NHS
North East Lincolnshire
Clinical Commissioning Group

NORTH EAST LINCOLNSHIRE CCG

GP FORWARD VIEW LOCAL DELIVERY PLAN

North East Lincolnshire – Delivering the GP Forward View – Transformation Plan

1. Vision

A clear narrative on the vision for and delivery of sustainable general practice that reflects the ambition set out in the General Practice Forward View

The North East Lincolnshire (NEL) locality is moving towards the delivery of local care services through an Accountable Care approach, which could ultimately encompass the provision and commissioning of all local community health and social care, along with elements of acute care that do not require delivery at a population size greater than NEL *[detailed scope yet to be agreed]*. This model will enable delivery of sustainable integrated services to the local population. Local organisations will work together under a formal legal arrangement to take accountability for providing integrated care and delivering outcomes for the local population under an outcome-based contract with the commissioner. It is recognised that general practice plays a pivotal role in the care system and will continue to do so at the centre of a more integrated health and social care system; the sustainability of general practice is therefore a high priority.

There will be a 'Place based' strategic commissioner that will structure the requirements for services (including access, quality, outcomes and finance) across different population sizes depending on the type of service, and will work jointly with other Strategic Commissioners where appropriate, for example for commissioning more highly specialised services which will need to be available at greater scale across larger population sizes.

As part of the local integrated accountable care system within NEL, general practices will work within a federated model across population sizes of around 30,000 to 50,000 (some may be larger) to provide an infrastructure for extended services which are most suited to delivery at this level, and funding for those services will be directed through these federations. General Practice extended services and other community-based health and social care services delivered at this population size will be aligned. The general practice enhanced level of service available at this population size is likely to include:

- Enhanced long term conditions management, supported by specialist resources
- Complex case management and care for the housebound
- Extended access to general practice, with evening and weekend provision delivered from designated centres for both pre-bookable and urgent appointments
- Primary care mental health provision

This infrastructure will also accommodate the shift of activity from acute to primary healthcare setting.

There will be consistency of service offered to all patients with NEL, although patients will not always be able to access all services within their own practice premises. There will be more effective use of technology to support the offer of advice and/or assessment via telephone, email and video-consultation to improve access and reduce the face to face requirement, where clinically appropriate. Further detail regarding this is set out within section 4.

To support the delivery of integrated care, we will deploy solutions for record-sharing, as set out

within our digital roadmap. The use of the enhanced summary care record is phase 1 of our shared record strategy, which will be in place by March 2017 at the latest. Information will be made available for acute, community, and mental health information through system viewers. Phase 2 of our record sharing approach will be the rollout of 'GP Connect', once this is available nationally to rollout from March 2017. Further detail regarding this is set out within section 5.

The provision of services across the 30,000 to 50,000 population size will ensure the most effective use of the multi-disciplinary workforce, optimising the current primary care skills available and drawing on new roles that will be supported and developed. They will also make more effective use of the primary care centres available within the locality, as well as providing an infrastructure to support the sharing of business support services such as finance, HR and information technology. The engagement of the public in service planning and improvement will also be facilitated at this level, building on the arrangements already in place across North East Lincolnshire including the Accord community membership body and the Patient Participation groups, with a strong link across to the local Healthwatch.

To achieve this vision, general practice will need to be supported to move from their current position and the following areas of support will be provided (more detail is provided within sections 3 and 6):

- Releasing time for Care (10 high impact actions) – The CCG will ensure that there is systematic support for all local Practices to help improve processes and free up GP time. This will rely predominantly on the national funding already signalled within the GPFV, but local development events will be supported by non-recurrent CCG funds.
- Workforce development – The CCG will work with NHS England, Health Education England, HYMS, the University of Hull and local Practices to support education and training for the wider workforce that will support general practice. In addition, there will be recruitment and retention schemes for various posts.
- Proactive support to stabilise vulnerable practices in the short term, to maintain access and support and encourage transformation of services to more sustainable at scale arrangements – this will be through non-recurrent support from the NHS England GP Resilience Programme and access to local CCG funds and support, where appropriate.
- Proactive support to those providers of primary care services that are in a stronger position to expand provision more rapidly – non-recurrent support will be provided by the CCG to the support the development of 'at scale' arrangements for those that are in a position to move further faster.
- Organisational development – Practices will be supported to ensure that they have time to engage in the detailed planning to support delivery of this vision, through transformational funding provided by the CCG. The CCG already funds a monthly Protected Time for Learning (PTL) for all practices, and we will be developing the forward programme so that it supports this vision.

Closer working with wider primary care contractor groups will also support delivery of this vision. In addition, a social prescribing service will commence within North East Lincolnshire from April 2017, which will support general practices to signpost their patients to voluntary sector solutions that will support improved health and wellbeing and self-management. More detail can be found at section 6 of this plan.

2. Investment in primary care

The investment plan (revenue and capital) in primary care to deliver all aspects of the General Practice Forward View, locally. Including:

1. High level modelling that provides evidence of:
   - the shift of activity from hospital to out of hospital care
   - total spend trajectories for the shift to primary care

2. Clarity on the resource shift so the STP can be clear on the new out of hospital /primary care expenditure plan –per capita shift to primary care and total spend reflecting the direction of travel for increased investment in primary care.

3. The CCG's proposed on-going investment plans and timescales for making this investment in-line with delivery of the service offer above (including where CCGs require access to supporting additional non-recurrent transformation resources)?

There is an investment plan which supports the GP Forward View delivery at a local level. A spreadsheet is attached, but in summary the investment includes:

£3 per head non-recurrent funding from the CCG allocation to support general practice transformation. This will be split equally across 2017/18 (£257k) and 2018/19 (£252k) and will support the following areas:

- Recruitment incentives for GP trainees (educational bursaries; support for overseas recruitment)
- HCA apprenticeship training costs
- Nurse training costs
- Project management support for practice grouping development
- Funding to support interim provision of 7 day extended access prior to the new national recurrent funding commencing in 2018/19.

Additional CCG non-recurrent investment from CCG-wide transformation fund, over and above the £3 per head of population, of £248k in each year 17/18 and 18/19. This will support the following areas:

- Backfill funding to support clinical leadership within federations
- Indemnity costs associated with collaborative working arrangements
- Funding for practices to undertake formal general practice improvement programmes/releasing time for care programmes
- Additional funding to support interim provision of 7 day extended access
- Additional laptops / IT equipment for practices, to support agile/remote working

Uplift to the existing CCG recurrent spend on enhanced general practice services of 1.9% in 17/18 and 18/19, equating to an additional £78.5k and £80k respectively.

Increase in CCG recurrent spend on enhanced general practice services of £150k in 17/18 and £300k in 18/19. This is funded through a shift from acute to primary care spend.

Non-recurrent support to premises developments , in line with existing CCG Estates and Technology Transformation Fund bids, of £100k in 17/18, £50k in 18/19 and £50k in 19/20.

NHS England funding for online practice consultation systems of £43.6k in 17/18 and £57.8k in 18/19.

NHS England funding for Receptionist training in care navigation and clinical paperwork of £15k in 16/17, £29k in 17/18 and £29k in 18/19.

A request for additional national non-recurrent funding, from NHS England, of £243k in 17/18 and £104k in 18/19 is being made. This includes additional costs for IT development work, a range of workforce initiatives and interim funding for extended access arrangements until the full £6 per head recurrent funding is released in 2019/20. The NEL area has a 7 day pilot (NEL Docks Collaborative) which was submitted as part of the Prime Minister's Challenge Fund but not funded via that route; however, it was supported by NHS England through the Primary Care Transformation Fund. Subject to the evaluation proving successful, we would wish to avoid the potential of having to cease the current pilot prior to having a recurrent solution in place. Funding streams for continuing this project would include CCG non-recurrent transformation funding and reinvestment of existing NHS England and CCG spend (e.g. extended hours DES), until the new national recurrent funds are received. Additional non-recurrent funding is therefore requested from NHS England to support the balance of costs for interim 7 day plans.

3. Support and grow the primary care workforce

A baseline assessment of workload, demand and supply side numbers.

Information relating to general practice workload is not routinely reported; the CCG has therefore worked with local Practices to collate data which enables us to better understand the current local position. We intend to undertake further work with practice representatives to refine the data collection, as an interim arrangement pending the release of the national tool as set out in the GPFV. This will also provide a baseline from which we can track any changes as a result of the initiatives and workforce development outlined within this plan.

Practices have provided appointment activity (this includes all types of appointments, not just face to face, for example those done by text or telephone) for a given week in September 2016. A small number of Practices also collected other aspects of workload relating to direct patient care by undertaking a prospective record of activity; this included capturing time spent on reviewing incoming correspondence and updating patient records, etc.

The total estimate of appointment activity[1] for the entire North East Lincolnshire population is 1,062,363 per annum, which is an average 6.3 appointments for each patient on the registered list, above the national estimate of 5.31[2].

Based on the split of current appointment activity across different professionals[3], GPs are currently

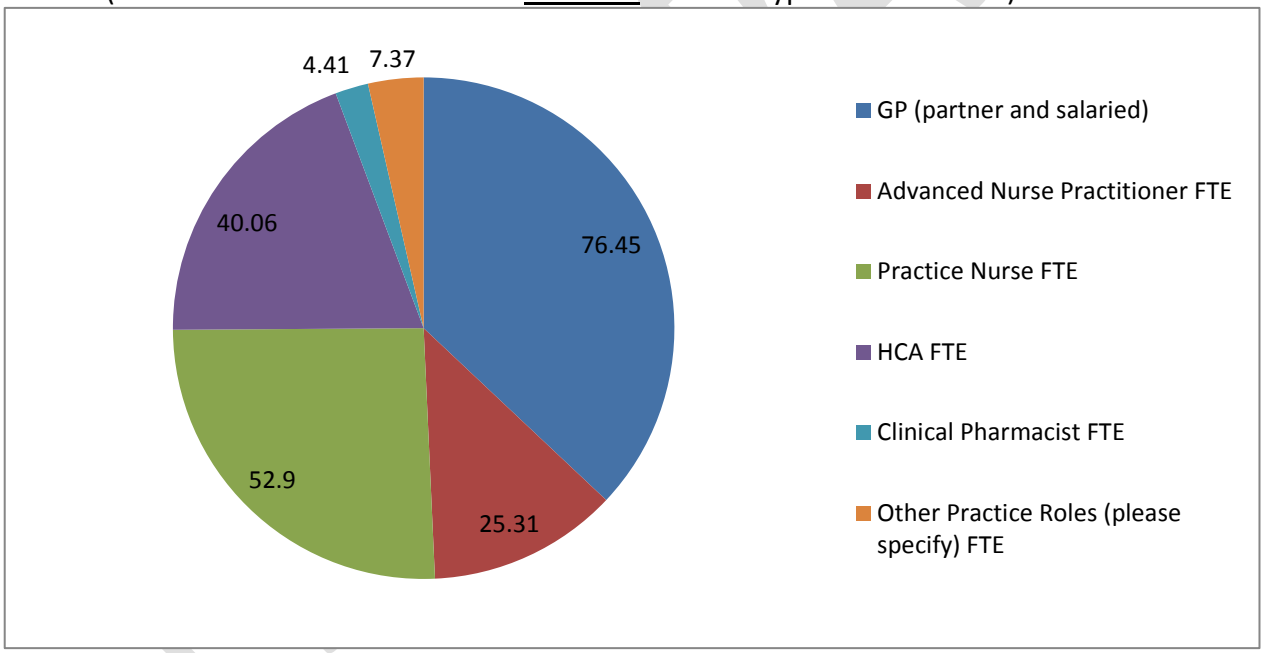
[1] This is an estimate based on local data collection with returns from 10 practices, which represent a good cross section of the local general practices (list sizes range from around 1,800 up to 20,000), equating to 51% of the local population. Activity covers the week 19/09/2016 to 23/09/2016

[2] http://www.practicemanagement.org.uk/demand-versus-capacity-a-simple-overview

undertaking around 44% of total appointment activity; qualified nurses around 33%; Healthcare Assistants around 21% and Clinical Pharmacists around 2%. It should be noted that data gathered was from practices that have only recently taken on Clinical Pharmacists and this may not reflect the level of activity that could be delivered by these professionals as they become more embedded. It also indicates that there is at least 2% of activity within those practices which don't currently have pharmacists that could be dealt with differently.

Local data collated from a small number of practices[4], which recorded how much time was spent on tasks directly related to patient care other than appointment activity, showed that GPs are spending around **at least** 3 additional hours per day on average on these tasks. These included reviewing letters, dealing with incoming electronic 'tasks' from other parts of the care system, reviewing blood results, medication queries, activity associated with 'not our patients' and calls /emails to patients that were not booked as appointment slots on the clinical system. Whilst some practices have established systems and processes for other staff types to undertake an element of this type of work, there is scope for embedding this more widely across North East Lincolnshire.

The full time equivalent clinical workforce figures have been collated manually from each practice, pending the HEE publication of the October 2016 workforce survey. The current breakdown is as follows (this chart shows the actual FTE numbers for each type of clinical role):



*'other' includes Community Matron, Advanced HCA, Apprentice HCA, Extended role Practice Nurse. GP includes partners, salaried and sessional.

GPs and qualified Practice Nurses (including both Advanced Nurse Practitioner and Practice Nurse roles) make up the significant majority of the workforce and currently undertake the significant

[3] This is based on local data collection and is the analysis of activity by professional type for 3 practices.
[4] Local data collection from 3 local practices – mix of large, medium and small practices.

majority of the workload. However, the latest publication of the Health Education England workforce figures[5] shows that 26% of GPs and 26% of nurses are aged over 55 and therefore close to retirement. This equates to around 20 GPs and 20 nurses.

Over the 5 years of this plan, we will be looking to replace retirements and fill current vacancies as far as possible to create a stable GP and nurse workforce. At the same time we will need to increase numbers of other professional roles to accommodate new models of care and shift of management of patients from acute to community setting.

Based on existing local staffing numbers, and nationally recognised ratios of staff to population size for LTC management[6], we anticipate requiring additional clinical staff with numbers in the region of 5 clinical pharmacists, 5 advanced nurse practitioner/specialist LTC nurses, 9 primary care mental health therapists[7]. Increases in other types of professional roles cannot be estimated until further evaluation has taken place (e.g. HYMS Physiotherapists in General Practice project, which we are taking part in) or further evidence is available (e.g. Physicians Associate roles).

We are working with CCGs across the STP and NHS England to develop a consistent approach to creating a more detailed workforce model at CCG level.

A plan to:

- develop initiatives to attract and retain GPs and other practice staff

Given the information set out above regarding GP and nursing posts, recruitment and retention support needs to be targeted at encouraging these roles as far as is possible. However, we have also identified initiatives aimed at supporting the development of a broader multi-disciplinary workforce.

In conjunction with local Practices, NHS England and the local education and training establishments, the CCG will support a range of initiatives to attract and retain GPs and other practice staff. Feedback at local engagement events has demonstrated support from some local Practices for these ideas, but some will require further discussion and agreement with the other parties involved.

- Providing an educational bursary during the final year of GP training to provide financial assistance for exams and courses. Trainees would need to sign an agreement to repay fees if they leave NEL employment during a 2 year period post-qualification. CCG non-recurrent funding.
- Providing additional extended posts for GP Registrars (a 4th year) to support development of greater experience, additional skills and orientation within NEL. We anticipate that this role would cover a federation/group of practices. The CCG is requesting additional national non-recurrent funding for the costs of the post. The CCG will provide support for an educational bursary on the same terms as set out in the point above.
- Create a new Salaried GP post, half time within one of the federations and half time protected for development, with special interest area to support local out of hospital service developments or

[5] HEE 'NHS North East Lincolnshire CCG GP Workforce Q1 April – June 2016', pg 3 (based on submissions from 24 practices.

[6] Based on the College of Social Work and the RCGP in their joint report (GPs and Social Workers, Partners for Better Care 2014)

[7] This is based on a population share of the 3000 additional MH therapists nationally, identified in the GP Forward View

clinical leadership role across the locality. The federation would pay for GP sessions, and the CCG would fund the remaining (recurrent) through a shift in spend from acute to out of hospital care. Additional funding is sought from HEE/NHS England for a bursary for development, including courses and a mentor.

- Federation(s) to develop a new salaried GP post which is shared across Practices within the federation. This would offer the flexibility of a locum post e.g. working across different practices with flexible times, but the security and support of a salaried post. This would be determined and funded by the relevant federation.
- Support for Dutch GPs (identified through previous international recruitment initiative) – the CCG will support those GPs recruited from overseas through match funding the National Recruitment Office (NRO) bursary for a maximum of 3 months. Funded by CCG non-recurrent funding, up to a maximum of 2 GPs per year. This would not be applied to any new international recruitment.
- The CCG is working with colleagues within NHS England and CCGs across the STP footprint to develop a proposal for a further international recruitment campaign. The proposal will be submitted at the end of January 2017, with a view to commencing the recruitment campaign in 2017/18. Funding will be from NHS England.
- The CCG will also continue to facilitate arrangements with Dutch medical schools for providing student placements within NEL, as this has the potential to develop foundations for future recruitment. There are no costs attached to this.
- Expand the support available for the apprenticeship programme for HCAs covering all Practices within NEL via an application process. We will work with HEE and the local Advanced Training Programme hub (Freshney) to develop this. Non-recurrent funding to support additional training requirements for HCAs to be made available from CCG. Support for contribution of half of the salary costs for two years is requested from national non-recurrent funds.
- Support the new local nurse degree course: Our community service provider has worked with the local further education college to establish a local nursing degree course (through collaboration with Northampton University, in order to secure NMC accreditation). The first intake commences in March 2017 and has the potential to create a supply of locally trained nurses. As nursing degrees no longer receive national funding, we would like to be able to provide support to contribute half of the full 3 year tuition fees for one place, with a focus on supporting local people from more disadvantaged backgrounds. We have requested £13.5k non-recurrent support from national funds so that we can help one local student.
- Nurse Prescribing courses – We would like to continue to support nurse prescribing course costs when HEE funding stops. We are requesting additional non-recurrent funding to support 3 per year over 2 years (£15000 over 2 years, £7500 each year).

During engagement with practices on this plan, a key issue has been identified in relation to the lack of availability of readily accessible training for practice staff. Mandatory courses for clinical roles are too infrequent, and often delivered from centres distant to NEL; this results in staff not being able to pick up their full range of duties for a significant period of time as well as large periods of time out of the practice. The frequency of courses needs to be addressed at a national level, but the local practices would also like to explore the opportunity to develop local training arrangements and we plan to have conversations with HEE regarding how to develop this. These could be delivered concurrent with our GP Education Events (protected time for learning), reducing the impact on core service delivery. An additional non-recurrent amount of money will be identified by the CCG to support the training costs.

- develop expanded multi-disciplinary primary care teams

  - Further adoption of clinical pharmacist initiative with full rollout across NEL by 2018. This would be available to all practices, who will work together to share Pharmacists, in line with the national programme. NHS England non-recurrent funding and practice part-funding.
  - Support the adoption of the Physician Associate (PA) roles, by providing non-recurrent support to practice federations that take up PAs from August 2018 to support education and training costs for two years post-appointment. CCG non-recurrent funding for two years.
  - Subject to successful formal evaluation of the HYMS physiotherapist pilot (due November 2016), roll out across NEL by 2018 with resources shared across practice federations. This will require NHS England additional non-recurrent funding to support introduction into practice at the same level as pharmacist initiative, and recurrent support from Practices
  - Expand the primary care mental health therapists, as outlined within the GP Forward View (9 therapists, based on population share of 3,000 nationally). This additional resource would be embedded within practice federations. This will rely on the new national funding and we will agree with existing providers how these roles are expanded and aligned to support primary care effectively.
  - An expansion of the workforce across general practice federations is expected as a result of CCG reinvestment of PMS premium, 'over 75s' funding, Service Improvement Plan (SIPs), CCG additional recurrent funding (shift of funding from the acute setting) and the additional recurrent extended access funding from NHS England. These roles will include (but is not limited to):
    - Specialist nursing roles to support rollout of LTC model (COPD underway now)
    - Community Matron role to support most complex patients and the vulnerable and housebound
    - Salaried GPs

The CCG will provide practical support with orientation for any recruits new to the NEL area. This will include providing help to find accommodation and arranging social events with other local general practice staff. A small amount of CCG non-recurrent funding will be identified to support this.

CCG funding for new appointments and funding identified for recruitment and retention initiatives will be channelled through the federations, as appropriate to service delivery.

4. Improve access to general practice in and out of hours

A baseline assessment covering local variation in access, in-hours and out of hours plus an assessment of current extended hours practices

The July 2016 national patient survey results[8] show that satisfaction with access to general practice has decreased since the 2013 survey across the CCG. Variation across practices is as follows:

- Percentage of patients saying it is easy to get through to their practice by telephone ranges from 38% to 93%
- Percentage of patients saying they were able to get an appointment last time they tried to see or speak to a GP or nurse ranges from 64% to 98%

[8] https://gp-patient.co.uk/slidepacks/July2016#N 'NHS North East Lincolnshire CCG'

- Percentage of patients saying their appointment was convenient ranges from 78% to 100%
- Percentage of patients saying they had a good experience of making an appointment ranges from 51% to 96%
- Percentage of patients saying they don't normally have to wait too long to be seen ranges from 32% to 87%
- Percentage of patients saying they are satisfied with the hours their GP surgery is open ranges from 62% to 91%

A single GP out of hour's service is available to the whole population across North East Lincolnshire. The quarter 1 2016/17 out of hours provider's own survey results (collected as part of our routine contract monitoring) demonstrate that 100% of patients are being seen within the 6 hour standard waiting time, and 100% rated the service as good, very good or excellent[9]. The results of the national patient survey for the out of hours services questions showed that 64% felt they received care or advice within the right length of time (national average 62%).

A pilot of extended access for urgent GP advice or assessment has been operating since June 2016 (NEL Docks Collaborative) and is due to continue until the end of March 2017. This is delivered by a collaboration of 10 practices and covers 50% of the registered population. Patients of those practices can access urgent GP advice up to 8 pm on weekdays and between 9 am and 12 noon at weekends. Formal evaluation is yet to take place, but some early lessons from this project will be used to support the detailed development of the new extended access arrangements.

Sign up to the extended hours DES is high and 90% of the local population have some level of extended access. This provides a total additional 58.5 hours per week across NEL, but there is significant variation between practices, ranging from 0.5 hours to 11.5 hours per week. The vast majority of extended hours are during evenings, most finishing at 7 pm, with one Practice offering an early morning session. The current extended hours do not provide a consistent offer to the local population.

The July 2016 national GP survey results showed that when patients were asked about additional opening times that would make it easier for them to see or speak to someone in general practice, the strongest preference was after 6.30 pm on weekdays (67%) and on a Saturday (66%). 40% selected Sundays, 28% before 8 am and only 10% lunchtime.

The registered population of North East Lincolnshire is set to increase to 170,074 by 2020.[10] This represents growth of 1,158 patients (0.7%) from the June 2016 registered list position of 168,916. Based on the average of 6.3 consultations for the total patient list[11], this equates to an additional 7,283 consultations per year across North East Lincolnshire, or 158 additional consultations per working week[12].

A plan to implement enhanced primary care in evenings and weekends – with a clear trajectory for delivery by 2020

[9] Core Care Links Ltd Quarterly Performance Report, Quarter 1, 2016/17
[10] NHS England 'Calculation of CCG estimated registrations 2016-2020', https://www.england.nhs.uk/2016/04/allocations-tech-guide-16-17/
[11] Local data collection
[12] Assumption of 251 working days in a year

Given the baseline position outlined above, the priorities for enhanced access are:
- ensuring consistency of offer for the whole population, including within extended hours
- improving the ways in which patients can get through to general practice
- ensuring patients are able to get to see a GP or nurse when they try to book an appointment
- ensuring that waiting times for appointments are reduced
- ensuring sufficient capacity to meet the demands of the increased list size.

It would not be possible to deliver a resilient extended access offer from within individual practices; nor would this address the consistency of offer. The local model will therefore be based on the federated general practice model, making more effective use of the primary care centres available within the locality.

The extended hours offer within the federations will be pre-bookable appointment slots, including appointments for long term condition management, within extended hour's clinics that are delivered from a designated centre within that federation. Federations will have the option to pool resources to manage their extended access arrangements. For example, their urgent/on the day demand could be managed via the local Single Point of Access, which provides a multi-disciplinary, integrated health and social care response 24 hours a day, 365 days a year. This will provide the opportunity for triage and potential diversion to a more alternative service. In addition, across both core and extended hours, practices and federations will provide care navigation services to support patients to access the most appropriate service for their needs.

One of the learning points from the current NEL Docks pilot is that solely relying on telephone automated options for urgent cases does not provide a quality response to the patient. Urgent requests will therefore be supported by call handling by trained care navigators, either within the federation or the SPA (depending on the approach selected), who can direct patients to the most appropriate service. Any requirement for face to face will result in an appointment booking into patient's own surgery, where appointments are available, or to the Urgent Care Centre if necessary and/or deemed more appropriate for the patient's needs. Telephone systems will enable a seamless switch between practices, the federation's arrangements and the SPA, to facilitate ease of access for patients, i.e. if the patient telephones their own practice the call could either be answered by the practice, the federation (during extended hours) or diverted through to the SPA with no call backs required by the patient. Staff taking calls on behalf of the federations will have the ability to book into appointment schedules across the grouping, either using shared admin function or use of 'GP Connect'. This technology will also allow all other organisations across the system, such as 111 or local SPA, to book into GP appointments.

There will be greater use of technology to support the offer of advice and/or assessment via telephone, email and video-consultation to improve access and reduce the face to face requirement, where clinically appropriate. Where a face to face appointment is required, this will be delivered from a designated extended access site during extended hours, not necessarily the patient's own practice premises.

The CCG, as part of the development of this plan, has undertaken engagement with local practices regarding the proposed extended access model and there is already a good level of consensus. However, there is further work to do on refining the detail and better understanding the actual costs

versus the proposed funding level. In addition, the current 7 day 'NEL Docks' pilot is still being tested and if this proves successful there may be agreement to continue these arrangements, pending the recurrent arrangements being put in place*. The CCG has also recently undertaken a local public engagement exercise on access to general practice services, testing out some of the ideas for the future model, e.g. accessing services at centres other than their own practice and seeing other types of professionals (where appropriate to need) if this means being seen at a more convenient time. The public engagement survey closed at the end of October 2016 and the CCG is currently analysing the results which will be used to inform the detailed planning of the extended access arrangements and the further comms and engagement activities that will be required to support this.

**the CCG has therefore included an additional non-recurrent funding request for extended access to mitigate potential issues. Some additional support is being made available from within CCG non-recurrent funding, but the remainder is requested from NHS England.*

Trajectory for delivery up to March 2019 (as per submission via CCG operational plan)

		E.D.14	Months 1-6	Months 7-12
Extended access (evening and weekends) at GP services	2017/18 Plan	Number of practices within a CCG which meet the definition of offering full extended access; that is where patients have the option of accessing pre-bookable appointments outside of standard working hours either through their practice or through their group. The criteria of 'Full extended access' are: • Provision of pre-bookable appointments on Saturdays through the group or practice AND • Provision of pre-bookable appointments on Sundays through the group or practice AND • Provision of pre-bookable appointments on weekday mornings or evenings through the group or practice	-	14
		Total number of practices within the CCG.	28	28
		%	**0.0%**	**50.0%**
	2018/19 Plan	Number of practices within a CCG which meet the definition of offering full extended access; that is where patients have the option of accessing pre-bookable appointments outside of standard working hours either through their practice or through their group. The criteria of 'Full extended access' are: • Provision of pre-bookable appointments on Saturdays through the group or practice AND • Provision of pre-bookable appointments on Sundays through the group or practice AND • Provision of pre-bookable appointments on weekday mornings or evenings through the group or practice	14	14
		Total number of practices within the CCG.	28	28
		%	**50.0%**	**50.0%**

Recurrent funding of £6 per head from 2019/20 will support full rollout to 100% of practices.

Delivery will be in line with the eligibility requirements set out within Annex 6 of the Shared Planning Guidance.

A description of how wider primary care (dental, optometry, community pharmacy) will contribute to this plan

Closer working with wider primary care contractor groups will support delivery of this plan. The CCG has recently launched a Minor Ailments Scheme with local community pharmacies, and will be exploring opportunities for other ways in which they could work in partnership with general practice. There is an enhanced service with local optometrists for referral refinement for glaucoma patients and the CCG is planning a procurement of local Ophthalmology services, which will support greater opportunities for working with optometrists. The CCG will work with NHS England to explore whether there are opportunities for closer working with local dentists to identify ways in which patients who are accessing their GP for dental issues could be better managed. To improve our working relationships with other primary care contractors, we are currently reviewing our various meetings to identify which would be most suitable to facilitate systematic involvement and engagement with these partners.

A description of how the plan for access to general practice is linked into the wider integrated urgent care system including 111.

A key element of the local urgent care system is the development of an Urgent Care Centre (UCC) within North East Lincolnshire. This 24/7 centre will be primary care and community led and provide an urgent care walk-in service for many of those who currently attend A&E as well as face to face consultations currently directed to the GP out of hours service and arranged by the SPA. The Urgent Care Centre will also include an ambulatory care unit and a medical assessment unit within an integrated delivery arrangement with acute services.

This provision of GP services outside of core and extended hours, delivered at the Urgent Care Centre and linked to the SPA, offers the opportunity for a variety of flexible ways in which practice based urgent GP requests can be serviced. For example, federations could consider collaborating on extended hours urgent GP requests with triage via the SPA and face to face consultations being arranged at the UCC or at a location shared within the practice federation.

The 111 service will have access to all of the local urgent care services as dispositions within the directory of services.

5. Transform the way technology is deployed and infrastructure utilised

A map of current estates and technology initiatives

All practices were invited to submit bids as part of the recent NHS England Estates and Technology Transformation Fund process.

Bids that were submitted include 4 refurbishments or extensions to premises to increase the clinical consulting and/or treatment space, across centres based within the Cleethorpes, Grimsby, Laceby and Immingham areas. This represents a good geographical spread.

Technology bids include:

- Expansion of automated telephony software (Patient Partner) to support:
  - Automated booking, amending, cancelling of appointments
  - Ordering of repeat prescriptions
  - Sign-posting into appropriate clinic and/or transfer to triage, including call-back facility
  - Automated access across groups of practices.
- Upgrade of the existing NHS N3 connections to superfast broadband to support effective shared working arrangements
- Upgrade of the Single Point of Access telephone system, to support increased volume of calls and also provide additional functionality across all partners to enable:
  - Web chat – this would provide the ability for patients with sensory impairment to access for all local Practices, as well as the SPA, thus providing equal access. This would support the delivery of Accessible Information Standards
  - SMS – co-ordinated messages could be sent from the SPA to all practice registered patients to support self-care and preventative measures, such as promotion of flu clinics, screening
  - Email – this enhances the choice of options for patients to access advice and to provide general information to support self-care and prevention, as per the SMS functionality.
- Implementation of video-consultation equipment within general practice setting for one practice to pilot*
- Implementation of 'AskMyGP' to support online assessment by patients, and transfer of data to GP where appointment is required, for one practice to pilot
- Laptops and IT support for all NEL Care Homes – this will enable staff within Care Homes to have access to the summary care record and NHS Mail. It will also support professionals visiting Care Homes to access their native systems. This could also be used to support e-consultations to reduce visits and potentially hospital admissions.

Additional non-recurrent funding for equipment to support local practices to adopt remote/agile working has been included within the CCG non-recurrent funding. This has been included within the attached investments spreadsheet.

A plan to deliver the requirements set out in the GP IT Operating Model 2016/18

GP IT is delivered by our partner organisation Embed, with whom we have a contract to deliver all of the requirements of the GP IT operating model. An IT Strategy Lead supports this and is co-ordinating the digital road map and driving delivery of the primary care priorities, which are outlined within the CCG's IM&T delivery plan. In addition to this, to develop our infrastructure we have been successful in our GP IT capital bids to refresh GP IT estate and improve the network infrastructure. We are also reviewing our future network requirements post-March 2017 when the N3 contract comes to an end.

A clear primary care estates and infrastructure strategy linked to the wider strategy for integrated out of hospital care.

The North East Lincolnshire locality already has excellent primary care facilities, with purpose-built centres, some of which house multiple GP practices and accommodate other community services. Recent utilisation studies suggest that there is scope to improve the utilisation of these centres. Plans to ensure improved utilisation will be developed in tandem with the development of

integrated service delivery within the locality.

The use of the enhanced summary care record is phase 1 of our shared record strategy; this will provide all local organisations with access to a more detailed level of information than the basic summary care record and will enable working at scale across different systems. This will be in place by March 2017 at the latest. Information will be made available for acute, community, and mental health information through system viewers. Phase 2 of our record sharing approach will be the rollout of 'GP Connect', once this is available nationally from March 2017. This will allow a greater level of integration between various GP systems, including appointment schedules and tasks, providing greater ability to work across different practices. Automated telephony software will support improved patient access and ensure patients are signposted to the most appropriate service. Greater emphasis will be placed upon ensuring that patients know how to access their records so that they can easily access information to help them self-manage, where appropriate to their care.

Additional non-recurrent funding is requested from NHS England to support the development costs of the local viewer solutions (£30k). This is included within the attached investments spreadsheet.

Confirmation that primary care requirements have been included in Local Digital Roadmaps

The North and North East Lincolnshire Digital Roadmap includes the primary care requirements set out within this plan. The feedback on our Digital Roadmap is that we submitted a comprehensive universal capability delivery plan, clearly setting out the activities. A number of areas have also been highlighted as potential exemplars.

Due to the number of appendices and size of the files, we have not appended the Digital Road Map to this document. NHS England already has a copy; however, another copy can be provided on request if necessary.

***Online general practice consultation software systems:**
The CCG will be looking to ring-fence the national funding for online general practice consultation systems when it becomes available in 2017/18 and will ensure that services are in line with the NHS England rules and specification (yet to be published). It is envisaged that the first tranche of funding available for the CCG in 2017/18 (£43k) would be aligned with early adoption of extended access arrangements. The second tranche in 2018/19 (£58k) will be used to support the remainder of the practices, as extended access begins to be rolled out with the support of the new national recurrent funding.

6. Better manage workload and redesign how care is provided

A plan to improve the capacity in general practice through redesign (eg LEAN / Releasing Time to Care) and collaboration (such as shared clinical services and back-office functions)

Initiatives to support Practices (particularly GPs) to free up time are a high priority for the CCG, as we recognise that it is difficult for practices to engage in transformational work while struggling with existing demand.

Time for Care Programme:
The CCG held a learning event with all local practices in September 2016, which focused on local Practices sharing their experiences of projects linked to the '10 High Impact Actions for General Practice'. The feedback from that event demonstrated that practices would benefit from support in the following areas:

- Training for practice staff in undertaking clinical paperwork
- Training for practice staff to undertake care navigation roles
- Project management support to provide additional capacity for change management
- Communications and engagement support to ensure that there are appropriate messages and plans for engagement with patients
- More events to share learning across the locality.

The CCG is already working with NHS England as an early adopter of the Productive General Practice Quick Start programme, and 12 of the local Practices are currently undertaking the programme which will be completed by early February 2017. Practices have selected modules relevant to their own internal issues, with the aim of providing fast, practical improvement to help reduce pressures and release efficiencies within general practice.

A further '10 high impact' workshop session across all Practices within the NEL area is already planned for 23rd February 2017. This will focus on sharing the learning from the Productive General Practice Quick Start programme, with a view to rolling this out to the remaining practices over a period of 1-2 years. This will be funded through CCG non-recurrent monies.

Care Navigation and Medical Assistants:
Using the same time as our existing GP protected learning time sessions, we will support the up skilling of administrative staff within general practice to help alleviate the workload across the following areas:

- Clinical paperwork – By the end of March 2017 we are planning to have completed a programme of training for all local practice staff to act as medical assistants, i.e. having the skills to review, filter, file and act on incoming discharge letters, and other clinical paperwork, within appropriate governance arrangements. Training costs will be covered by the NHS England funding outlined within the GPFV and the planning guidance (current year allocation for the CCG is £15k). The CCGs within the STP are looking to pool the 2016/17 allocation for care navigation and clinical paperwork training and focus on the clinical paperwork/medical assistant training, as this could have the greatest immediate impact on GP workload.
- Care navigation – training for GP Receptionists will be made available to all local practices in early 2017/18, as soon as the directory of accredited providers is available and the second tranche of funding to support this area has been received. Successful care navigation training is subject to completing local work on developing a robust directory of local alternative services which the practices are happy to support (this is a key learning point from the West Wakefield Vanguard experience). We are again planning to work jointly with the CCGs within the STP to pool the funds provided by NHS England to secure this training. The care navigators will be supported with online information, which will also be accessible to patients and the public. This is planned to take place early in 2017/18.
- Medicines optimisation – In addition to those areas specified within the GPFV, the CCG has provided training for practice staff in Medicines Optimisation. This has already been

completed during October and November 2016, supported by our Medicines Optimisation provider (North of England Commissioning Support – NECS). This will enable practice staff to support prescribing processes, both freeing up clinicians' time and identifying opportunities to optimise medicines usage and eliminate waste.

We intend to plan all training sessions for Receptionists to take place at the same time as the monthly protected learning time sessions that already exist, in order to mitigate impact on service delivery.

Shared Clinical Services:
There will be an increase in shared clinical services, supported by CCG commissioning of enhanced LTC management and support for the housebound, as well as the extended access arrangements across the 30,000 to 50,000 population size. These federations could also facilitate shared back-office functions, which will be supported by the IT developments that enable shared IT system management. Shared business analytics expertise will also support the federations to develop effective processes for identification and stratification of their population. All of our local practices are on hosted systems, either EMIS or SystmOne (both of which are well supported nationally), which gives greater opportunities for integration. Practices have been on electronic systems for a long time and the majority are working paper-free.

Managing workload associated with secondary care interface issues:
The CCG recognises the burden placed on general practice as a result of issues within the hospital/general practice interface. All of the items set out within the GPFV document formed part of the contract negotiations for 2016-17 and 2017-18 and the Trust has been made aware of the elements of the contract which needed to be satisfied. We have developed a process for ensuring that instances where breaches occur are notified to both the local hospital trust and the CCG; this is complemented by the development of standard templates by the local LMC which have been shared with all practices. These will be discussed within our regular contract monitoring meetings and action taken accordingly.

Supporting general practice resilience: Vulnerable Practice fund and GP Resilience Funds:
The CCG has worked with NHS England to deploy the Vulnerable Practice fund and the first tranche of GP Resilience Programme funding to local Practices in need of support. This includes those practices that have lists temporarily closed to new patients, those with an overall CQC rating of 'requires improvement', and those Practices that either have indicated through discussions with the CCG or NHS England local team that they are facing significant difficulties currently or have been assessed against the criteria as requiring support. The type of support included within the VP and RF allocations include funding to support recruitment, organisational development, review of clinical processes, and backfill to allow developmental work.

Focus on self-management:
In order to support manageable workloads for general practice, we intend to do more work on patient access to online solutions to support self-management. We have recently undertaken a public engagement exercise and review of our local Information and Advice services and will be developing a plan, based on the feedback received, to develop more accessible and comprehensive advice and guidance for the public and patients.

A social prescribing project is under development utilising a Social Impact Bond payment by results approach. This service will be made available to all local general practices during 16/17. This will have a specific focus on patients with long term conditions, including COPD, Diabetes, Atrial Fibrillation and Asthma, enabling them to easily access a range of community service based interventions delivered by Voluntary and Community Sector organisations to improve their health and wellbeing and reduce their utilisation of both primary and secondary care services.

7. Organisational form

A description of the current organisational form of general practice within the CCG
There are currently 27 individual Practices with list sizes varying between 1,200 and 20,000.

Practices generally all have their own individual back office staff, although an increasing number of practices are beginning to share support staff.

The ambition for primary care at scale underpinned by a delivery plan

The ambition has already been articulated within the vision and extended access sections above – there will be federated general practice groups covering population sizes of around 30,000 to 50,000 (potentially slightly larger in some cases). The following high level plan sets out the steps to achieve this*:

CCG discussions with individual practices to identify preferences for federation	November and December 2016, January 2017
Work with system partner organisations delivering care focused around similar population sizes, to agree how these will align	end February 2017
Membership and population size of federations to be confirmed	end February 2017
Support to develop legal frameworks for each federation	January to March 2017
Organisational development support on culture and behaviour change (working with AHSN and Improvement Academy)	January to March 2017
Contracts for enhanced services that support community matron and enhanced LTC services	March 2017

*There will be some flexibility within these timescales, as some Practices are more advanced than others in developing their federation. The aim is to have at least one federation formalised and ready for some operational delivery by April 2017, with additional development in year to ensure readiness by April 2018**.** We will work up more detailed implementation plans with each federation once these are confirmed.

Freeing up both managerial and clinical time to lead change has been identified as a significant challenge by the local practices. The CCG has identified non-recurrent funding to support additional project management capacity and/or backfill some of the local practice business managers to support the development of the federations, as well as backfill for clinical time to support clinical

leadership within the federations.

One of the concerns raised by local practices in respect of collaborative working across the larger footprints is the likely increase in indemnity costs. The CCG has therefore included some provision for this within the non-recurrent allocation for GPFV delivery.

A description of how the "future state" is linked to the wider strategy for integrated out of hospital care

This is set out within the narrative for the vision at the beginning of this document.

8. Engagement

A description of the CCG is engaging local primary care professionals (GPs, dentists, pharmacists, optometrists) and the local population and patients in the development and delivery of the Transformation Plan.

The following engagement has already taken place:

- GP Development Group – includes practice representatives
- Practice Manager Forum
- Specific workshops with GPs and practice managers on access and 'releasing time for care'
- 'Drop in' session at local protected learning time event
- General practice meetings
- Service specific engagement with the public; currently engaging on extended access
- Ad-hoc meeting with local GPs and practice managers
- The local LMC have had open invites to all local general practice engagement events and have attended the vast majority of them.

Engagement will continue with groups mentioned above, as well as:

- Local Community Forum – includes local public representatives who engage regularly in CCG business
- Shadow Accountable Care Partnership group
- Accord membership – public membership body to support engagement
- CCG Triangles – Clinical, managerial and public reps across service specific areas
- Local Pharmaceutical, Dental and Optometrists Committees – specific meetings and regular invite to Co-Commissioning Committee

9. Risks and mitigation

A description of the key risks and mitigation

The key risks to delivering the plan are set out within the table below.

Risk	Mitigation
Current capacity constraints may impact on ability to engage in developmental / transformational	Draw on immediate support from NHS England for Vulnerable practice fund and GP Resilience programme, where appropriate to practice. Make

work	best use of protected time for conversations regarding general practice development Provide non-recurrent project management/backfill.
Funding constraints could limit ability to deliver on some aspects	Utilise current year non-recurrent funding to support development. Ensure CCG financial planning includes elements of funding identified within this plan. Request support from additional national funds
Lack of capacity and capability within CCG	Work with colleagues across STP and NHS England, utilising GP Forward View aligned support posts, to share expertise and do things once where projects overlap
Practices unable to maintain resilient primary care workforce	Ensure practices have opportunity to be supported through GP Resilience Programme Continue work on developing alternative professional roles to assist with GP workload
Practices unable to agree how to come together at sufficient scale	On-going engagement with practices Work with early adopters to demonstrate benefits and share the learning
Patient and public opposition to plans for new models of care, particularly primary care at scale	Early engagement (current survey).Continued, on-going engagement, making effective use of Accord membership, Community Forum, PPGs, and working with Healthwatch
Increased indemnity costs associated with new models of care	Ensure new NHS England scheme from April 2017 is taken up. Include provision within non-recurrent funding to support indemnity costs while progressing new models of care.
IT Transformation lagging behind required pace of change	Agree and implement interim solutions to support record sharing (viewer solutions/enhanced summary care record), in line with Digital Roadmap plans Continue to lobby national teams and system providers
Premises: Current ETTF bids for premises upgrades may not align with hubs for new federations	Revise PIDs for premises schemes scheduled for 17/18 if necessary
Inability to recruit	Work with NHS England, STP colleagues and LMC on GP recruitment campaign. Utilise existing non-recurrent funding to support recruitment initiatives.

10. Governance

A description of the governance arrangements to provide the CCG with assurance that the plan is being delivered fully and on time.

The CCG's Co-Commissioning Committee will sign off the GPFV plan and oversee delivery.

The practical aspects will be supported by the CCG's General Practice Development Group.

The CCG will use their Covalent system for active management of individual projects within the plan.