pharmacist
- Physical — Physio
- Mental —MH Therapist; CPN

At this point, this is a top down estimate at STP level, albeit based on previous work as part of implementing the *GP Forward View* and tested with localities that are already developing a similar model. We plan to refine this model over the coming months as CCGs work in detail with their practices and emerging localities to determine the skill mix that is best able to meet local needs. We also anticipate that many localities will want to work with local partners, such as councils, to design new, flexible and innovate roles that are best able to meet individual's needs, rather than be designed around traditional organisational silos.

STP general practice workforce strategy

It is clear that expanding and changing the workforce in our STP is the biggest challenge we face. We believe that implementing our future model of care will be crucial in differentiating mid and south Essex from other areas, and make it easier to recruit the staff we need.

We have also identified a number of areas where, working together across the STP, we need to do more. We have recently agreed to establish a single resource (a workforce 'hub' or PMO) to co-ordinate our work across the STP.

<u>Recruitment</u>

We know that in some cases, such as the recent international recruitment of GPs, there is a benefit to recruiting on a larger footprint such as an STP. As we get a clearer 'bottom up' picture of the additional staff that practices and localites are looking to recruit, we will develop STP wide recruitment campaigns, including holding information evenings and running regular assessment centres for cohorts of staff. In this way, we think we will achieve a higher profile for our STP, encourage more applicants for local roles and be able to establish and 'at scale' approach to recruitment.

The recent establishment of the new Medical School at Anglia Ruskin University will be of huge benefit to our STP, and will greatly support recruitment. The new School has a specific focus on training general practitioners, which should help establish a local source of new recruits. In addition, the establishment of the Medical School will support a range of other workforce initiatives, including improving research opportunities and strengthening continuing professional development.

Retention

We will explore the further steps we can take to encourage and enable existing staff to continue to work and contribute locally. This will include looking at further financial incentives for key groups, better meeting development needs and identifying clearer opportunities for career progression.

Workforce intelligence

We recognise that having clear, timely and accurate local workforce data is key if we are to plan effectively at CCG and STP level. We will work more closely with HEE, the Local Workforce Action Board and practices to develop our workforce intelligence function, and see this as a vital role for the hub/PMO that we are establishing.

New roles and job design

Our new model of care relies on recruiting a wider range of staff, but also on developing new roles, such as physician assistants, generic care workers and support staff. In order to minimise duplication, we plan to work with practices and stakeholders to develop a common approach to these roles, such standardised job descriptions, person specifications and competency frameworks.

Role rotation

We are keen to expore how we can make all primary care roles in our STP more attractive and rewarding. One aspect we will look at is designing roles that enable staff to move across localaities and care settings, building on previous work to develop staff 'passports'. We think that such a development will lead to higher job satisfaction, improved professional development and better recruitment and retention.

Training and development

Our new model of care places considerable emphasis on all primary care staff working to the top of their skill set; for example, over time we envisage that the majority of direct pateint contact for many GPs will be with patients with the most complex needs. As a result, having comprehensive, ongoing training and development programmes for all staff groups will be vital.

As practices are in general relatively small orgnisations, training and development programmes can be fragmented. Working with practices and emerging localities, we plan to address this by building STP wide training and development programmes, and will seek to identify how we can support practices and localities to release staff, for example by helping with backfill.

5. DIGITAL

About this section

This section sets out our plans to accelerate the deployment of digital solutions. We view digital as a key enabler that will support practices to reduce workload, manage demand and provide a better service for patients. We outline the main areas in which we think digital can make a contribution, and summarise our approach to prioritisation.

We know that the use of digital and other technologies will be a key enabler for our future model of care. Digital and other technologies have the potential to help with the better management of demand, create capacity in general practice, reduce bureaucracy and support localities to operate at scale. We also know that to date we have made limited progress in this key area; work has been somewhat fragmented and we lack a unifying vision and architecture.

Digital as an enabler

In section 3 of this document – future model of care – we identified a number of potential solutions which, taken together, could help practices reduce their workload and close the gap between demand and capacity. Several of these solutions are dependent upon, or would be significantly enhanced by, the systematic deployment of digital solutions. Examples include:

<u>Managing demand</u>

- *Self-care and community support*. These tools are well developed and have a range of applications, including apps and software that support behaviour change (for example people with diabetes) as well as providing online support for people with a wide range of conditions including anxiety and depression
- *Care navigation and triage*. These technologies support self-care, such as by navigating patients to appropriate sources of information and support, as well as by providing opportunities for rapid access to consultations, often via computers or smartphones
- *Prediction and risk stratification*. There are a number of established tools that can support practices to risk stratify patients on their list and identify those patients that have 'rising risk'. This enables comprehensive care plans to be put in place for these individuals, enabling them to stay well for longer

<u>Creating capacity</u>

- *Patient pathways and treatment*. These tools can support patients and professionals to provide improved on-going care and reduce the need for regular consultations, for example through remote patient monitoring where the patient's readings are constantly logged and reported automatically, with anomalies or concerning patterns flagged to the patient and their GP

- *Processes and productivity*. There is considerable scope to better harness technology to reduce bureaucracy in primary care. Solutions that are already available include digital dictation that is integrated with clinical systems, and tools that enable automated data extraction from primary care platforms such as SystemOne.

Operating at scale

- *Communication across settings*. Having access to patient level information across a range of care settings is vital, especially as patients are frequently in contact with multiple services. As well as a core shared core record, further digital solutions now enable summary records to be held on smartphones, and for automatic communication with patients (such as appointment reminders, medication alerts etc.)

More detail on some of the digital solutions that we have reviewed in developing this strategy are included in the appendix.

Implementing Digital Solutions

There are many reasons why our uptake of digital solutions has been relatively slow. One key aspect is that there are now so many technologies and solutions available, and this makes it difficult to prioritise and sequence any roll out. A second factor is that in general decisions to purchase or roll out any particular solution rest with individual practices, which inevitably results in a somewhat disjointed approach and makes 'at scale' decisions problematic. Thirdly, there is a recognised lack of skills and capacity in this area: we do not yet invest in roles whose prime purpose is to support practices and partners to implement digital solutions.

To help address the first issue, in developing this strategy we have found it helpful to segment digital solutions into three main areas:

- Core to implementation of our strategy and system wide – such as shared care records
- Well-developed technologies that are low cost, easy to implement and with a clear impact – such as those that reduce bureaucracy for practices
- 'Big bet' opportunities that are not yet proven but have the potential to have a significant impact – such as AI based triage systems

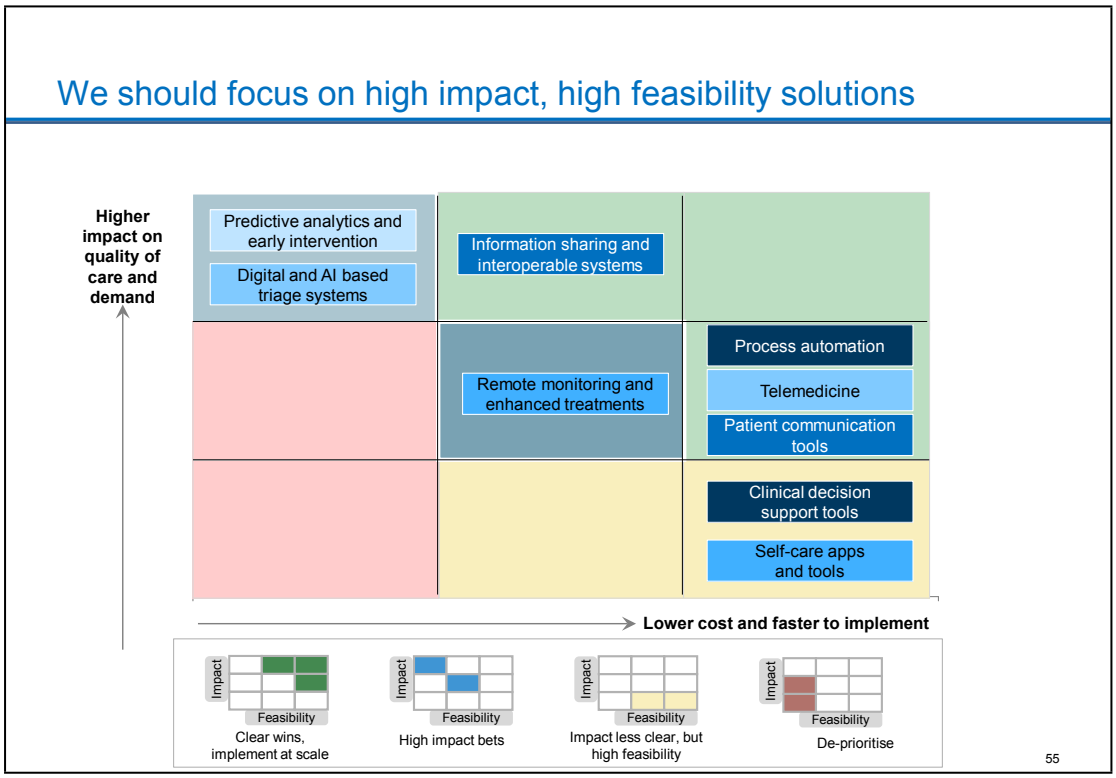
Segmenting in this way helps to break the solutions down into more manageable categories, and should also help our STP to prioritise.

We think that our approach of encouraging practices to come together to work in localities will help address the issue of fragmentation. We are developing a diagnostic tool for localities so they can assess where their strengths and weaknesses lie, with the intention that this then results in a development plan. One aspect of this tool is considering digital solutions, so that in future we hope to see whole localities agreeing a clear approach to rolling out the digital solutions that will best meet their needs.

The final issue – capacity and capability – has been recognised across the STP. As the five CCGs within our footprint increasingly share management capacity, addressing this deficiency will be a priority.

Approach to decision making and implementation

In order to help prioritise possible digital solutions that could support practices, localities and our STP, we have developed an approach to determining which areas to focus on. This considers both the potential impact of the technology on quality of care and demand, and the cost and likely speed of implementation:



We know we need to think 'digital first' as we implement this strategy. Our priorities to help ensure this happens are:

- Build appropriate capacity and capability within the STP to support localities and practices
- Work with existing and emerging localities to develop and agree a digital roll out plan
- Complete a prioritisation exercise to identify solutions which, in agreement with localities, could be developed STP wide
- Set aside investment to support the roll out of digital technologies (set out in the Finance Chapter).

6. ESTATES

About this section

This section highlights the importance of improving and developing the quality of the estate in primary care. It sets out the current position, details the proposed capital 'pipelines' that have been developed by each CCG to support delivery of this strategy and highlights the areas in which our STP will need support if we are to accelerate progress.

Our existing primary care estate

Having modern, fit for purpose buildings is a central part of our vision for the future of primary care. As a starting point, all practices need to be able to provide services in premises that are accessible, attractive and of high quality. But to fully deliver our new model of care we need to go further, by developing physical or virtual hubs that support locality working, provide accommodation for the additional staff we plan to recruit and enabling services to be integrated and - where possible - co-located.

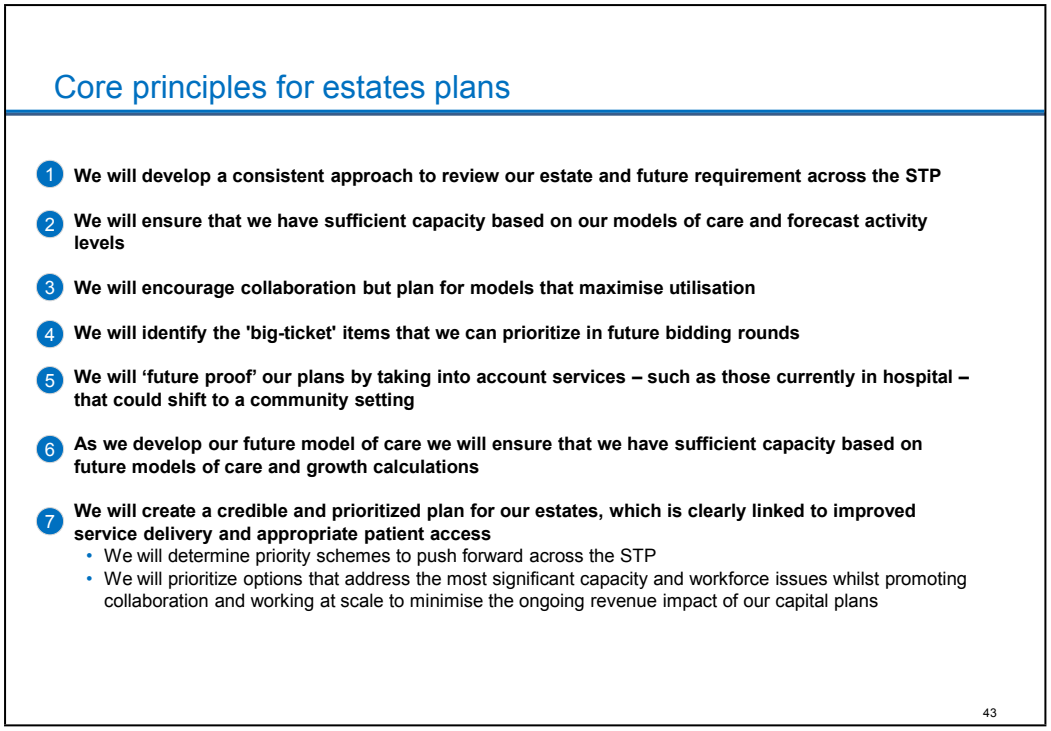
Our starting point is some way from this vision. Our existing primary care estate is below current benchmarks for our region:

- Although at present services are currently provided from 220 premises across the STP with a total internal area of almost approximately 62,000 square metres, we estimate that we have a current space deficit of over 21,000 square metres
- We estimate that population growth, shifting demography and the development of new models of care may require up to an additional 14,000 square metres
- A number of premises are well below the standards expected of a health care facility
- Current utilisation of buildings is poorly understood, but is highly variable across the STP

Although CCGs already have plans in place to address many of these issues, in developing this strategy we have refined our approach and developed more detail on the developments that are being planned in each CCG.

Principles for estates development

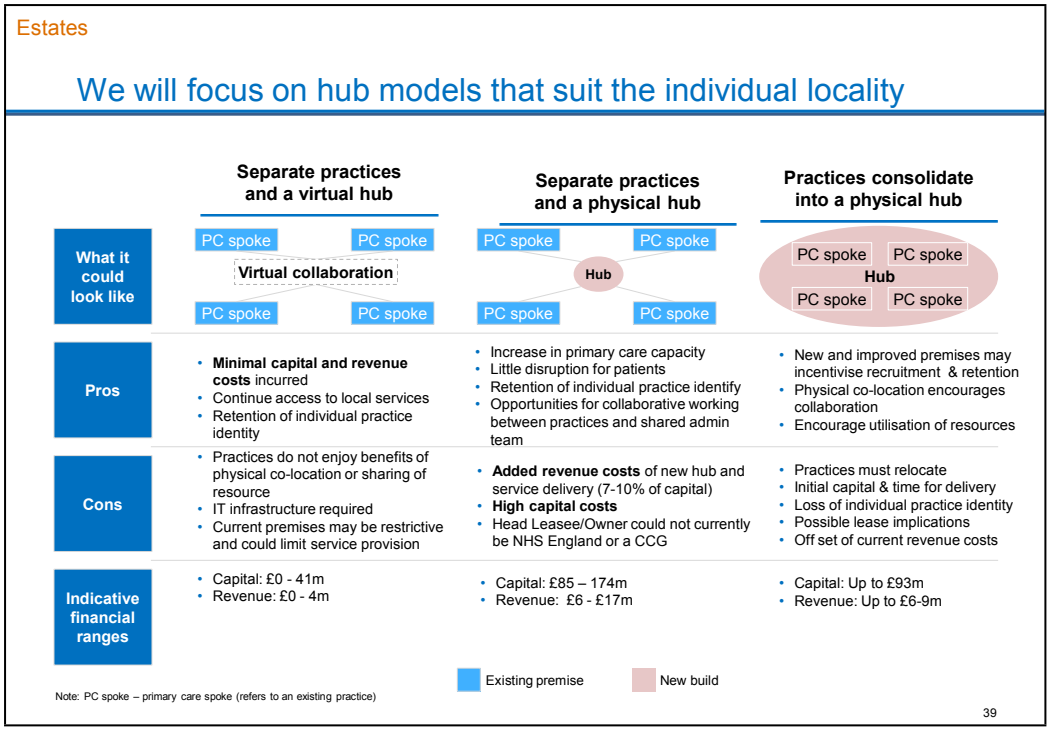
In developing our work on estates, we discussed and agreed a set of high level principles that we have used to guide our work:



Our approach to developing hubs

As set out in our new model of care, in future we want practices to work together and from localities. Over time, we anticipate that a wide range of services will 'wrap around' or integrate with these localities, including community nursing, social care and voluntary organisations. We have agreed that we will prioritise estates solutions that directly support delivery of this vision.

However, at the same time we recognise that building a physical hub potentially housing several practices and a wide range of other services is not practical in all areas, particularly in the more rural parts of our footprint. As a result, we have developed a broad model that is flexible, and is able to support the development of hubs at three different levels:



In some instances, geography will determine that we will need to establish a virtual hub, with distinct practice premises remaining but with significantly improved facilities and an upgraded IT infrastructure to enable joint working. In other cases, the best solution may be to retain separate practice premises but supplement these with a single hub (which could be an existing building that is repurposed or a new build) to form the base for the wider team and for the delivery of a broader range of services. Finally, in some areas it will be possible to establish a physical hub, bringing together two or more practices and a wider range of services into either a new or existing building. A number of our CCGs have plans to develop this type of hub.

Our development 'pipeline'

As part of our work on estates, each of the five CCGs in our footprint has been reviewing its approach to potential future capital development, and has established a draft development pipeline. At an aggregate level, the total capital cost of the entire programme (spread over the next 12 years) is £242m, with the peak years profiled to be 2019/20 – 2022/23:

CCG	Scheme	Value £m Total Capital	Profile Dates - Capital Spend 2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	Future
Scheme Summary:														
Mid Essex	CCG led primary care and LHC developments	68.24	1.80	20.74	11.34	3.99	6.00	0.00	0.00	0.00	1.17	2.33	9.17	1.83
B&B	CCG led primary care and LHC developments	28.65	0.45	9.34	9.52	2.01	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Thurrock	CCG led primary care and LHC developments	48.54	7.31	16.59	11.19	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Southend	CCG led primary care and LHC developments	48.40	1.60	3.05	12.93	14.52	5.70	5.40	3.20	0.00	0.00	0.00	0.00	0.00
CPR	CCG led primary care and LHC developments	49.13	1.60	2.00	19.03	15.82	3.80	4.38	1.87	0.00	0.00	0.00	0.00	0.00
		242.95	**12.76**	**51.73**	**64.02**	**36.33**	**15.50**	**9.78**	**5.07**	**0.00**	**1.17**	**2.33**	**9.17**	**1.83**

The tables that follow set out the latest position in each CCG, including the estimated capital cost and which year it is likely to fall in, the estimated on-going revenue consequences and an assessment of progress to date in identifying the source of capital, developing a business case and identifying the development (note the practice names have ben removed).

Mid Essex CCG

Scheme	Scheme Capital £m	Annual Revenue Cost £m	TBC £m	2018/19 £m	2019/20 £m	2020/21 £m	2021/22 £m	Future £m	Source of Capital Identified	Progress with Business Case	Development Costs Identified
Community Hospital	10.60	0.74	0.00	0.00	8.48	2.12	0.00	0.00	R	A	G
Health Hub	7.90	0.55	0.00	0.00	0.99	5.93	0.99	0.00	A	A	G
GP Practice	5.50	0.55	0.00	0.00	0.00	0.00	1.83	3.67	R	R	R
GP Practice	5.50	0.39	0.00	0.00	0.00	0.00	0.00	5.50	R	R	R
GP Practice	5.50	0.39	0.00	0.00	0.00	0.00	0.00	5.50	R	R	R
GP Practice Hub	5.00	0.50	5.00	0.00	0.00	0.00	0.00	0.00	R	R	R
GP Practice	5.00	0.50	0.00	0.00	4.00	1.00	0.00	0.00	R	R	R
GP Practice	3.50	0.35	0.00	0.00	2.57	0.93	0.00	0.00	R	A	R
GP Practice	3.50	0.25	0.00	0.00	0.00	0.00	1.17	2.33	R	R	R
GP Practice	3.50	0.25	0.00	0.00	0.00	0.00	0.00	3.50	R	R	R
GP Practice	3.00	0.11	3.00	0.00	0.00	0.00	0.00	0.00	R	R	R
GP Practice	2.10	0.21	0.00	1.40	0.70	0.00	0.00	0.00	A	R	R
GP Practice	2.00	0.07	0.00	0.40	1.60	0.00	0.00	0.00	A	R	R
GP Practice	2.00	0.20	0.00	0.00	1.33	0.67	0.00	0.00	A	R	R
GP Practice	1.00	0.04	1.00	0.00	0.00	0.00	0.00	0.00	A	R	R
Other schemes (Capital <£1m)	2.64	0.14	0.86	0.00	1.08	0.70	0.00	0.00			
Total	**68.24**	**5.21**	**9.86**	**1.80**	**20.74**	**11.34**	**3.99**	**20.50**			

Basildon & Brentwood CCG

Scheme	Scheme Capital £m	Annual Revenue Cost £m	TBC £m	2018/19 £m	2019/20 £m	2020/21 £m	2021/22 £m	Future £m	Source of Capital Identified	Progress with Business Case	Development Costs Identified
GP Practice	5.00	0.18	5.00	0.00	0.00	0.00	0.00	0.00	R	R	R
Health Centre	5.00	0.50	0.00	0.00	0.00	3.89	1.11	0.00	R	R	R
GP Practice	4.75	0.48	0.00	0.32	3.80	0.63	0.00	0.00	A	A	G
GP Practice	4.50	0.45	0.00	0.00	3.60	0.90	0.00	0.00	A	R	G
Health Centre	4.50	0.32	0.00	0.00	0.00	3.60	0.90	0.00	A	R	R
Community Hospital	2.00	0.20	2.00	0.00	0.00	0.00	0.00	0.00	R	R	R
GP Practice	2.00	0.20	0.00	0.13	1.60	0.27	0.00	0.00	R	A	G
Other schemes (Capital <£1m)	0.90	0.01	0.32	0.00	0.34	0.24	0.00	0.00			
Total	**28.65**	**2.32**	**7.32**	**0.45**	**9.34**	**9.52**	**2.01**	**0.00**			

Thurrock CCG

Scheme	Scheme Capital £m	Annual Revenue Cost £m	TBC £m	2018/19 £m	2019/20 £m	2020/21 £m	2021/22 £m	Future £m	Source of Capital Identified	Progress with Business Case	Development Costs Identified
Healthy Living Centre	12.00	0.42	0.00	6.40	5.60	0.00	0.00	0.00	G	G	G
Healthy Living Centre	15.00	1.05	0.00	0.00	6.00	9.00	0.00	0.00	A	A	G
Healthy Living Centre	15.00	1.50	0.00	0.00	7.00	8.00	0.00	0.00	A	A	G
Community Hospital	5.00	0.50	5.00	0.00	0.00	0.00	0.00	0.00	A	R	R
Health Centre	4.80	0.34	4.80	0.00	0.00	0.00	0.00	0.00	R	R	R
Health Centre	3.66	0.13	3.66	0.00	0.00	0.00	0.00	0.00	R	R	R
Community Hospital	2.00	0.07	0.00	0.13	1.60	0.27	0.00	0.00	A	A	G
Other schemes (Capital <£1m)	2.28	0.05	0.00	0.77	1.34	0.17	0.00	0.00			
Total	**59.74**	**4.05**	**13.46**	**7.31**	**21.54**	**17.44**	**0.00**	**0.00**			

Southend CCG

Scheme	Scheme Capital £m	Annual Revenue Cost £m	TBC £m	2018/19 £m	2019/20 £m	2020/21 £m	2021/22 £m	Future £m	Source of Capital Identified	Progress with Business Case	Development Costs Identified
Integrated Care Hub	10.00	1.00	0.00	0.00	0.00	4.00	6.00	0.00	R	R	R
Primary Care Spoke	4.00	0.40	0.00	0.00	0.00	0.00	0.00	4.00	R	R	R
Primary Care Spoke	4.00	0.28	0.00	0.00	0.00	0.50	3.00	0.50	R	R	R
Primary Care Spoke	4.00	0.40	0.00	0.00	0.00	0.00	0.00	4.00	R	R	R
Primary Care Spoke	3.00	0.21	0.00	0.00	1.40	1.60	0.00	0.00	R	R	R
Primary Care Spoke	3.00	0.30	0.00	0.00	0.00	0.00	1.80	1.20	R	R	R
Integrated Care Hub	3.00	0.30	0.00	0.00	0.00	0.00	0.00	3.00	R	R	R
Integrated Care Hub	3.00	0.30	0.00	0.00	0.20	2.40	0.40	0.00	R	R	R
New Integrated administrative Hub	2.50	0.09	0.00	0.00	1.00	1.50	0.00	0.00	R	R	R
Primary Care Spoke	2.00	0.07	0.00	0.00	0.25	1.50	0.25	0.00	R	R	R
Primary Care Spoke	2.00	0.00	0.00	0.00	0.00	0.00	1.20	0.80	R	R	R
Integrated Care Hub	2.00	0.20	0.00	0.00	0.00	1.33	0.67	0.00	R	R	R
Primary Care Spoke	2.00	0.20	0.00	0.00	0.00	0.00	1.20	0.80	R	R	R
Primary Care Spoke	1.50	0.00	0.00	1.50	0.00	0.00	0.00	0.00	G	A	R
Other schemes (Capital <£1m)	2.40	0.07	2.00	0.10	0.20	0.10	0.00	0.00			
Total	**48.40**	**3.82**	**2.00**	**1.60**	**3.05**	**12.93**	**14.52**	**14.30**			

Castle Point & Rochford CCG

Scheme	Scheme Capital £m	Annual Revenue Cost £m	TBC £m	2018/19 £m	2019/20 £m	2020/21 £m	2021/22 £m	Future £m	Source of Capital Identified	Progress with Business Case	Development Costs Identified
Integrated Care Hub	8.00	0.80	0.00	0.00	0.00	3.20	4.80	0.00	R	R	R
Integrated Care Hub	8.00	0.80	0.00	0.00	0.00	3.20	4.80	0.00	R	A	G
Integrated Care Hub	6.00	0.60	0.00	0.00	0.00	4.80	1.20	0.00	R	R	R
Primary Care Spoke	5.00	0.50	0.00	0.00	0.00	3.00	2.00	0.00	R	R	R
Primary Care Spoke	4.00	0.40	0.00	0.00	0.00	0.00	0.75	3.25	R	R	R
Health Centre	3.00	0.30	0.00	0.00	0.60	2.40	0.00	0.00	R	R	R
Primary Care Spoke	2.00	0.20	0.00	0.00	0.00	0.00	0.00	2.00	R	R	R
Primary Care Spoke	2.00	0.20	0.00	0.00	0.00	0.93	1.07	0.00	R	R	R
Primary Care Spoke	2.00	0.20	0.00	0.00	0.00	0.00	1.20	0.80	R	R	R
Primary Care Spoke	2.00	0.20	0.00	0.00	0.00	0.00	0.00	2.00	R	R	R
Primary Care Spoke	2.00	0.20	0.00	0.00	0.00	0.00	0.00	2.00	R	R	R
Health Centre	2.00	0.00	0.00	1.60	0.40	0.00	0.00	0.00	A	A	R
New Integrated administrative Hub	1.50	0.05	0.00	0.00	0.60	0.90	0.00	0.00	R	R	R
New Integrated administrative Hub	1.00	0.04	0.00	0.00	0.40	0.60	0.00	0.00	R	R	R
Other schemes (Capital <£1m)	0.63	0.00	0.63	0.00	0.00	0.00	0.00	0.00			
Total	**49.13**	**4.49**	**0.63**	**1.60**	**2.00**	**19.03**	**15.82**	**10.05**			

Accelerating progress - support required

We know that the pipeline outlined above is ambitious, and recognise that our STP will require support from NHSE, as well as system partners, to deliver it.

Capital

The majority of the schemes that are well developed do not rely on accessing additional public sector capital over and above existing ITTF funds, as there are a range of other sources of funding available for these developments, including:

- Councils (for example Thurrock Council investing in Integrated Medical Centres)
- Third Party Developments
- Section 106 funding
- Development grants

However, it is possible that there may be an increased demand for public sector capital in the outer years of the programme, as a number of the these proposals included in the CCG schedules do not yet have a confirmed source of capital.

Capacity and cost of development

A significant barrier to accelerating progress with the delivery of our capital programme is a lack of expertise in the local footprint to develop the business cases to the required level of detail, and the limited access to non-recurrent funding to commission expert support, such as the completion of feasibility studies. We are however making progress in this area, with the establishment of a senior post to focus on estates across our STP.

These twin issues are clearly challenges for most STPs; we plan to discuss possible solutions – such as devolving capacity currently held in NHSE or a more innovative approach to the use of ETTF funding – with partners in the system.

Meeting recurrent costs

Perhaps the biggest single barrier to implementing the estates solutions outlined above is a lack of revenue to support each scheme's on-going costs. Although the exact cost varies scheme by scheme – and in some cases can be offset by other savings – we estimate that the average revenue cost of is circa 8% of the capital cost. Although the revenue consequences do not feed through to CCGs for some time, meeting these costs is clearly a concern and acts as a brake on the delivery of the capital programme.

In the following section (finance) we have included an estimate that up to £8m of additional revenue will be required to support the costs of the major schemes identified by the CCGs. However, if the *entire* capital pipeline were to be delivered, the revenue consequences would likely exceed this sum.

STP estate strategy and workbook – next steps

All STPs are required to prepare and submit to NHSE a comprehensive estate strategy (covering the entire estate, not just primary care) by July 2018. We will be building on the work completed as part of preparing this strategy to review the overall capital pipeline for primary care and complete further prioritisation of proposals, drawing on the principles set out above. We anticipate that this work will be co-ordinated by the primary care estates group that we plan to establish (see Implementation section, below), and in liaison with local partners such as councils.

7. FINANCE

About this section

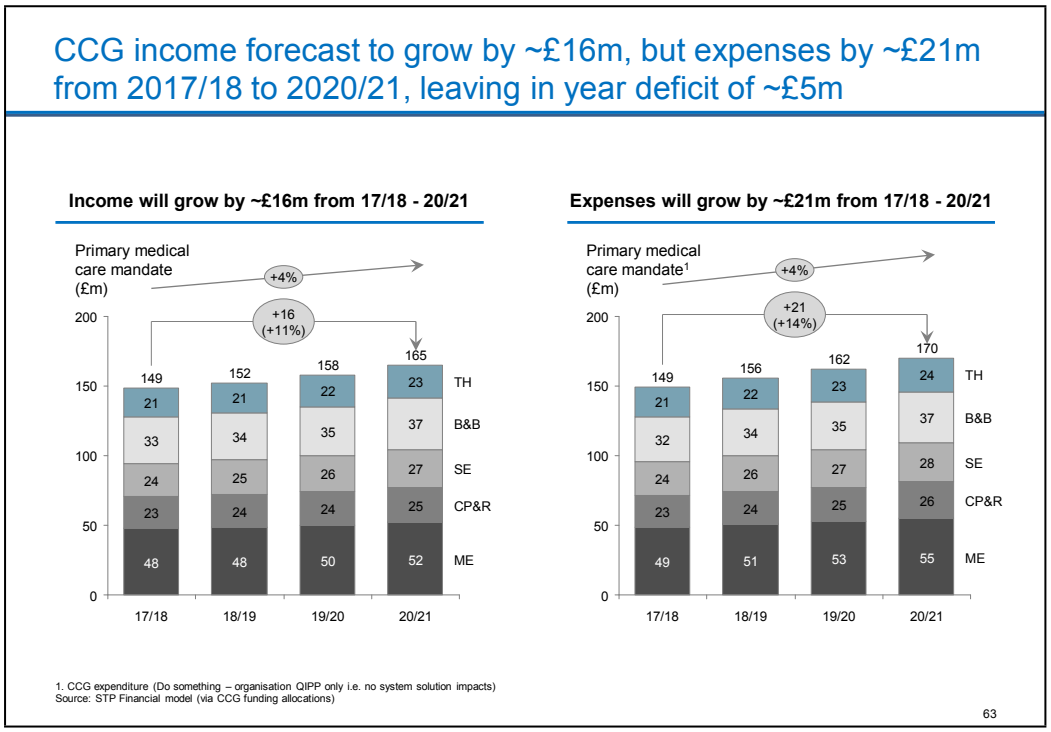
In this section, we set out how much we estimate implementing our new model of care is likely to cost, and identify how we might be able fund the increased expenditure on workforce, estates and other enablers. Although we can see a path to a balanced financial position, there are a range of risks; mitigating these will need CCG Boards to take some difficult decisions about priorities as well as the support of NHS England.

Current and planned levels of expenditure

At present across the STP we invest approximately £149m in core general practice services. As we have a mixed commissioning landscape, these budgets are split across the five CCGs and NHS England. Based on likely increases to funding that have been announced nationally, we anticipate that this total budget will increase by approximately £16m to £165m in 2020/21.

In developing this strategy, we have used national growth assumptions to estimate how much the cost of our existing model is likely to increase during this same period (2017/18 to 2020/21); our modelling suggests that costs will go up by approximately £21m to £170m.

Taking the anticipated increases in funding and expenditure together, it can be seen that by 2020/21 there is likely to be a 'do nothing' deficit of approximately £5m in these core services.



Costs of new model of care

However, as set out in the case for change, we know that we cannot continue with the same model of care, and we have worked with a wide range of practices and other stakeholders to design a new approach. Once the broad outline of the model had been developed, we were then able to estimate its likely cost.

We believe that the additional costs associated with the new model fall into three main areas:

- Workforce – the cost of the additional staff that the system is likely to require in order to close the capacity gap set out in the case for change
- Estates – the additional *recurrent* costs associated with building new or refurbishing existing premises, with a focus on those developments that will make the most significant contribution to delivering this strategy (set out in detail in the previous section)
- Other key enablers – focusing in particular on the likely cost of digital solutions and the change management capacity that may be required

Workforce

In our new model of care, we move from a principally GP delivered service to one that is GP led, supported by a much wider range of clinical and other disciplines than is presently the case. Based on a range of discussions, we have estimated how many additional staff we would require (over the 2017/18 baseline) across the key staff groups. We have then been able to estimate the additional cost of these staff.

At this point this is a 'top down' analysis and will change as CCGs and localities develop detailed plans. It can be seen from the below that if half of our practices have introduced the new model by 2020/21, then this will cost an additional £22m over the current baseline.

Based on the model chosen, the future model workforce could have recurring costs of between £16–£22M

Preliminary

Skill mix	Baseline *(2017/18)*	Est. cost per FTE (£K)	Flat GPs and mixed skilled workforce (2020/21) FTE Δ to baseline	Flat GPs and mixed skilled workforce (2020/21) Additional cost (£M)	Current GPFV targets (2020/21) FTE Δ to baseline	Current GPFV targets (2020/21) Additional cost (£M)	Essex draft strategy (2020/21)[1] FTE Δ to baseline	Essex draft strategy (2020/21)[1] Additional cost (£M)
GP	562	101	-	-	120	12.2	120	12.2
Clinical practitioner	256	48	142	6.9	84	4.1	69	3.4
Physical	0	48	84	4.1	17	0.8	42	2.0
Mental	0	48	40	1.9	0	0.0	20	1.0
Social	0	48	24	1.2	0	0.0	12	0.6
HCA	77	27	29	0.8	29	0.8	29	0.8
Other DPC	63	27	13	0.3	13	0.3	13	0.3
Admin	990	23	26	0.6	26	0.6	87[2]	2.0
Total	**1.9k**		**0.4k**	**16**	**0.3k**	**19**	**0.4k**	**22**

Suggested mapping of roles to skill mix

- Social —Social prescribing; VS support; Social worker
- Clinical practitioner— ANP, Practice nurse; Physician Associate; ECP; Pharmacist
- Mental —MH Therapist; CPN
- Physical — Physio

1. Based on 50% of practices moving to the proposed locality workforce model 2. Assume uptake of 0.5 GP Assistant FTE per practice; GP cost—2015/16 GPMS income; £48k for AFC 7 and 24% uplift to FLC; HCA and other DPC—AFC4 and 24% uplift; Admin—AFC3 and 24% uplift
Source: M&SE NHSE submission; Agenda for Change Pay Scales; Sep-17 MDS and Mar-17 MDS (corrected by CCG leads – based on individual practice submissions)

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Estates

As set out in the previous section, to implement the new model of care we have assumed we will need to invest in premises, in particular to enable the working at scale which is at the heart of our strategy.

As part of our work we have developed a detailed general practice capital 'pipeline' at CCG level. We have estimated that if every scheme in this multi-year pipeline were to be delivered, the total capital cost would be in excess of £240m, although we anticipate this will fall markedly as we prioritise developments. There are a number of options open to CCGs in order to raise the capital required, including third party developments, collaboration with partners – especially local authorities - and public sector capital.

In order to create a sustainable recurrent financial strategy, we have focused on the ongoing costs of increased capital investment. At this point it is difficult to be certain about the exact costs (as this depends on the a range of factors, including how much of each CCGs pipeline in progressed, who owns and runs any new buildings, the cost of facilities that are being replaced etc.), but we have assumed that we will want to develop a number of hubs and other improvements over the coming years, and estimate that the direct additional recurrent estates costs will be between £3m and £9m.

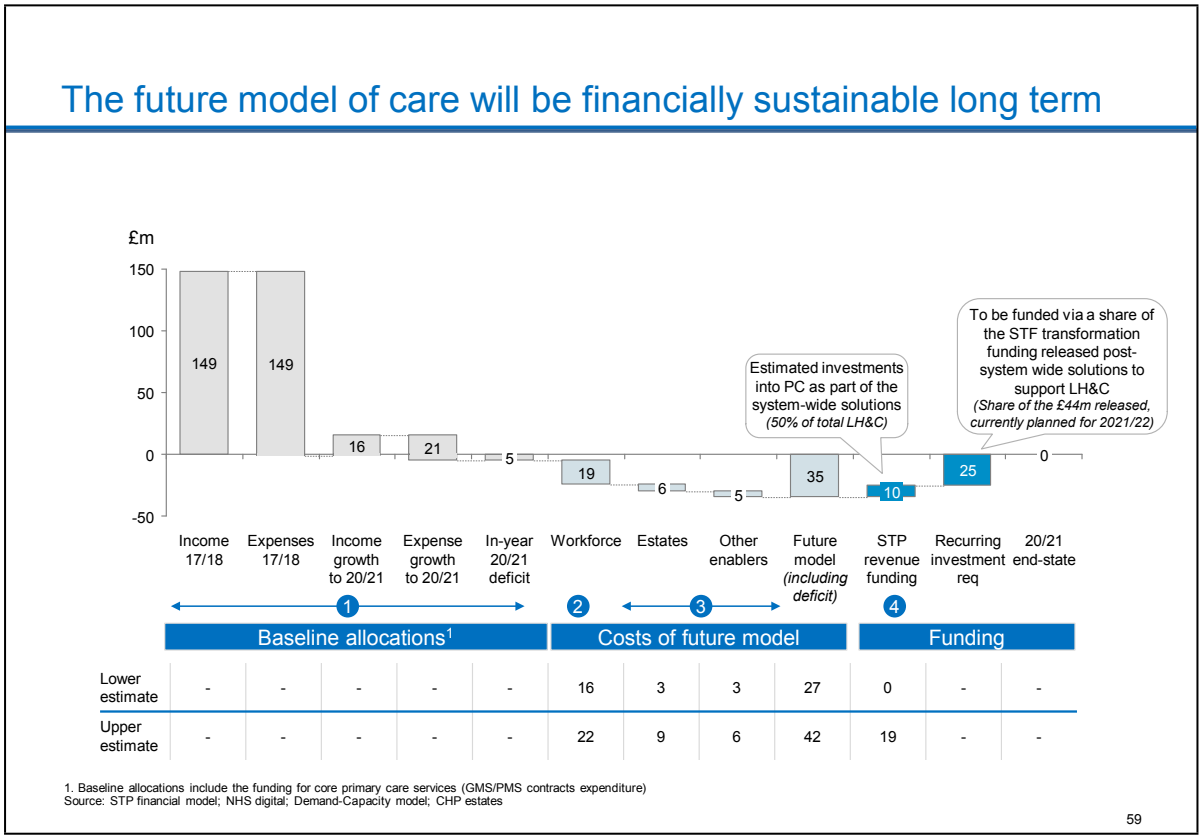
Other enablers

To fully implement this strategy, we think we will need to invest in a small number of other enablers, in particular digital solutions and change management capacity. At this point we do not have detailed plans across each of the five CCGs, but a 'top down' assessment suggest that we will need to invest between approximately £3m and £6m to support the introduction of these key enablers.

Category	Potential schemes	Recurring costs (£m)	Comments
Other enablers	Population health and data analytics support	£0.3 - £0.6m	• Lower – Assume 1 FTE per CCG at £50k FLC • Upper – Assume 2 FTE per CCG at £50k
	Technology enablers	£2 – 4m	• Lower – Assume ongoing cost of ~£2m (as planned for 2018/19 GPIT spend) • Upper – Assume twice '18/19 spend for provision of additional digital services
	Management resource to engage GPs	£0.6 – 1.6m	• Lower – assume 0.5 FTE per locality at £50k FLC • Upper – assume 1 FTE per locality at £65k FLC
	Total	**£2.9 – £6.2m**	

Overall financial position

We have combined our estimates of current and planned increases in expenditure and the anticipated cost of introducing our new model of care so that there is a clear overview:



Section 1 (the first five bars) shows that after taking into account anticipated growth in income and expenditure over the period 2020/21, there is a likely deficit of approximately £5m if we continue to provide these services with no major changes to the delivery model. Sections two and three (the next four bars) show the anticipated additional cost of introducing the new model, which is approximately £30m by 2020/21. Taken together, this suggests an overall deficit position after

moving to our new model of care of £35m by 2020/21. The final section (4 – the three bars on the right) set out how this financial gap could be closed; this is outlined below.

We have broken down the STP financial bridge into each CCG in order to understand the local position. These are included in the detailed annex to this strategy.

Funding our new model of care

There are three main elements to our plan to close the financial gap identified above and ensure we have a financially sustainable system. However, it is important to emphasise that there are risks associated with each element; addressing these will require CCG Boards to make some difficult decisions about priorities, and will also require the support of NHSE (see below).

Firstly, all CCGs have in 2017/18 and 2018/19 invested additional resources in primary care over and above core GMS and PMS, in particular to support extended access. Although some of these funds are non-recurrent, we anticipate similar levels of funding to be future years so should be available for investment in primary care. We have estimated this will be £9m a year across the STP. We believe the risk of these funds not being available for investment is relatively low, and CCGs laregely control where they are invested.

Secondly, we know from national planning guidance that our STP is scheduled to receive an additional £78m in Sustainability and Transformation Funds (STF) in 2020/21. These are funds that are currently top sliced nationally by NHS England to pay for a range of programmes such as the Vanguard initiative.

These funds are not earmarked specifically for primary care and there will be competing demands for investment. Therefore, in order to be prudent we have assumed that approximately £16m is available to support this strategy, which is consistent with national estimates on the likely cost of implementing the *GP Forward View*. We believe that this level of funding is likely to be made available and within the control of CCGs, but recognise that there is a significant risk that they will be required to address other pressures (e.g. overspends in hospitals or funding new national imperatives).

Taken together, we have assumed that these two elements (other CCG funds of £9m and STF funding of £16m) provide an additional £25m to support the implementation of this strategy.

Thirdly, we have identified that an additional £10m may be available by 2020/21 as a result of wider changes to the way in which services are delivered. In our STP's overall plan, we agreed a model that would see some services (principally outpatients) that are traditionally provided in hospital move into a community setting, allowing our acute providers to concentrate on services which can only be delivered in a hospital setting. The funding released from providing these services in a community setting enables us to both pay for those new services and also invest a proportion into our core community and primary care services. We have estimated the element for investment into primary care services will be circa £10m.

However, we know that this element of funding is the riskiest: experience tells us that releasing real savings from the hospital sector for investment in the community is far from straightforward.

Support required from NHSE to deliver this strategy

Although we have developed a financial strategy that indicates our new model of care is affordable, we know there are significant risks to this plan. These risks, together with the support that we think we need from NHSE to mitigate them, are set out below:

Funding source	**Approx. amount (20/21)**	**Level of risk**	**Support required**
CCG baseline funding (in addition to core PMS/GMS)	£9m	**Low** – funds are largely either included in CCG baselines or available via bidding process	CCGs supported to 'ring fence' current expenditure on primary care CCGs encouraged to increase primary care spending from within allocations (e.g. an element of 0.5% investment fund) Allocations that are currently made following bidding processes moved to CCG baselines, to maximise local flexibility
Additional STF allocation	£16m	**Medium** – the amounts to be allocated to our STP in 2020/21 are clear, but there is a risk that these are either ring fenced or tied to delivering additional requirements	Full STF allocation made without any ring fencing of funds or tied to the delivery of new or additional commitments
Funding released from re-provision of acute services	£10m	**High** – if acute demand exceeds our wider STP plan, or if services are not successfully re-provided in an out of hospital setting, these funds will not be available	Explore other funding options with CCGs, such as repayment of historic debt, prioritising primary care for investment of any additional growth received, development of STP investment pool

8. COMMUNICATIONS AND ENGAGEMENT

About this section

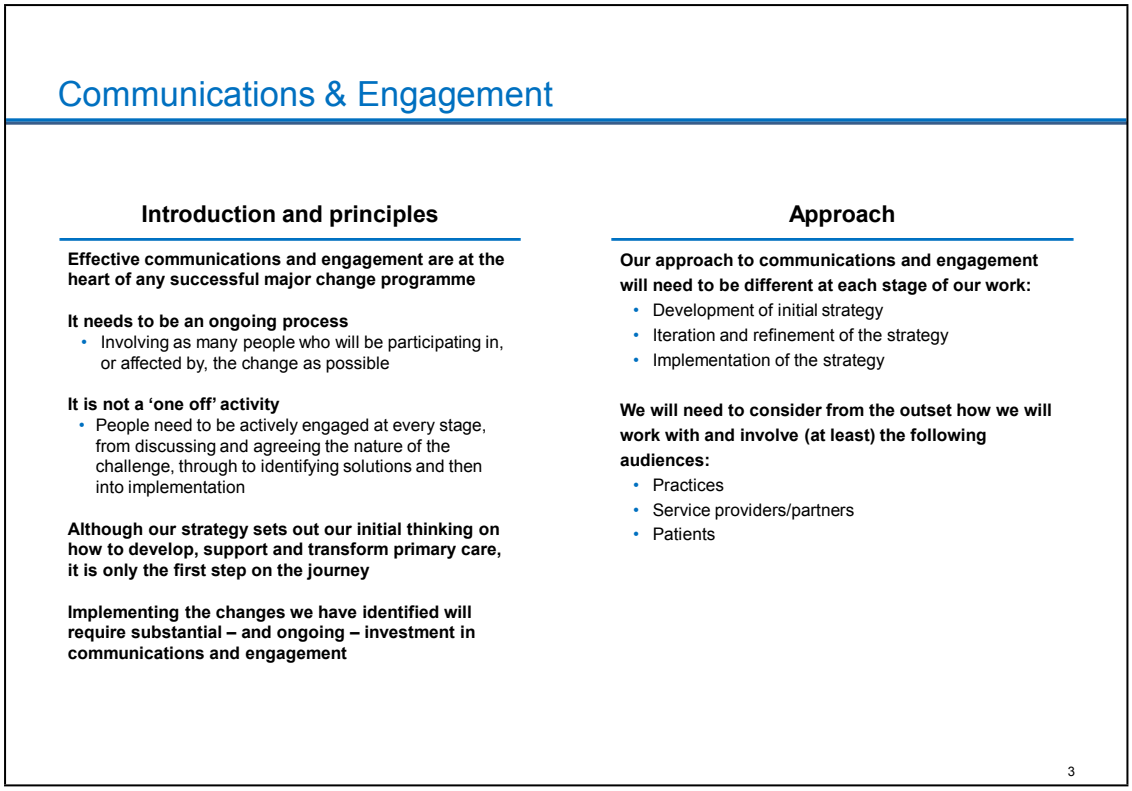
This section sets out the work we have already done to engage local practices and other partners in agreeing the case for change and developing the solutions proposed in this strategy. It then outlines how we plan to build on this by continuing to work closely with patients, practices and partners as we finalise our strategy and, crucially, move into implementation.

Context

Effective communications and engagement are at the heart of any successful major change programme. It is not a 'one off' activity – people need to be actively engaged at every stage, from discussing and agreeing the nature of the challenge, through to identifying solutions and into implementation.

Although this document sets out our initial thinking on how to develop, support and transform primary care, it is only the first step on our journey. Designing the detail of and then implementing the changes we have identified will require substantial – and ongoing – investment in communications and engagement.

The principles and broad approach we agreed in developing this strategy are set out below:



Phases

Our broad approach has been to divide our communication and engagement work into three main phases, and our approach is necessarily different at each stage as more and more people are affected by implementing our new model of care. The main phases are:

- *Development* of initial strategy
- Iteration and *refinement* of the strategy
- *Implementation* of the strategy

Audiences

General practice sits at the centre of our health and care system. As a result, because we are seeking to work with practice to make changes to the way it operates, we need to engage not just with practices and their patients but also with the very wide range of other services and partners that they interact with. In fact, many of the opportunities or solutions we have identified in this strategy are entirely dependent on other organisations changing what they do, so their ongoing involvement is vital.

In applying our three phase approach, we have identified three main audiences to focus on in our communications and engagement:

- Practices
- Service providers and system partners
- Patients

Engaging with Practices

Effective engagement with practices has been our top priority during the first phase of our work; without practice level buy in, little will change and this strategy will not be delivered. We have worked hard to engage practices in the first phase of developing this strategy, and want to build on this as we move into refinement and implementation:

Phase	Objective	Activity	Status
1 - Strategy development	Raise awareness of programme and its objectives	Updates on progress and emerging thinking to CCG Joint Committee	Complete
	Raise awareness of programme and its objectives	Presentations to and discussions with practice 'Time to Learn' events at each CCG	Complete
	Discuss and agree main solutions to be developed	Discussion at each CCG Clinical Executive (or equivalent)	Complete
	Discuss and agree main solutions to be developed	Presentation to and discussion with CCG senior management team	Complete
	Discuss and agree main solutions to be developed	Meetings with CCG Chairs	Complete
2 - Refinement of strategy	Discussion of draft strategy	Meeting with Joint Committee of the CCGs	April
	To share draft strategy, gather feedback and update/finalise plan	Discussion at each CCG Clinical Executive Presentations to and discussions with practice Time to Learn events	Apr/May
3 - Implementation	To finalise approach to implementation	Discussions at each CCG Governing body, including final sign off of the strategy and local implementation plan	May/June
	To share/review progress with implementing agreed priorities and spread learning across the system	CCG executives/Governing Bodies Updates to Practice Time to Learn events in each CCG	Ongoing feedback

Providers and system partners

Successful implementation of this strategy will necessitate some changes to the way our partners organise and deliver services. For example, developing localities as a way of integrating services may require some staff – such as those employed by community providers – to be realigned. This will need the agreement of many organisations, making their involvement in each of the three phases vital.

Phase	Partner	Objective	Activity	When
1 - Strategy development	**Acute Trust Group**	Ensure awareness of primary care strategy at strategic level	Discussion with senior staff	Complete

	Community and MH providers	Ensure awareness of primary care strategy at strategic level	Meeting with CEOs/lead directors	Complete
	Health and Wellbeing Boards	Ensure awareness of primary care strategy at strategic level	Briefings for HWBs	Complete
	Healthwatch	Ensure awareness of primary care strategy at strategic level	Discussion with senior staff	Complete
2 – refinement of strategy	**Acute Trust Group**	Identity potential joint solutions (e.g. access to consultant expertise to practices, OP clinics in community)	Discussion with trust Medical Directors Share draft papers for comment with key staff	Apr/May
	Community and MH providers	Opportunity to gather/contribute ideas on solutions and implementation	Involvement of senior provider staff in solution design workshops/new models Share draft papers for comment with key staff	May
	Health and Wellbeing Boards	Identify implications of emerging strategy on social care/create opportunities to contribute to solution design	Involvement of senior provider staff in solution design workshops/new models Share draft papers for comment with key staff	Apr/May
	Healthwatch	Involvement in co-ordination of patient awareness	Discussions with senior officers from each of the three Healthwatch organisations	Apr/May

As we move into implementation, which will be led by the five CCGs across the STP, we anticipate that detailed local arrangements will be put in place (such as implementation or delivery boards) to ensure that all local partners are fully involved in local discussions at all stages. There are already good engagement mechanisms in place in many parts of our STP, but we envisage that delivering this STP-wide strategy will provide renewed focus an impetus.

Patients

Involving patients in the development of this strategy and, in particular, in identifying potential solutions in each locality will be important. If we fully implement our new model of care, the service patients receive from general practice will increasingly look and feel different, for example:

- There is likely to be routine triage in place when a patient contacts the practice, rather than 'automatic' access to a GP

- Patients will increasingly see a wider range of professionals at their practice rather than being directed to a GP or a nurse
- Patients may sometimes be asked to travel to a locality hub or a neighbouring practice in order to be seen

These changes will, over time, require some shifts in patient behaviour if our new model of care is to be successful. This is much more likely to happen if patients are involved in discussing solutions at every stage.

Although we will seek to co-ordinate patient engagement in the development and implementation of this strategy at an STP level, including working with partners that represent and advocate for patients such as the three Healthwatch organisations and the STP Service User Advisory Group, we think that in order to be effective most patient engagement work needs to be led locally.

This is because the broad model of care that we have set out in this strategy will look different in each place – no two CCGs or localities are the same. It is therefore vital that the conversation with patients and carers about exactly what the service model should be in a given areas is a local one.

We have strong foundations in place to progress this work. For example, all CCGs have lay members that have a particular role in advocating for patients, and many have well established patient advisory panels. Another key route for involving patients at every stage will be at practice level, through practice patient participation groups (PPGs), which are ideally positioned to discuss very local challenges and proposed solutions.

9. IMPLEMENTATION

About this section

This section sets out our thinking on how to make this strategy a reality, moving at scale and at pace. It describes an approach where each CCG leads local implementation, but in a co-ordinated way, doing things once across the STP where that makes sense. It sets out our 'offer' to practices, as well as plans to identify a first wave of localities and the support that they can expect to receive.

Overview of approach to implementation

This document is an 'umbrella' primary care strategy for our STP, building on and complementing pre-existing plans in each of the five CCGs.

In determining our approach to implementation this strategy, we have considered the best way of balancing several factors, including:

- We are not all starting from the same place – in some of our CCGs, plans to develop general practice and localities are better developed than others
- Implementation will not be at the same pace everywhere – we have been explicit with practices that implementing the new model of care is voluntary; as a consequence, it is natural that some areas will progress faster than others
- The local context is critical – we know that the challenges in each part of our patch are different and, as a result, the approach to implementation will differ also.

As a result of these factors, we have concluded that the right approach is for each CCG to lead implementation in partnership with their local practices and localities, but within a consistent STP wide framework.

Establishing a 'leading edge' of localities

We are keen to work with a small number of localities that have the capability and drive to make rapid progress. We believe that this will be the best way of generating momentum, capturing learning and acting as a wider catalyst for change in general practice.

As a first step in implementing this strategy, each of the five CCGs plans to identify practices/localities that could become a 'wave 1' locality. In order to enter the first wave, practices and localities must be able to demonstrate that they meet some essential criteria, including:

- Appropriate population coverage (size and geographically coherent)
- Credible leadership
- Commitment to ongoing development of locality
- Demonstrable practice sign up

The 'offer' to practices

We anticipate that there will be a clear incentive or 'offer' for practices to enter wave one. Although the details of the offer will vary CCG by CCG, the core elements are likely to be:

- *Reducing workload* – by accessing additional support including workforce, as well as rolling out support to more effectively triage and manage patient flow
- *Access to recurrent funding* - in order to build the locality model and the extended workforce that is required to increase capacity, as set out in our future model of care
- *Support with estate* – where required, a clear 'route map' for a locality to secure the capital required for new or redeveloped premises, including the non-recurrent revenue needed to develop the case, as well as the on-going revenue costs
- *Access to CCG management support* – depending on the locality's needs the CCG will commit to making relevant management expertise, such as change management, HR, governance or data skills, directly available to support the locality
- *Access to learning networks* – localities in wave one would have prioritised access to both local and national packages of development
- *Support to pilot innovation* – localities in wave one would be encouraged to innovate and actively supported to trail new initiatives, especially digital solutions

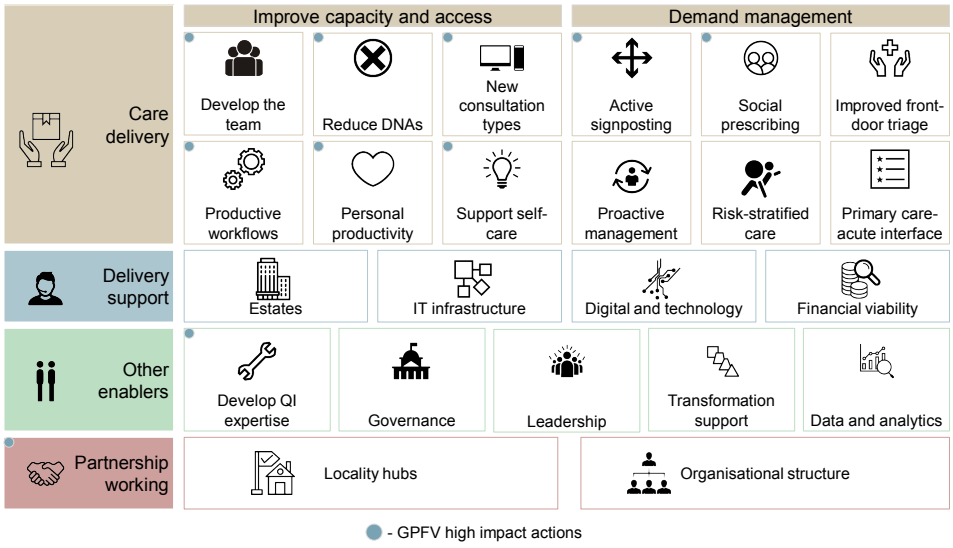
We are also exploring the potential NHSE national funding that may be available to support leading edge localities.

Locality self-assessment/diagnostic

Because the starting point and needs of each locality will be different, the first step in supporting localities will be for them to complete, in partnership with their CCG, a simple self-assessment or diagnostic tool that we have developed. This is flexible tool that is designed to structure a series of conversations to determine where a particular locality's development priorities lie. It is *not* intended to be a checklist or an assurance tool.

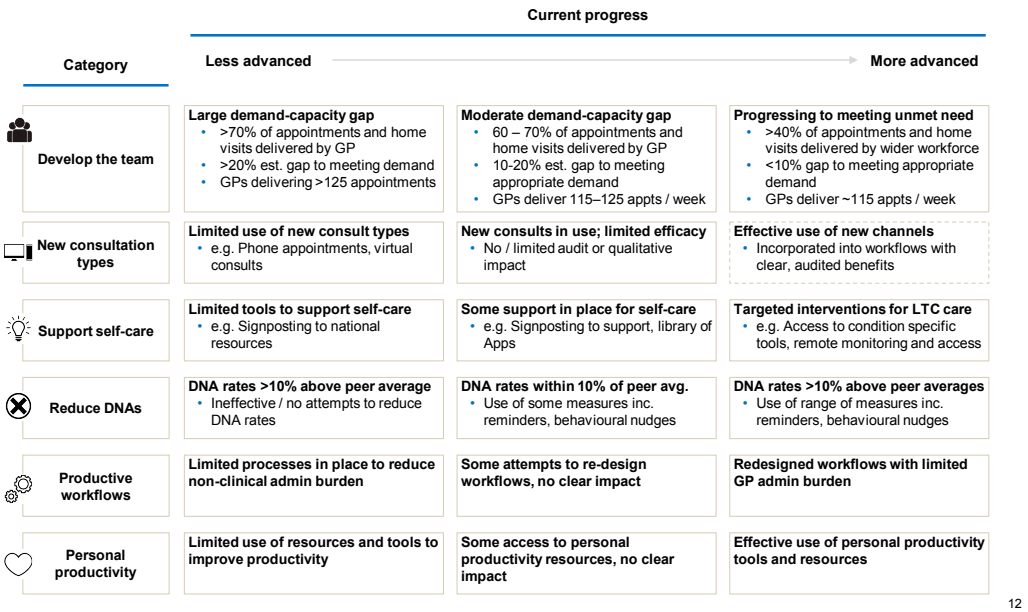
The development tool will consider a range of domains that are relevant to becoming a high performing locality, and also help localities to consider where they are now as well as where they might need to be in future:

Locality development guide: Key areas



The tool we have developed will also enable localities to assess where they lie on a spectrum of development in each of the domains, against a description of best practice:

Locality development guide: progress to date



More detail on the tool we have developed is available in the appendix to this document.

Locality development plans

The self-assessment will result in an agreed locality development plan. This plan will set out who will do what by when in order to move the locality on to the next stage of their development, and is likely to cover:

- The demand-capacity gap
- The numbers and skill mix of any additional staff required to close this gap
- Any estate or capital implications
- Approach to innovation and digital

Where appropriate, this plan would take the form of a specific commitment between the locality and the CCG, covering, for example:

- Approach to meeting costs of any expansion in the wider workforce
- Prioritisation of any capital development that is required
- Access to and funding for specific tools, such as enabling new types of consultations
- Working with local partner such as councils
- Outcome metrics that will be put in place

STP wide work streams

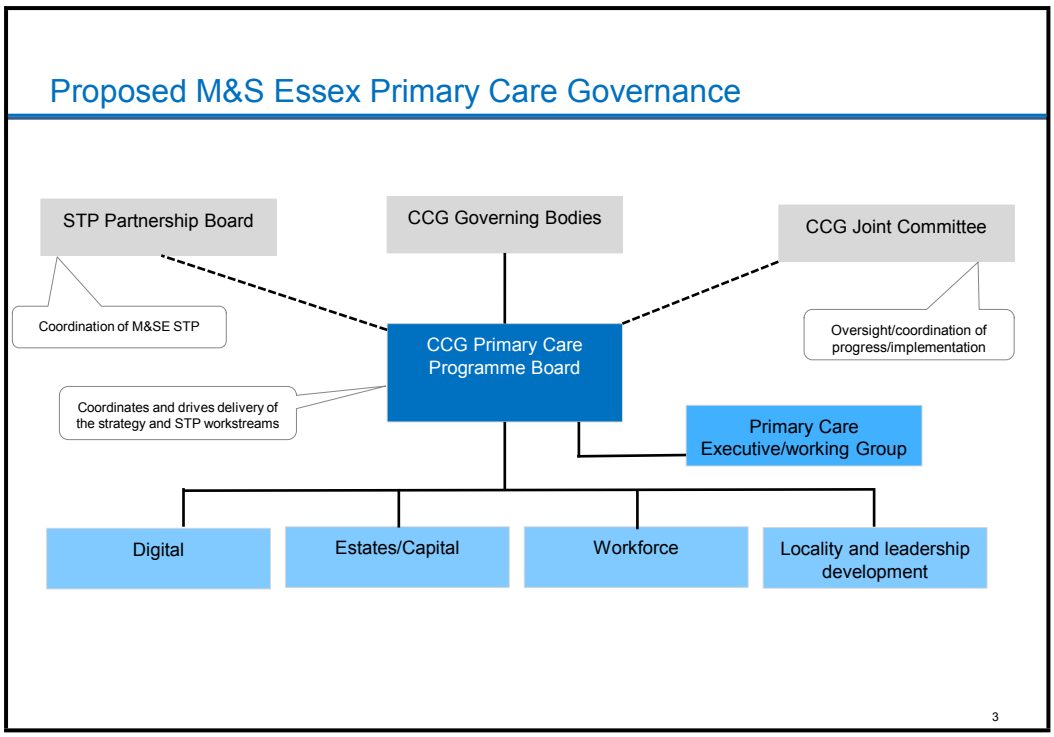
Although implementing this strategy will principally be the responsibility of the five CCGs in our footprint, we know that in some areas is will make sense to coordinate and do things once, adopting an STP wide approach. The key areas we have identified to date, and in which we will develop co-ordinated implementation plans, are:

- Digital
- Development of estates/capital
- Some aspects of workforce, such as work on defining consistent new roles and STP wide recruitment activities
- Practice/locality development offer, which could span legal advice, organisational development expertise and HR support

Governance

Work to develop our STP primary care strategy was initiated by the Joint Committee of the five CCGs. Although this Committee does not have delegated authority to take decisions on primary care, it is an invaluable co-ordinating mechanism, and will continue to act in this capacity as we move into the implementation phase.

To support implementation, we are recommending establishing an STP Primary Care Programme Board so that there is appropriate co-ordination and to ensure that pace is maintained. This Programme Board will be supported by workstreams in each of the four areas of STP wide work outlined above, and will report joint to the five CCGs and the Joint Committee:



Timetable and immediate next steps

We anticipate the key next steps to implement this strategy are:

Date	Activity
6 April 2018	Joint Committee of CCG to discuss this draft strategy and identify areas for further development
4 May 2018	Joint Committee of CCGs invited to endorse this strategy and recommend that it is considered by each CCG Governing Body
June 2018	CCG Governing Bodies invited to formally approve this strategy and its local implementation and investment plan
Late May to August	'Leading edge' localities identified by CCGs Successful localities selected and diagnostic tool completed First locality development plans agreed and signed off
6 July 2018	Joint Committee of CCGs notes that the STP Primary care strategy and local implementation/delivery plans have been agreed by all five CCGs

APPENDIX

See separate supporting document