Oversight and Governance
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HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE – SUPPLEMENT PACK

Wednesday 7 September 2022
2.00 pm
Council House

Members:
Councillor Mrs Aspinall, Chair

Councillor Deacon, Vice Chair

Councillors Finn, Harrison, McDonald, Murphy, Nicholson, Partridge, Mrs Pengelly, Reilly, Salmon, Tuffin and Wheeler.

Members are invited to attend the above meeting to consider the items of business overleaf. For further information on attending Council meetings and how to engage in the democratic process please follow this link - Get Involved

Tracey Lee
Chief Executive

Health and Adult Social Care Overview and Scrutiny Committee

5. Health and Adult Social Care Policy Brief **(Pages 1 - 6)**

To include risks pertinent to the committee.

7. Primary Care: **(Pages 7 - 44)**

Health and Adult Social Care Overview and Scrutiny Committee

Date of meeting:	07 September 2022
Title of Report:	**Risk Monitoring Report**
Lead Member:	Councillor Mark Shayer (Deputy Leader and Cabinet Member for Finance and Economy)
Lead Strategic Director:	Giles Perritt (Assistant Chief Executive)
Author:	Robert Sowden
Contact Email:	Robert.Sowden@plymouth.gov.uk
Your Reference:	RS/RM
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report

The attached report provides an update on the Strategic risk register pertinent to the committee. The register offers additional information including detail on Key Controls and Sources of Assurance and how progress against mitigation will be measured.

Adult Social Care reforms have been highlighted as a new risk. There are a number of reforms that will create financial uncertainty in terms of being able to accurately understand the impact on costs and resources. This amber risk has been scored as 'Likely' to happen and a 'Major risk' to the operation of the council.

Recommendations and Reasons

The Health and Social Care Overview and Scrutiny Committee is recommended to:

1. Note the current position.
2. Consider whether any risks identified should be programmed for further discussion by the Committee.

Reason: As part of the Committee's responsibility for monitoring the implementation and ongoing processes for identifying and managing key risks of the authority.

Alternative options considered and rejected

Effective risk management processes are an essential element of internal control and as such are an important element of good corporate governance. For this reason alternative options are not applicable.

Relevance to the Corporate Plan and/or the Plymouth Plan
The Strategic Risk and Opportunity Register includes links to the Corporate Plan priorities – monitoring of control action for strategic risks therefore contributes to the delivery of the council's core objectives.

Implications for the Medium Term Financial Plan and Resource Implications:
None arising specifically from this report but control measures identified in Directorate Operational Risk and Opportunity Registers could have financial or resource implications.

Financial Risks
None arising specifically from this report but control measures identified in Directorate Operational Risk and Opportunity Registers could have financial or resource implications.

Carbon Footprint (Environmental) Implications:
Failure to deliver against actions in the Climate Emergency Action Plan and Corporate Carbon Reduction Plan are included on risk registers.

Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:
** When considering these proposals members have a responsibility to ensure they give due regard to the Council's duty to promote equality of opportunity, eliminate unlawful discrimination and promote good relations between people who share protected characteristics under the Equalities Act and those who do not.*
The risk registers specifically supports the council's overall governance arrangements.

Appendices
**Add rows as required to box below*

Ref.	Title of Appendix	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
		1	**2**	**3**	**4**	**5**	**6**	**7**

Background papers:
**Add rows as required to box below*

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are <u>unpublished</u> works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

Title of any background paper(s)	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	**2**	**3**	**4**	**5**	**6**	**7**

Sign off:

Fin	BA22.23.71	Leg	EJ/38851/11.7.22	Mon Off		HR		Assets		Strat Proc	
Originating Senior Leadership Team member: Giles Perritt											
Please confirm the Strategic Director(s) has agreed the report? Yes Date agreed: 14/07/2022											
Cabinet Member approval: Councillor Mark Shayer (Deputy Leader and Cabinet Member for Finance and Economy) Date approved: 13/07/2022											

APPENDIX A PLYMOUTH CITY COUNCIL STRATEGIC RISK REGISTER MAY 2022

RISK REF	Directorate	Service	DEPT	DESCRIPTION OF RISK (Risk description should include cause / risk event / consequence and risk category)	KEY CONTROLS / SOURCES OF ASSURANCE (aligned to three lines of defence) Policies and procedures Link to business plan Delegations of authority / Fraud checks Risk and control framework Performance Management Project Management reviews	PREVIOUS RISK RATING			PREVIOUS RISK RATING			CURRENT RISK RATING			RAG RATING /CHANGE IN RISK RATING	ACTION PLAN / FUTURE MITIGATION / ASSURANCE PLAN	RESPONSIBLE OFFICER(S)	DIRECTOR / ASSISTANT DIRECTOR
					First Line of Defence (Operational management activity)	Oct-21			Feb-22			May-22						
						P	I		P	I		P	I					
PEOPLE (IC) COVID-19 IRR	People	SC	Strategic Commissioning	Lack of adult social care workforce and growing fragility of Adult Social Care Market leading to inability of Authority to meet statutory duties and meet eligible need. Risk Category: Compliance, Regulation, Safeguarding and Financial	Real time management information Provider Contingency Plans and Mutual Aid Protocol Established Review Programme to release hours Activity Dialogue with Care Market Enhanced risk management process around individual client list.	4	5	**20**	4	5	**20**	4	5	**20**	— R	Establishment of Community Capacity Command Centre to provide greater oversight of market and capacity Local Authority has set up a Care Company to ensure continuity of provision in the event of market failure Care Home liaison work being undertaken by Livewell Southwest, to increase levels of support to Residential and Nursing care marker Risk to be continued to be monitored through contract monitoring and market intelligence Supporting market wide workforce recruitment / retention across residential and domiciliary sector Remodelled bed bureau launched to support Care Homes to manage complex discharge cases Incentive payments to workforce. Managing risks for the domiciliary care market	Anna Coles/ Gary Walbridge	Craig McArdle
STS2 COVID-19 IRR ORR	ODPH	OPPH	Office of the Director of Public Health	**Ongoing COVID-19 rates (with potential for further peaks) affect city's recovery / reset plans.** It is not yet clear what mitigations will be needed for us to live with COVID-19. There remains a high risk of further waves but the timing is not certain. Rates remain high and are likely to increase over the Winter period. Risk Category: COMPLIANCE, REGULATION & SAFEGUARDING	Local Outbreak Management Plan co-designed and published. Multi-agency Health Protection Board meets monthly to discuss management of the pandemic locally. Incident Management Group established and meets fortnightly to discuss issues related to COVID-19 and other infectious diseases.	4	4	**16**	4	4	**16**	4	4	**16**	— A	The key mitigation of vaccination has now reached around 85% (one or more doses) of those eligible. There have been reductions in the mitigations (reduced testing, support payments and legal need for self-isolation) and this has created uncertainty around case rates and the risk of delayed detection of new variants. The longstanding advice to the general public remains in place and is re-emphasised at regular intervals.	Sarah Lees / Rob Nelder	Ruth Harrell
STS1 IRR COVID-19	ODPH	ODPH	Office of the Director of Public Health	**Failure to reduce Health Inequalities will mean our poorest residents continue to live shorter lives as well as more years in ill health.** Mounting evidence that COVID-19 is having differential health impacts across communities, adding to existing health inequalities. This is through either the disease itself or the mitigations put in place. There is an ongoing impact of this due to the economic downturn. The primary role of the ODPH and the Public Health Team in particular is now to try to manage COVID-19 in the city therefore protecting most deprived communities from further negative impacts. Risk Category: COMPLIANCE, REGULATION & SAFEGUARDING	The Thrive Plymouth framework was adopted by full Council in 2014 and links directly to the Plymouth Plan and Integrated Commissioning Strategies. It provides a good foundation to achieve prevention in all services and decision making processes. The focus of Thrive Plymouth in year one was on workplace health and wellbeing, in year two it was on schools and young people, in year three it was on localising the national 'One You' health improvement campaign. In year four was on mental wellbeing (focussing on the five ways to wellbeing) and in year five was on people connecting through food. The intention was that the year six focus would be arts, culture, heritage and health (using the Mayflower 400 commemorations as the vehicle for delivery). However, this year was curtailed as a result of the pandemic and a two year pause was put on the programme. Thrive Plymouth Year seven was launched in May 2022 with a focus on Listening and Reconnecting. In addition to the Thrive Plymouth-related work, the Public Health Team has worked with an extensive network of internal and external partners to secure the opening of a number of Wellbeing Hubs across the city.	4	4	16	4	4	16	4	4	**16**	— A	Persistent action across the Council is required at many levels to tackle inequalities by addressing the wider detriments of health. The Public Health Team and partners continue to work with employers (year one focus) and schools (year two focus) to influence healthier lifestyles. The team continues to embed and promote the national One You campaign across the city. The 'five ways to wellbeing' has been adopted across the City as the single approach to improving mental wellbeing. The work that started in year five on 'people connecting through food' is ongoing with a number of new initiatives developed. The intention was that the year six focus would be arts, culture, heritage and health (using the Mayflower 400 commemorations as the vehicle for delivery). However, this year was curtailed as a result of the pandemic and a two year pause was put on the programme. Subsequently, Thrive Plymouth Year seven was launched in May 2022 with a focus on Listening and Reconnecting. There is a need to reflect on our experiences and acknowledge what we have been through. Though there has been much trauma, we believe that there have also been some positives which we want to help the city to build on and apply to the wider challenges of inequality. Evidence has been provided to the Health and Wellbeing Board on the risk of widening health inequalities which partners are working together to try to mitigate. The Local Care Partnership priorities are being refreshed and includes tackling inequalities. Both of these routes bring partners together to understand the issues and the steps needed to tackle health inequalities in the City. In addition to this, to support the work of the Council's cross-party Child Poverty Action Plan Working Group, a high level review of the evidence of the impacts of the pandemic on the mental wellbeing of children and young people has been carried out. As already stated, the primary role of the ODPH and the Public Health Team in particular is now to minimise the impact of COVID-19 in the city therefore protecting most deprived communities from further negative impacts.	Sarah Lees / Rob Nelder	Ruth Harrell
PEOPLE (IC) COVID-19 IRR	People	SC	Strategic Commissioning	Increased and sustained pressure on Adult Social Care budget due to increased costs of providing care, growing numbers of people and increased complexity of need. As this is a statutory service and largest single budget it could have a significant impact on the Authorities overall financial position. Risk Category: Financial	Real time management information Strong Reablement Offer Established Review Programme Commissioning Intentions and Commissioning Activity to develop new models of care.	4	4	**16**	4	4	**16**	4	4	**16**	— A	Real time management information - Strong Reablement Offer - Established Review Programme - Commissioning Intentions and Commissioning Activity to develop new models of care - Budget containment meetings in place - Focus on reviews and reablement to right size packages of care including focused work on 18 to 64's - Emergency Plan to cover need to prioritise critical services	Anna Coles/ Gary Walbridge	Craig McArdle
	People	SC	Strategic Commissioning	Adult Social Care (ASC) Reforms - There are a number of reforms to ASC that will create financial uncertainty in terms of being able to accurately understand the cost and resources impact once reforms have been implemented. It is not clear whether any additional monies will be sufficient to meet these changes and at this time it is not possible to accurately forecast this risk. Examples of reforms include; Fair cost of care Charging reforms Local Protection Safeguards Care Quality Commission Assurance programme	National and regional groups including Local Government Association and ADASS ASC reform programmes established Fair cost of care exercise to better understand position Departmental and directorate management teams				New	New	**New**	4	4	**16**	A	Seeking to understand impact through reform programmes Potential use of Offers and Asks due to cost of new burdens on the service	Anna Coles/ Gary Walbridge	Craig McArdle
SIC1 COVID-19 HSW	People	SC	People (Commissioning & Children's Services)	**The Council is unable to fulfil its legal obligations regarding the safety of its citizens and service recipients** Significant challenges presented by the scope of service activities, range of workforce environments, clarity of guidelines/legislation and unpredictability of epidemiology, with the added pressures of supply chain management and organisational capacity to deliver Risk Category: COMPLIANCE, REGULATION & SAFEGUARDING	Safe Systems of Work Programme Performance Data Contract Management Weekly review of risk assessments, management oversight and audit	3	4	**12**	3	4	**12**	3	4	**12**	— A	Statutory Post holders Commissioning and service Improvement plans Budgetary Management Revision of business plans	Sharon Muldoon / Craig McArdle	Sharon Muldoon / Craig McArdle

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NHS Devon

General Practice Strategy

Covering note for the Overview and Scrutiny Committee – September 2022

Members will recall briefings to previous Overview and Scrutiny Committee meetings regarding the development of a new General Practice Strategy, which will set the vision for General Practice in Devon for the next 10 years.

This Strategy will replace the previous iteration, published in 2019, much of which has now been achieved, but which requires substantial revision to incorporate learning from the pandemic and to reflect the increased pressure on the system.

Consideration has also been given to the national picture, considering the findings from the national Fuller Stocktake review, which looked at what is working well, why it's working well and how we can accelerate the implementation of integrated primary care.

In terms of the process involved in developing the Strategy over the course of the last few months, care has been taken to ensure wide engagement with key partners and stakeholders.

29 reference-style group meetings have taken place with GPs, practice managers, other health professionals (for example within secondary care and mental health services), system partners, patients and Healthwatch.

Surveys were also widely circulated – two different surveys tailored to those working within the healthcare system and those the healthcare system is here to care for.

A number of emergent themes arose from the engagement, for instance, differentially investing to tackle health inequalities, consistency of access and support to users when accessing technology, a strong focus on the prevention agenda and supporting practices with a Greener NHS plan.

The new Strategy has therefore been developed taking into account the output from the engagement. A further opportunity is now being given to all parties who contributed (both in terms of healthcare partners and patients) to review the draft Strategy document and provide further comments.

So far, the early feedback has been extremely positive; the Strategy is viewed as addressing issues that are difficult for Primary Care with an overall positive message.

A sample of comments received from GPs, practice managers, stakeholders and Healthwatch includes:

> *"Good to have the phrase 'needs versus wants' – it is so important to have those discussions"*
>
> *"An accessible document – easy to read"*
>
> *"The document describes what Primary Care wants to be and can do"*
>
> *"The differential funding and deprivation section of the strategy is a progressive move. Traditional measures of deprivation tend to under-estimate coastal towns as it is usually taken as an average"*
>
> *"The engagement with practices can be heard in the document"*
>
> *"The Strategy is well written, supportive and flexible. It says we need to change and move forward but affords opportunity to deliver services to meet local population need. Really like the sharing of stories, it makes the document real"*
>
> *"It is of high quality, and I'm pleased to see the inclusion of patient participation groups within the priorities"*
>
> *"The document demonstrates that you listened to the panel"*

The document is acknowledged as presenting challenges; however, feedback so far suggests that it is considered both practical and actionable.

Once finalised and approved, operational plans will be developed in conjunction with the Local Medical Committee (LMC) and Collaborative Boards.

The draft Strategy is therefore presented today to members of the Overview and Scrutiny Committee for consideration and to seek feedback.

Following conclusion of the second round of engagement, the full complement of feedback will be worked through and, where necessary, reflected in the final Strategy document.

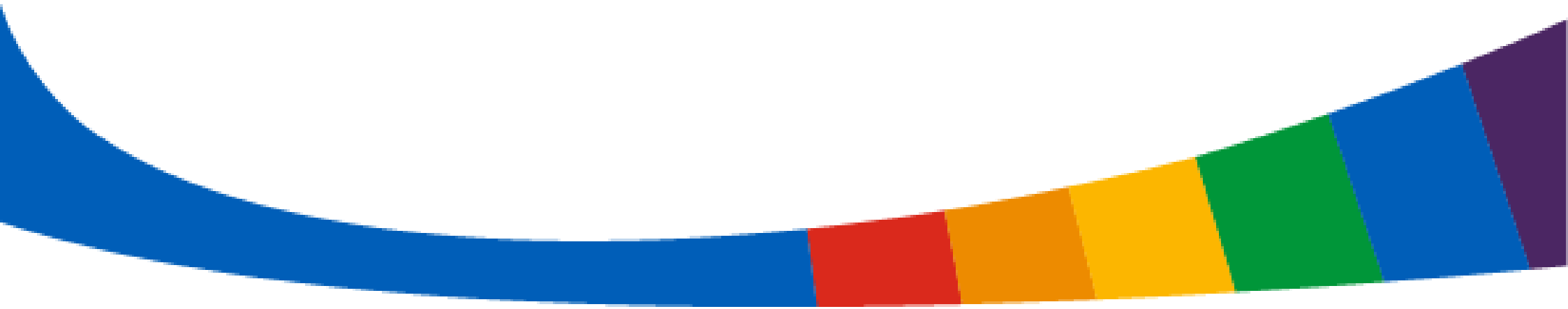
The final Strategy document will be presented formally to NHS Devon's Primary Care Commissioning Committee for approval at the end of September 2022.

NHS Devon

NHS Devon Strategy for Primary Care (General Practice)

DRAFT

2022-2027



One Devon

Proud to be part of One Devon: NHS and CARE working with communities and local organisations to improve people's lives

Contents

1. Foreword

This strategy sets out our ambitions for General Practice in Devon, and how practices will work together as Primary Care Networks (PCNs) and as part of wider Neighbourhood teams over the next 5 years. Partnership working is key to the delivery of this strategy and is founded in the PCN model.

We are proud of the excellent general practice we offer in Devon, with nearly all of our practices being rated as 'Outstanding' or 'Good' and achieving consistently high satisfaction rates in the annual GP Patient Survey.

Devon has been a national exemplar, leading the way in developing digital solutions for GP practices, with other systems learning from us to make improvements to digital access in general practice.

The outbreak of the COVID-19 pandemic presented general practice with unprecedented challenges, which compounded the existing threats to the stability of primary care across the country. A forced transformation took place, resulting in general practice and our patients having to adjust to significant changes in the way that health services were accessed and delivered. Being ahead of the game with digital innovation meant that we were well-placed to shift to new, safe ways of working in the very early stages of the pandemic, when our priority was to limit exposure to both patients and staff. We will now need to learn to live with further waves of Covid infection, using this insight to shape how we can do things differently

Within the wider system we are undergoing a major restructure with the establishment of the Integrated Care Board (ICB) from July 2022, a Devon-wide approach to the delivery of health and social care, meaning health and care providers will work much more closely together, in a partnership known as One Devon.

We look forward to increased collaboration with our partners across Devon and further scope for innovation, joined-up care, helping us to achieve a collective aim - to improve outcomes for our population. General practice has a pivotal role within the new system and the success of our plans is reliant on general practice services that are fit for the future.

Now is the time to describe our strategic priorities and we revisited our 2019 general practice strategy to take stock of the successes and achievements so far and to establish a framework that sets our priorities for the future, describing how we will achieve them.

Our strategy will enable the transformation of General Practice, ensuring we have an offer that is stable, resilient, and sustainable into the future.

This document focuses on the future delivery of general practice, but primary care includes pharmacists, dentists, optometrists, allied health professionals and the voluntary sector. As the ICS evolves and commissioning responsibilities move to the ICB, we will include all areas of primary care in our collective aims.

Dr Nigel Acheson
Chief Medical Officer
Integrated care system for Devon (ICSD)

2. Executive Summary

In developing this 5-year strategy, we heard from people across General Practice in Devon. Their dedication and passion about wanting to provide the best care possible to their patients was clear.

Patients told us how much they value General Practice, how they want services to be accessible, and that sometimes they don't find it easy to access care in the way they would like. Patients saw the value of care being delivered differently and that continuity of care is far more important for some than others. It is clear that there is a difference between what some patients need and what some want, and that how care is delivered is just as important as by whom. Patients reported that digital access is often welcomed as a helpful route to care but for others it is seen as a barrier, making access to General Practice harder.

General Practice in Devon is mainly rated Good or Outstanding by the CQC, but we know from the reported pressures that practices are struggling.

For both patients and staff, change can be difficult and significant changes are required in the way that services are delivered, and by which clinician/professional.
As part of the development of this strategy, we have reviewed national documentation, key research, primary care models and existing strategies in place nationally. We have also conducted extensive engagement with healthcare professionals, Devon system partners, patients and other key stakeholders, to ensure this strategy reflects the opportunities available to best meet the challenges faced by General Practice and the wider system over the next 5 years.

A number of demographic and environmental factors set out in this Strategy make transformation an absolute necessity. A rising population, weighted to an older demographic, areas of high deprivation, significant workforce challenges, limited capital investment opportunities and a wide range of unsuitable estate make working more effectively across health care teams and doing things differently essential.

Honesty with patients and the wider population is required, as is the ambition to describe how these changes will lead to better care for the patients who need it most, and in better health outcomes for those in society whose needs are not always identified and met.

Care in General Practice is provided by a rich variety of clinical and non-clinical staff and patients reported they want to see the right person. We need to shift perception that the right person is always a GP and show how much value every member of the team brings to their care in General Practice.

2.1 Strategic Principles

Our key set of General Practice Strategy principles, underpinned by the national and local research, come with clear financial commitments and priorities. They are:

- General Practice is a speciality which has a key role in prevention, the identification and management of long-term conditions, and the treatment of certain urgent

care issues. Each of these specialisms may require a different delivery model

- Good access to good quality General Practice services for all patients will be based on what is clinically appropriate. This includes the type of professional that a patient sees and the method of delivery of care
- To ensure General Practice remains sustainable it needs to work as part of broader neighbourhood teams, utilising population health management
- Investment will be focused at Primary Care Network level and distributed differentially to ensure we address health inequalities and areas of deprivation
- Evidence and data will be required to adapt and improve services for patients
- Devon geography means that one size does not fit all but a scaled up general practice is likely to be more sustainable

For General Practice to be sustainable it will be delivered differently with more at-scale working at PCN or locality level. We already know that this works from examples in larger practices and where PCNs deliver services, such as extended access at scale. How this happens will vary and range from smaller practices working collectively, supra-practices or vertically integrated provision.

Honest and open discussions with patients about why their services are changing will be embedded throughout General Practice and in the wider system.

2.1.1 Investment

We will differentially invest, to focus resources where change is needed most, in our most deprived populations and where life expectancy and outcomes are lowest. This will in turn support the wider health and care system to manage demand.

2.1.2 Models of care

We will work with General Practice to support working to a model of care which differentiates prevention, long-term condition management and on the day care. We will support the development of specifications, outcomes and SLAs which will support PCNs to work together to deliver services at scale.

Our key drivers to enable change and support access for patients across the county are **workforce, modern infrastructure for estates and digital** and **population health management** (**PHM**).

2.1.3 Workforce

We will invest as an ICS in delivering the right workforce for Devon both to retain the workforce we have, and, in the people, we will need in the future to meet our rising and ageing population. We will work with providers to develop service level agreements and job descriptions which support integrated working and give staff the right level of clinical and professional support. We will also build on the success of the Digital Locum Pool to support practices which have short-term capacity challenges.

2.1.4 Estate

We will utilise our estate in the best way possible and for General Practice this means more at scale working across their PCNs and as wider neighbourhood teams. We will actively prioritise investing in the co-location of services and at scale provision. Where available, ICS capital investment will be open to General Practice and targeted towards our more deprived areas, and where it will have the biggest benefit to patients.

2.1.5 Digital

The Digital Front Door will continue to be the route into care, but we will ensure this does not disadvantage those who do not have access to modern technology by agreeing standards with General Practice for support to people who need it.

2.1.6 Population Health Management

PHM will ensure we use evidence base to target investment and resources where they are needed most and will ensure our neighbourhood teams are able to shape services in the best possible way for their patients. We will fund dedicated business intelligence and change management support in order to drive this forward.

The next five years will be difficult but by setting out our commissioning intentions now we will be able to focus resources where they are needed most and support General Practice in Devon to continue to deliver care to their patients in a way that existing staff are able to and will attract the staff we need for the future.

3. Shaping the Strategy

3.1 What we have already achieved

Devon has achieved great successes through collaboration and General Practice working collectively as PCNs and Localities. Much of this achieved a global pandemic and significant changes in how care is provided across a large geographical area.

3.1.1 Access

- All practices deliver online services with more than 500,000 online consultations taken place in 2021/22.
- Huge increase in remote working capability deployed to help GPs and practice staff work flexibly, nimbly, from anywhere.
- Extended Access (evening and weekend appointments) commissioned and provided across Devon.
- Extended Access repurposed temporarily to support the COVID-19 vaccination programme which saw PCNs deliver the majority of Devon jabs.

3.1.2 Workforce

- 335 WTE recruited to additional roles and reimbursement scheme (ARRS) with all PCNs successfully recruiting new and additional staff.
- Digital locum service created that allows clinicians from anywhere in the country to work safely as part Devon GP practice teams
- Primary Care Workforce Bank, originally set up to support COVID-19 vaccinations, now providing another option for GP practices seeking additional staff
- Investment into Practice Manager training
- General Practice Nurse strategy in place and shaping training and development
- Recruitment successes through use of funded (BMJ) advertising for all practices.
- Investment in meetings to ensure GP clinical voice is part of General Practice workplans, including LCP-level funding

3.1.3 Modern Infrastructure

- New practice buildings in Crediton, with others such as Dartmouth and Brixham in progress
- Huge increase in remote working capability deployed to help GPs and practice staff work flexibly and from anywhere
- New online consultation software provider procurement complete, giving practices a choice of system for the first time

3.2 Research

The NHS Long Term Plan (2019) described the approach to delivering strategic and GP contract objectives.

The key changes pertinent to this strategy are described as:

- Local NHS organisations increasingly focused on population health and local partnerships with local authority-funded services through new Integrated Care Services
- Boosting 'out of hospital' care, dissolving the historic divide between primary and community health services and health inequalities
- Patients will get more control over their own health and more personalised care when needed
- Digitally enabled primary and outpatient care across the NHS
- Redesign of the NHS to reduce pressure on emergency hospital services

The COVID-19 pandemic accelerated some changes, such as digital enablement and accessing care differently, whilst hindering development of others, such as prevention and reducing inequalities.

Recent reports such as the Kings Fund (2020) and the Policy Exchange (2022), reinforce the need for us to plan for the next 10 years. Recurrent themes include workforce challenges, continuity of care, on the day access, quality of service, working at scale and digital access.

The Fuller Stocktake (2022) with its framework for increased integration suggested the following priorities for General Practice:

- PCNs need to evolve into integrated neighbourhood teams with shared ownership for the health and wellbeing of their populations by investing time and space to solve problems collaboratively
- Services for urgent, same day care should be streamlined; using data and digital technology to ensure the right person provides the right care
- Continuity of care where it's needed for patients should be more proactive and accessible
- Being more proactive in reducing ill health, creating healthier communities by working across the voluntary sector and local authorities

These national findings mirror the Devon engagement conducted for this Strategy, most notably the clear separation between on the day care and long-term condition management.

3.3 Devon engagement

Engagement with local patients, partners and healthcare professionals took part in focus groups and surveys were sent to patients and staff across Devon.

3.2.1 System partners and healthcare professionals said:

- The strategy must describe what General Practice does and should be communicated with the population effectively
- There needs to be access to data and business intelligence
- Prevention should be a priority with strong links to community. It should help provide good access and support continuity of care
- The strategy should seek to address health inequalities
- We need to promote the Additional Roles and Reimbursement Scheme (ARRS)
- The strategy should be more of a guide and enabler, allowing more local delivery plans and models
- We need to support the mixed economy of rural and urban in Devon
- We need to address issues where estates (buildings) may be a barrier to change
- We need to support practices with the Greener NHS plan

3.2.2 While patients and public said:

- Mixed experiences of using general practice services – some very positive experiences during the pandemic
- GP services can be difficult to access and there are barriers to accessing care, impacting on the level of care and support they received
- Feedback emphasised the value of face-to-face appointments, continuity of care and having a good relationship with the GP and wider practice staff
- Technology was useful for busy people, routine appointments, specific care and accessing a broad range of services
- Some participants were less positive about the use of technology, reporting long waiting times for responses, lack of access to technology and lack of skills
- There should be consistency of access and experience
- Support for users when accessing technology to ensure it meets the needs of those with differing skills or access
- We should manage patient expectations with clear communications, signpost well, support access and build trust with patients
- We should explore how positive aspects of living and working in Devon can be emphasised through the strategy to support recruitment
- Self-care can be a vibrant part of general practice. The strategy could set out how these aspects can be delivered alongside more traditional forms of health and care
- We need to incorporate patient participation within the strategy and redefine the roles of patient participation groups (PPGs) following the pandemic

The findings of this engagement and the feedback collated has been key to the development of this Strategy.

3.3 Current Access

The role of General Practice is to detect, treat, and safely manage the ongoing health of their patients, in both the short- and long-term, according to patient need. Appropriate access must be in place to enable this to happen.

In 2021/22, General Practice in Devon delivered:

- 8.1 million appointments, of which 4.8 million were face-to-face
- Over 43,000 home visits were conducted
- Over 2.7 million on-line and telephone consultations
- And exceeded the number of appointments delivered when compared to the previous 3 years, and when compared with the national average
- Above the regional and national average for both on the day and face to face appointments, and online consultations.

All Devon practices offer online services and there has been a huge increase in remote working with resources deployed to help GPs and practice staff work more flexibly. Devon has been testing a digital locum service that allows clinicians from anywhere in the country to work remotely to provide greater access than our existing workforce could accommodate. Digital locums help manage triage and online consultations, ensuring there is enhanced capacity on-site for local GPs to see people face-to-face. Evening and Saturday appointments are also available through Extended Access in all practices.

More than 500k people in Devon are now registered on the NHS App (NHS Digital 2022), providing access to General Practice.

Procurement has recently been completed for new online consultation software for Devon practices, giving them a choice of system for the first time. This choice will enable PCNs to have the flexibility to care for patients in a way that meets their needs.

Rapid changes had to be made at the start of the COVID-19 pandemic. To limit exposure to both patients and staff, access changed radically with the digital front door becoming the first point of access. Some patients like a digital approach but it has led others to see General Practice as ‘closed’ or hard to access and this needs to be resolved.

Our patient survey showed mixed responses, from real benefits such as prescriptions, to on-line services not being intuitive or easy to use. Patients were also concerned about digital inequity with some being excluded from accessing care.

We have invested in additional capacity to meet some of the most immediate issues and pressures commonly experienced over winter through the National Winter Access Fund. This investment created over 130,000 appointments and we further invested into additional capacity through local funding with the Devon Spring Access Fund, providing short-term, immediate benefits to patients and the wider Devon health system. But these are short-term measures and do not provide a viable solution to the long-term challenges we face.

Why and how patients access care was a key theme; whether for long term conditions, accessing one-off care or supporting the identification of illness. This diversity of need must be reflected when changing access to care, to best reflect what is clinically appropriate and on a needs-based approach.

The pandemic has also resulted in a backlog of work where patients often actively avoided using health services, which was further compounded by reduced staffing due to COVID-19 illness.

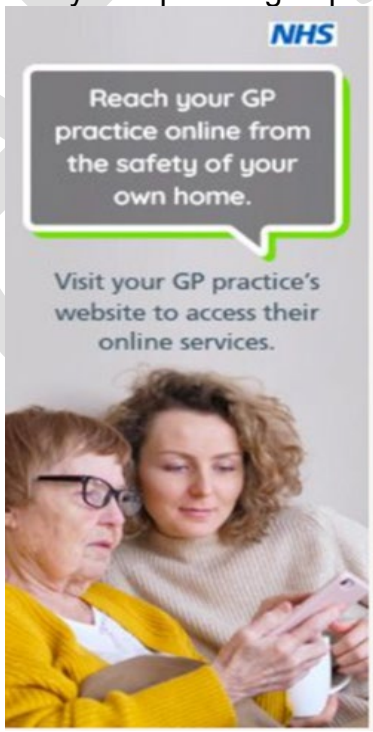
Our patient survey question on access (including getting through on the telephone) reported 34.5% having 'bad' access. 13.6% reported 'good' access (including on the telephone). This shows a significant variation in patient experience and probably expectation. What is reasonable will vary but telephone access remains a crucial point of contact for all patients. Many practices already ask patients to call for non-urgent matters such as test results outside of peak times and this should be respected by patients. A reasonable average waiting time for a call to be answered we consider as no longer than 5 minutes.

The latest Ipsos patient survey reports 80% of patients in Devon are satisfied with the appointment offered, higher than the National average of 72%. Experience of making an appointment is lower; 65% rated as Good in Devon though higher than the national average of 56% (Ipsos, 2022).

One of the biggest challenges we face is addressing the difference between what patients want, feel they need, and what their actual clinically assessed requirements are.

Patient overall experience described as 'Good' in Devon has dropped from 86% in 2020 to 80% in 2022. Although still higher than the national figure of 72%, whether it is the waiting time for an appointment, ease of getting through on the phone or who delivers care and from where, we must tackle patients perceiving barriers to accessing care in an increasingly busy system. And in a way that is realistic, sustainable, and safe. This will ensure patients know the right care is delivered in the right way by the right person.

Significant change requires a national change in policy, but we should press on in Devon with addressing this challenge locally with patient groups.



4. The Case for Change

Devon has excellent General Practice, with most practices consistently achieving 'Good' or 'Outstanding' ratings from the Care Quality Commission (CQC). But there is still variation in terms of access and quality of care according to where people live, and we need to address this.

Demand on services was already extremely high before the COVID-19 pandemic and this will increase not just because of the pandemic backlog, but because of an ageing and growing population.

4.1 Future planning

The population of Devon is set to grow by 17,308 (14%) by 2043, with low growth in under 65s (0.4% for 0-15 years and 5% for 16-64 years), but considerable growth in the older population (40% for 65-84 years and 92% increase in people aged 85 and over). With a higher-than-average age profile and associated long term conditions, continuing to deliver services in the same way will not be sustainable.

AREA	AGE GROUP	2022	2027	2032	2037	2043
Plymouth	All ages	264,780	267,235	269,810	271,129	273,161
Torbay	All ages	139,170	143,021	146,411	149,479	153,086
Devon	All ages	826,095	860,677	889,291	912,665	938,240
Devon ICS	**All ages**	**1,232,066**	**1,272,960**	**1,307,543**	**1,335,309**	**1,366,530**
Cumulative growth (from 2022)	**All ages**	**3.0%**	**6.4%**	**9.3%**	**11.6%**	**14.2%**

Figure 1 ONS Devon projections 2022-2043

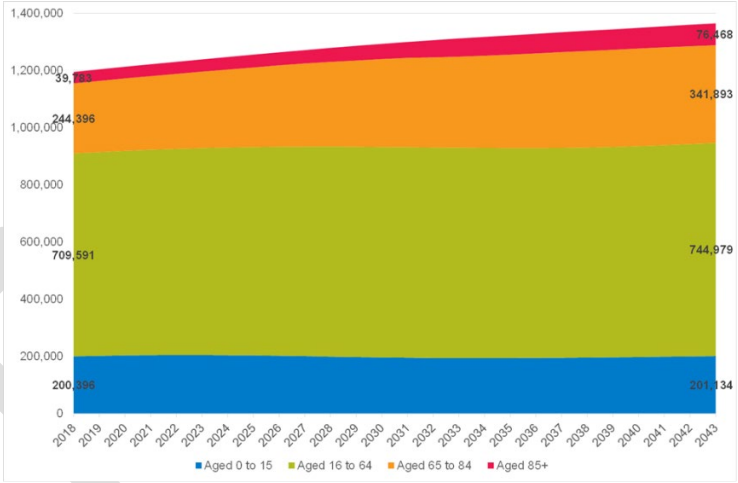


Figure 2 Population Change in Devon 2018-2043 (ICSD)

The ICS has been placed in the most challenged category nationally owing to longstanding financial and performance challenges. We must make improvements and General Practice has an integral role in our plans to deliver care differently and make best use of all available funding, by making smarter choices in how and where we target investment.

Pressure with General Practice has been reported on a weekly basis through the Devon LMC General Practice Activity Report. Localities are consistently reporting unsustainable demand, staffing issues and unrealistic patient expectations.

4.1.2 Workforce

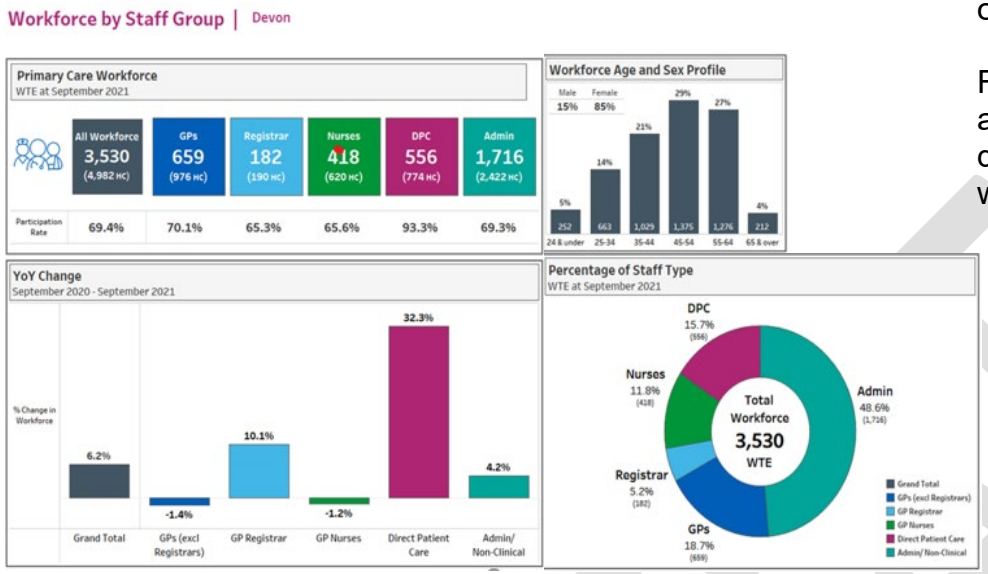


Figure 3 - Primary Care Workforce in Devon (Health Education England) 2021

There are 121 GP practices in Devon, providing care to our 1.2 million patients. Within these practices there are 3,530 total staff (WTE). Between March 2020 and March 2021, there was an increase of 0.8% of GP Nurses, 4.6% of admin/non-clinical staff and 8.9% in Direct Patient Care staff. However, there was also a 0.2% fall in the number of GPs. Workforce planning will need to consider the broad range of roles and the number of practices and PCNs in our large geographical area.

We know there are increasing staffing issues linked to staff burnout, high vacancy rates, and low retention. We will also lose a significant number of professionals in the next ten years because of the age profile of our workforce, which is more pronounced than many other parts of England. Currently, 19% of GPs are over the age of 55 and across other staff roles in General Practice 30% of staff are over 55.

Forecasts show the current workforce will need to grow over and above 2022 numbers by 906 in order to meet growth demand by 2030. On current service delivery models this would include 203 GPs, 107 nurses and 440 administrators.

The working patterns of clinicians are changing; the intensity of clinical sessions, choice of non-clinical and specialist roles and national policies influencing retirement age make recruitment and retention investment ever more pressing.

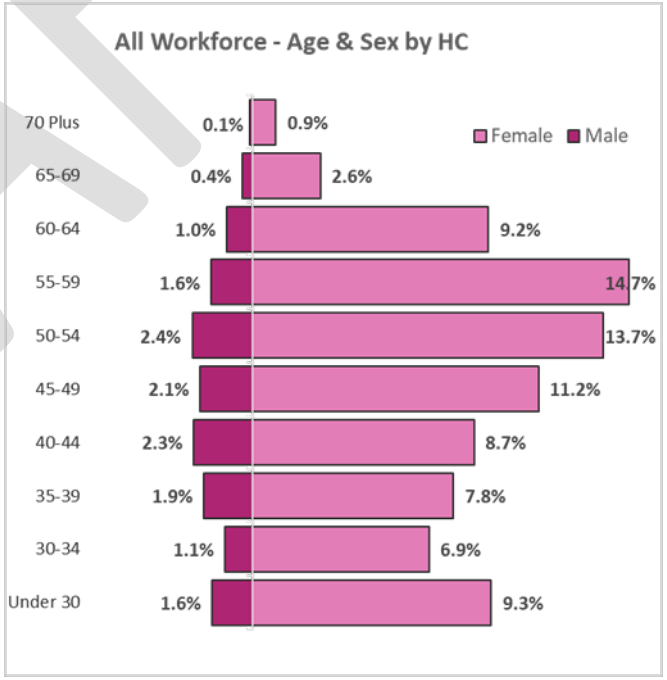


Figure 4 Workforce by age and gender in Devon (HEE, 2021)

GPs make up less than 20% of the overall workforce so we need to consider all areas of workforce and how to recruit and retain the best. In 2021/22 PCNs received £12.5m new investment into Additional Roles; 429 professionals in PCNs who are able to support patients across a wide range of health conditions and needs. But we were unable to utilise all available funding as recruiting the right people is challenging within the landscape of still newly evolving PCNs.

It is recognised that staff will often move between primary care and secondary care. General Practice therefore cannot operate in isolation and must work as part of the ICS in workforce planning. To ensure we invest where most needed, it is crucial that practices and PCNs submit accurate staff detail into the National Workforce Reporting Service (NWRS) as this data will inform where and how funding is allocated.

As an ICS it is unaffordable to continue to develop as we are, as to match expected increased annual demand growth of 2.9% by 2030 the ICS would need to find over 24,000 WTE staff across all providers.

In order to maintain the current workforce position over the next 3-5 years, the ICS will need to make best use of all available staff through different ways of working, embedding digital innovation and maximising the skill mix of staff across all provider organisations, including General Practice.

Engagement for this Strategy demonstrated the clear link between where and how services are delivered should help support General Practice to successfully attract and retain the workforce it needs. Both in terms of attractive roles and reducing the risk of burn out trying to deliver all things to all patients. Other linking factors were co-location of services, working in a medium to large practice, and working as PCNs.

This is reflected in the way services are already being shaped, either through designing Health and Wellbeing Centres, or delivering services such as Extended Access at scale across PCNs.

With the growing complexity of PCNs, Collaborative Boards and LCPs, commissioners must not lose sight of grassroots GPs and wider practice and PCN staff. There is an unprecedented opportunity for genuine co-design between commissioners and General Practice Leaders.

It essential that our future planning provides a pipeline of the trained staff required and we will need a robust and responsive training hub that provides appropriate, accredited training, supports retention and the development of all staff groups, aligning to ICS priorities.

4.1.3 Digital

Has the technology used by General Practice teams improved your ability to access General Practice services?

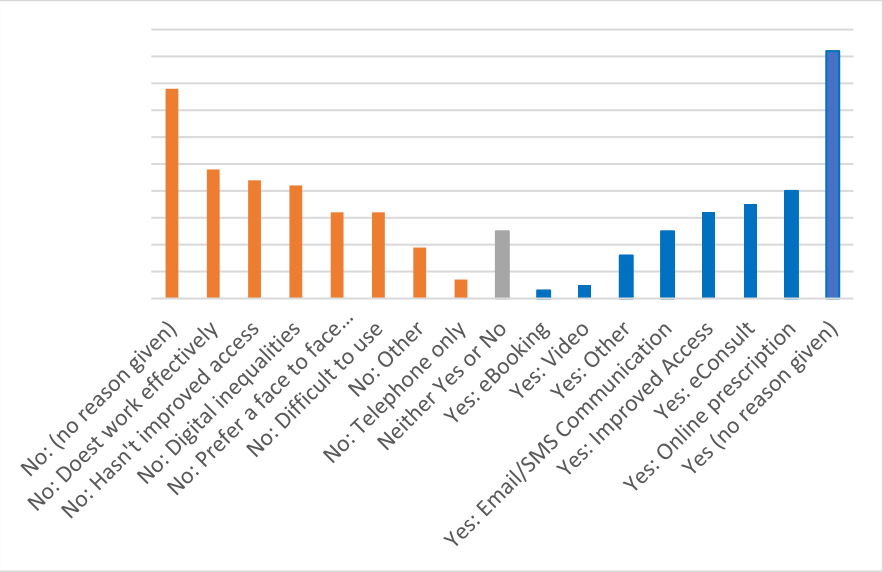


Figure 5. Has technology improved access to General Practice (Devon Patient Survey, 2022)

Digital advances are continually creating possibilities for new ways of enabling people to stay well, prevent ill-health, and provide care. The ability to share information across all our services will improve quality and in particular the safety of services and transform the ways we work.

The use of digital solutions and data will drive collaborative system working, connecting health and care providers, improve outcomes, and put the patient at the heart of their own care.

4.1.4 Estates

Although familiar to patients the traditional converted house has become more difficult to staff effectively, be an effective way to deliver 21st care and be affordable and sustainable in the upkeep of aging buildings. This is further compounded by the rapidly changing health system requiring greater integration of services and buildings only 20 years old becoming outdated and in need of investment.

Without enough space, correctly configured PCNs are limited in how they can expand their services, makes recruitment more difficult and can often hinder practices attracting new partners as many do not wish to take on building ownership.

How we use buildings is key to improving access to care, driving prevention and wellbeing. Creating safe, accessible, and modern facilities that are capable of housing more staff and adapting to new models of care need to be fit for the future. We recognise that the capital investment required to develop every building in Devon is unachievable and so difficult choices will need to be made.

4.2 Model of Care

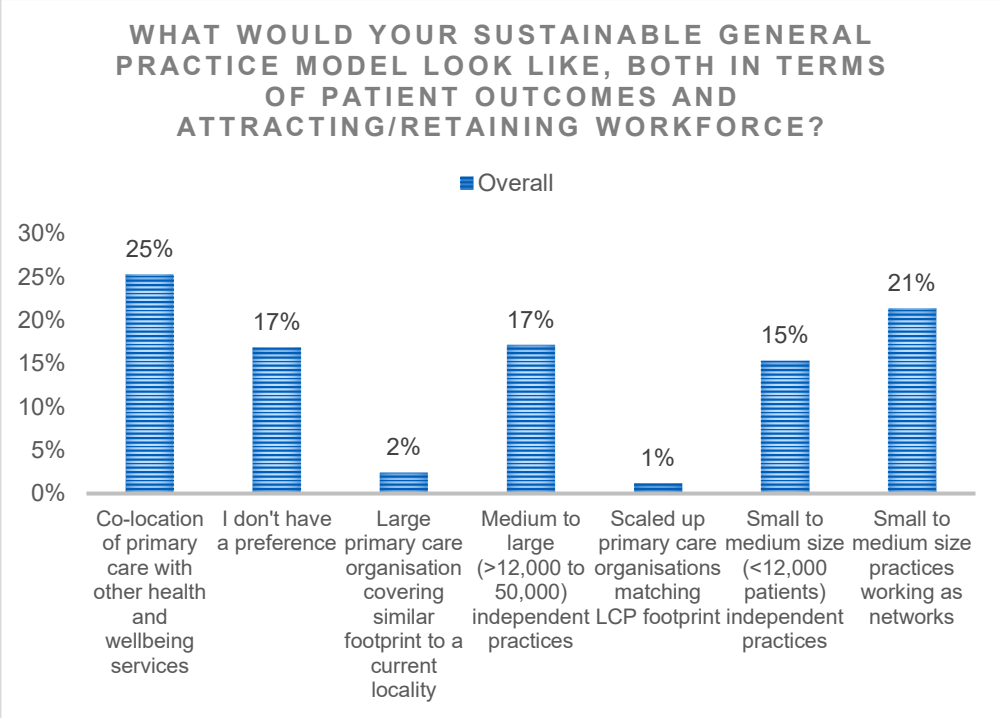


Figure 6. What healthcare staff and GPs told us. Devon Strategy Survey (2022)

Evening and Saturday access is already in place and from October 2022 will form part of the National requirements for PCNs. 'Good' access includes a mixture of online, telephone and face-to-face consultations as this means the needs of patients can be met effectively. Working at scale across PCNs allows for a more diverse range of clinical staff available to see patients and help meet clinical need, sometimes at locations away from the patient's practice.

4.2.1 Continuity of Care

General Practice plays an essential role in detection and management of Long-Term conditions (LTCs) with continuity of care and face-to-face consultations reported as a key priority by both health professionals (71%) and patients (76%) living with complex LTCs.

The number of research articles and case studies showing its link to reduction in mortality are significant and show why this this needs to be a key focus when shaping future service delivery models. How PCNs develop services will need to accommodate a rising, aging population and the associated increased need for continuity, balancing against those patients requiring less continuity but still requiring access to care.

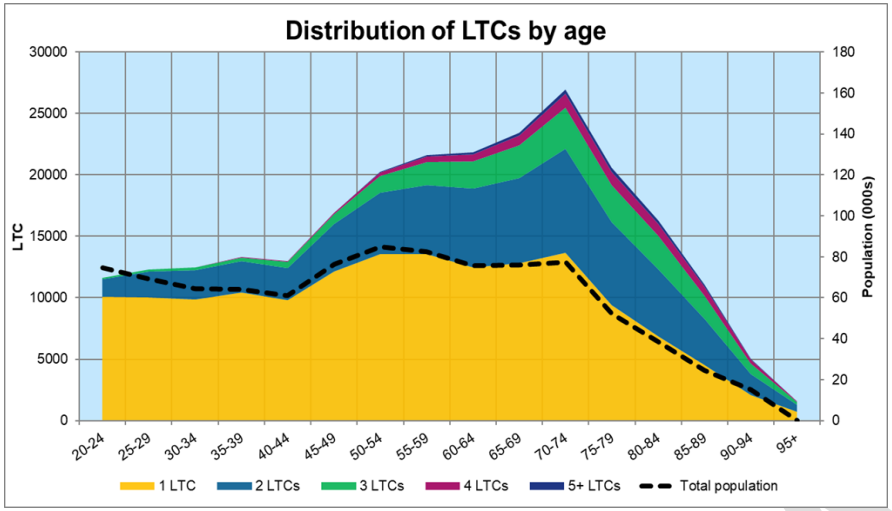


Figure 7. Distribution of Long-Term Conditions by age

With the expected continued growth of an older population, and a forecast of 2.3% annual growth in General Practice contact, effective and accessible continuity of care will be an even greater part of any change and, coupled with workforce challenges, reinforces the need for PCNs to work differently.

4.2.2 On the day care

Timely access when patients need it most was reported as a key priority for both health professionals and patients. In contrast to LTCs any patients with generally good health and digitally aware, reported that continuity was less of a priority, and were happy to adapt to digital access or a remote, online locum.

The evidence both locally and nationally is that we need to facilitate, and support scaled-up, on the day access for General Practice. This in turn will support practices to deliver continuity of care where it's needed most. This may look different for patients as the change from practice to PCN delivery means visiting different locations according to need. But this is already happening in extended access, demonstrating patients are willing to travel if it makes sense, something our patient survey showed.

4.2.3 Preventative care

General Practice plays a key role in the prevention of future illness through the delivery of national screening programmes, proactive interventions identifying new symptoms early so investigations and referrals happen in a timely manner, reducing patients at risk from developing long-term conditions.

Our practices and patients reported there was scope for development of online platforms as a tool for providing healthcare information, advice, and signposting. Patients reported that social media platforms should also be developed for this purpose.

4.2.4 Deprivation

We know there are significant health inequalities in Devon that must be addressed. With an increase in poor mental health and wellbeing, even greater pressure is evident across the whole health and care system.

General Practice already works with partner organisations including the voluntary sector and the addition of roles like Social Prescribers has further improved actively connecting patients to preventative and supportive care. This needs to be expanded, particularly where there are existing inequalities.

Our plan to invest differently into where services are needed most will be guided by deprivation and the known health inequalities that follow.

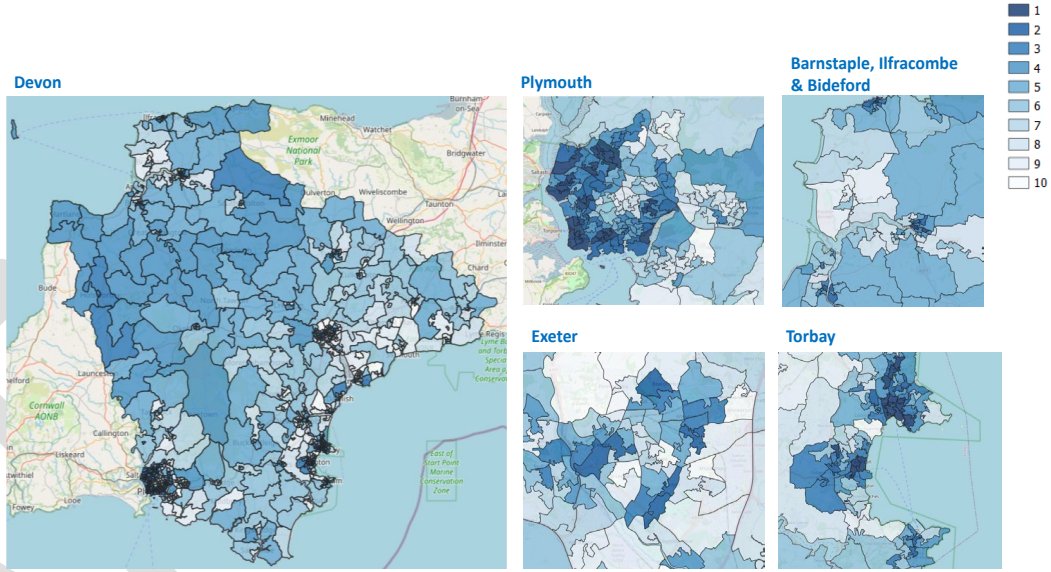


Figure 8: Devon Population Deprivation Decile Distribution

5. What will be Different

5.1 Different for patients

5.1.1 Access

PCNs already work differently, and this will expand, with where and how patients are seen, led by clinically appropriate timelines
and whether patients need urgent, pressing, routine, preventative care and whether continuity of care is crucial.

The ICS will lead and support open conversations with patients on why things need to change and what is reasonable to expect. This will vary across our population both in terms of clinical need, deprivation and geographical location; what works in a city may not work for a rural community, but the reasons for working differently set out in our case for change will be universal.

Patients will also see an increase in signposting to self-care, or other areas of Primary Care as an alternative to General Practice.

5.1.2 Communications and engagement activity

To support General Practice, we will launch a new public communications plan so patients understand why and how General Practice will change in the future. It will include what patients can expect, how to access services, what expectations there are on them, and to raise the profile of the wider clinical roles in PCNs.

5.1.3 Making digital inclusive

We need to collectively support patients with digital access, training, access to tools and skills. Some practices already have great examples/case studies of in-house training they offer to patients in using online consultations and we need to further develop skills and knowledge across Devon.

Specific support has been trialled to develop patient's skills in using online GP consultations, including online learning and face-to-face support using an iPad in a waiting room. Digital 'trainers' will help local people with their digital queries via online 'virtual drop-in sessions, social media or even 1-to-1 advice and guidance either over the phone, via email or webchat. We will learn from these projects and support PCNs to ensure this type of support is available where it is needed.

5.1.4 Patient Participation Groups (PPGs)

PPGs can and should be hugely important in improving the wellbeing of our communities. Working with Healthwatch Devon, Plymouth and Torbay to support PPGs is an effective partnership in helping community groups develop a stronger voice in shaping local health and social care services.

Support such as the Healthwatch Assist Network is already available with support for promotion, resources, running surveys, and events.

PCNs, in conjunction with their member practices, will need to develop their member practices' PPGs further to:

- Strengthen and improve their PPGs with clear roles and responsibilities for members
- Introduce more innovative ways of working across their PCNs
- Provide training and support for people to be informed and active members, supporting self-care, empowering local long term condition support groups
- Support patients in how use of social media, apps and digital platforms

5.1.5 Equality, diversity and inclusion

Primary care services share the system vision for equality, diversity and inclusion.

"Everything we do will be inclusive of our people and communities across Devon. We will prioritise co-production, actively involving local diverse communities and listening to the voices of our population. Our senior leaders will champion diversity and build trusted relationships." (NHS Devon People and Communities Strategy (2022))

As the front door to healthcare, General Practice should be welcoming and accessible to all. Examples of our priorities include (but are not limited to)

- Ensuring availability of translation services
- Providing awareness training to staff e.g. – cultural awareness training and Pride in Practice.
- Being fully inclusive of all its staff, patients, and communities

5.2 Different For General Practice

5.2.1 Neighbourhood teams

PCNs are already working with their Local Care Partnerships (LCPs) and this work will expand. Working collectively to meet patient needs will mean more collaborative working and moving away from the traditional model of delivering everything General Practice does for their own registered patients from their own premises. We have already seen this works well for the highly successful COVID-19 vaccination programme, demonstrating how much General Practice can do when it works together both with each other and with other parts of the Devon health system.

5.2.2 Provider model

We have practices ranging from 2,500 to over 40,000 registered patients with GP partners predominantly holding the responsibility for delivering General Practice. There is no desire to move away from GP partnerships, but we must recognise the challenges faced in the traditional model and how this will become increasingly hard to sustain. This is further compounded by the changing role of General Practice and the multi-disciplinary teams providing a range of care, including PCN staff.

This does provide opportunities for GPs to share practice responsibility with their wider clinical and non-clinical team and this is already happening on a small scale.

There is no one size fits all and not one model that can, or should, be replicated across urban and rural practices. We will actively support practices through contractual mergers, closer partnership working or integrating with other providers in Devon. We will support and actively encourage changes that add real value to the care offered to patients and the ongoing resilience of General Practice across Devon.

5.2.3 Integrated estates

Building ownership must not be a block in developing health services in Devon. We must use all means available to us to allow General Practice to work in different settings and in different ways to make best use of all health estate we have across Devon.

We must use our estate across the whole health system as efficiently as possible and make sure investment is targeted wisely.

Whether rural or urban we will actively support General Practice to use their own estate differently across PCNs and to share estate with other local providers to offer the best and most sustainable care to their patients.

5.2.4 Greener NHS

As part of this strategy, the Greener NHS agenda will be a key area in how we can support general practice to improve the environmental impact of our services. We have to achieve an 80% reduction in our 1990 baseline carbon-footprint by 2030.

5.2.5 Workforce

The ICS workforce strategy is due to be completed by Autumn 2022. As part of the work to inform the strategy, detailed

analysis of current workforce and the workforce required to meet future demand will be shared with PCNs.

The ICS is developing a workforce planning tool, which will be available for all organisations within Devon to use in planning future workforce requirements and addressing any gaps. We will ensure General Practice is an equal partner within the ICS, planning and recruiting collectively both for clinical and non-clinical roles.

5.2.6 Primary Care Leadership

The four Collaborative Boards represent General Practice in the North, South, East, and West, comprised primarily of GPs and Practice Managers. Their operational role increased under the urgent need to work differently under the COVID-19 Pandemic and now is the time to take stock and review the way ahead. We recognise the challenge of being both a leader in the ICS and being personally invested in individual practices and how these priorities can sometimes come into conflict. Change must be safe, supportive and in the context of building sustainable General Practice for the future and we will need to further develop provider collaboratives.

5.2.7 Deprivation

Using good and consistent data through the One Devon dataset will ensure we effectively target investment into all areas of deprivation across the County.

5.2.8 Quality Dashboard

Led by the Quality team, the quality dashboard will support investment decision with input from provider collaboratives to ensure support and focus is on the right place for the right reasons.

5.3 Different for systems

5.3.1 Integrated Care Systems (ICS)

The ICS function is to enable partner organisations to work together through the established Primary Care Networks and Local Care Partnerships and around the provider collaboratives for specialised services that already exist.

The key aims of ICSs are to:

1. Integrate care
2. Improve health outcomes
3. Tackle inequalities
4. Enhance productivity
5. Support social and economic development of communities

A large proportion of daily patient contacts is within General Practice; in May 2022:

- 26k patients attended an emergency department in Devon
- 620k appointments were delivered in General Practice in Devon

It is essential that General Practice is given the right support to enable there to be collective stewardship of our system to deliver the best value for all available funding.

5.3.2 Local Care Partnerships

Working collaboratively can be challenging but it when underpinned by good and honest relationships good decisions are made. LCP's want a happy and healthy workforce, vibrantly supporting and enabling every person to improve health and wellbeing outcomes and reduce health and wellbeing inequalities and do so by working across the health and wellbeing system. Often a cause for strained relationships, LCPs will work to reduce the unwanted overspill into each other services.

LCPs will be the route to enact the changes set out in this Strategy.

5.3.3 System flow

As practices continue to step beyond the traditional patient list and work at scale, managing patient flow at scale, this will enable a more robust General Practice which can meet the needs of patients and avoid unnecessary escalation within NHS services.

5.3.4 Investment

Organisations have previously been driven by an activity-based model of commissioning rather than value, contributing to distorted priorities and making it more difficult to invest in preventative approaches. National funding makes stepping away from activity-based prioritisation difficult so where we commission locally, it will be outcome-based and at scale to support better access to the right service for patients.

5.3.5 PHM

PHM data will identify specific clinical needs that could be met more effectively, including service redesign at neighbourhood or place level. It will help tackle health inequalities by delivering targeted MDT interventions that lead to health improvements and better outcomes for patients, including children and young people and those with mental health issues.

A PHM approach will also result in the development of more sustainable, increasingly integrated services that make better, more effective use of our physical and financial resources. Differential investment will be aligned to demonstrable patient need and include supporting health prevention and closer working with the voluntary sector. It can also help inform future workforce requirements; patient needs will be different across LCPs and require variation in staffing models across PCNs.

Primary Care Networks delivering vaccinations
North Devon

Three Primary Care Networks in North Devon worked in partnership to deliver the first phases of the covid vaccination programme. They identified Barnstaple Leisure Centre as a central venue large enough to hold clinics safely. Clinics were held throughout the week and weekends, staffed with a mix of admin, clinical pharmacists, pharmacy technicians, nurses and doctors from all the practices, on a rota basis.

A lead manager for the programme coordinated vaccine delivery and a site manager was in the clinic at all times to oversee and trouble shoot. A bank of enthusiastic volunteers helped at every clinic supporting and directing patients.

6. Implementing the Strategy

To enable continued delivery of safe, quality care in sustainable ways we will provide support across 4 key areas:

- Workforce
- Modern Infrastructure: Estates
- Modern Infrastructure; Digital Devon
- PHM

And with targeted investment to ensure General Practice can engage and thrive in the Integrated System for Devon

6.1 Workforce

Without the right workforce, trained and well supported, General Practice will not be able to deliver the right care in the right way. We will work towards a more resilient, stable and competent integrated multi-disciplinary workforce and, to reduce barriers to employment options, encourage parity of contractual terms for all staff.

We are committed to working with General Practice to tackle the workforce challenges that we collectively face. We do not underestimate the challenge of retaining good staff who continually face pressure at work; nearly 50% of staff are non-clinical and the first person a patient speaks to. We will foster a better employment culture through wellbeing support and continued investment into our health and wellbeing offer available to all staff working in General Practice.

- Place-level funding to target care in the areas of greatest need
- Service Level Agreements to support joint or rotational roles across services
- PHM data will be used to help shape the right workforce for PCNs
- Working with the Training Hub, we will create whole career pathways across General Practice roles with the right accredited training
- We will support PCNs recruit from outside of the county by funding finders fees charged by agencies across the of roles available to General Practice. To ensure this is a sustainable approach we will prioritise PCNs with the greatest health challenges and where recruitment has been a historically challenging
- We will build resilience in place-based teams by making use of alternative employment models such as community trusts, supra PCNs or third sector
- We will continue to invest in the future workforce of Devon by supporting accredited training. PCNs will need to work with us to ensure trainee posts are supported both in time to study and a practice to work in

- We will continue to support practices and PCNs to secure International Medical Graduates for Devon

- We will support at scale recruitment and development of retention initiatives and attend recruitment fayres outside of Devon

- We will invest to minimise the risk of GP burn-out by working closely with the LMC and appraisers to ensure the right level of support is available when its needed.

- We will expand the workforce bank offer to include more roles, including funded training for those able to commit to bank hours and who will support PCNs with the greatest need

- The ICS will use a workforce planning tool for use in planning future workforce requirements and addressing gaps, ensuring General Practice is an integral part of Devon-wide workforce planning

- We will support PCNs to retain good staff by supporting PCNs to develop shared processes and procedures, essential for working at scale, and create opportunities to develop ARRS roles into portfolio careers

6.1.2 Leadership

- We will commission an independent assessment of the overall value of how we currently engage, and plan, and we will work together to deliver good value for money planning and leadership

- We will work with Collaborative Boards to establish a suitably representative and empowered Provider Collaborative with a wide range of clinical and professional roles represented in discussions.
- We will continue to invest in PMs wishing to move into system roles

- We will equip people with effective leadership skills and will support the development of Clinical Directors and other PCN leaders, with particular emphasis on nurturing those who have not yet felt able to step forward, and those from under-represented groups, such as pharmacists

Paramedics undertaking home visits
St Thomas Medical Group, Exeter

The St Thomas Medical Group (and Exeter West Primary Care Network) employs four paramedics, along with GPs and Advanced Nurse Practitioner's (ANP), for a home visiting service. The team visit people who are housebound and need acute care home, as well as Quality and Outcomes Frameworks (QOF) activity. The service frees up GP time and patient feedback is extremely positive. When fewer home visits are needed, the paramedics focus on acute care and manage urgent illness for the wider PCN.

6.2 Modern Infrastructure: Estates

The best use of buildings is key to enable the delivery of 21st Century services, together with the changing working patterns and skill mix of staff. A One Public Estate approach with integration of community assets and existing buildings is required.

To support both urgent on the day, and continuity of care for patients who need it, PCNs should deliver services across their combined sites. Patients must be part of the change from the beginning and any proposed changes in how a registered patient population will access care will require good patient engagement.

Investment for new estate will be primarily targeted to where there is greatest need in health inequalities and where there are opportunities to bring services together. This will allow financial scope to maximise opportunities where they arise and where they align to the ICS priorities. The ICS capital funding will prioritise health and wellbeing hubs with PCNs at the heart of developing the right hub for the registered population.

Working at greater scale can be done in different ways; from one practice as a PCN to multiple PCNs. We will support models that encourages integration and the best use of both staff, buildings and accessibility for patient.

- We are supporting PCNs to review and assess their current estates with outcomes integrated into Locality Plans.
- We will facilitate innovative ways of collaborative working to maximise the use of our buildings, share facilities and expand services.
- We will support PCNs in their engagement to ensure the challenges we face are transparent and on why sustainable and safe General Practice will be delivered differently. Service change will be underpinned by a patient able to see the right person and the right time for the right reason.
- We will support PCNs to deliver services at scale. An example would be on the day care as a 'hub' model at one site for all patients.
- In line with the NHS Plan and the Investment Plan and Toolkit, we will continue to invest into the Section 106 team and work with local authority partners to access the Infrastructure Levy as part of new building developments to ensure continued investment into General Practice.
- Prioritisation will be based on supporting delivery of integrated services at scale and will be by exception only at practice-level where geography makes investment essential.
- We will ensure there is full utilisation of Minor Improvement Grant, investment shaped on the outcomes of the Devon Toolkit.

6.3 Modern Infrastructure: Digital Devon

We will take a 'digital first' approach, whereas many interactions as possible with health and care will begin or be done digitally.

There is a new national commitment to make the NHS App the front door to NHS Services and we will encourage and support practices and patients to use it. Over 40% of the population of Devon already use it now, the national target is to have 75% of the population using it by 2024.

The NHS App already allows people to order repeat prescriptions and access their healthcare record and we are linking our new online consultation systems to it, so people can consult online with their practice. In future it will be expanded to allow people to manage appointments across the NHS, allow GP practices to send messages to their patients and allow patients to report some information back.

We will work with practices to improve the ways people can book appointments online, via the NHS App or other means. This will take on the learning from the development of a new generation of online booking systems developed for Covid vaccinations.

We know that some areas of Devon face challenges with broadband connectivity and mobile phone signal. This is improving and we are working with partners to help with that where we can. As faster connections become available, we will use them to connect our GP practices. We will also use new technologies such as 5G, initially for backup services. We will work closely as part of the One Devon Partnership to identify areas where there are the biggest gaps and signpost people to other local suitable alternatives for accessing the internet to use health tools e.g. local libraries

- We will help people and clinicians find and use trusted apps through our online Health App finder, ORCHA

- We will maximise the use of social media platforms to share healthcare information to as wide an audience as possible. We will work with GP Practices to help them make sure their websites are consistent, simple, informative, up to date and secure and that they are offering patients the services they need online

The Devon and Cornwall Care Record (DCCR) will ensure safe and secure access to patient medical records for the right people across NHS services throughout the peninsula, as patients access services across county borders. As our hospitals digitise more of their services and connect to the DCCR the scope quality of that record will improve. The record held and managed by a person's GP will still be the heart of their electronic health and care record.

- We will continue to provide technology to GP practice staff to allow them to work securely as flexibly as

possible. This will include expanding the use of new solutions such as ‘GP in the Cloud’

- We will support practices in the adoption and utilisation of technologies, so they are able to fully exploit their potential, while at the same time ensuring a levelling up of best practice happens across Devon.

- The Primary Care Digital Programme Board will continue to provide a route for innovation and development, ensuring reducing health inequity is an embedded part of the decision-making process

- We will take a problem-based approach to innovation, using technology to help improve primary care. By understanding the particular challenges and use cases, we will explore at scale the best options to address these challenges. Our team will support the adoption and adaption of these technologies into practices, while looking to ensure the best value. The innovation programme will be overseen by the digital board but will be based on real time evaluation and feedback from frontline primary care teams

- We will help staff collaborate through systems like Office 365 and the shared Devon GP Intranet

- We will support PCNs and wider geographies to consolidate onto the same GP Clinical system

- We will continue to give practices choice over the technology they use where we can

- We will continue to maximise the benefits of the Devon-developed digital locum platform

- We will primarily use national frameworks and catalogues as the preferred way to purchase new technology

- To avoid digital exclusion, we will ensure that there are always alternatives available to patients for accessing their GP practice, when internet or mobile phones aren’t available

Developing hubs for patient care
Beacon Medical Group, Ivybridge and Plympton

Beacon Medical Group in Ivybridge introduced the use of total triage for same day, urgent care demand. This is accessed through online consultations, telephone or walk-ins.

Patients are reviewed by members of the Urgent Care Team, comprising of a GP, paramedic, nurse practitioner, clinical pharmacist, physiotherapist and a minor illness nurse, and then directed to the most appropriate clinician for their needs at the appropriate location.

Multi-disciplinary working has fostered a great team ethos, with all clinicians providing expertise and knowledge as part of their speciality, managing 200-300 patients per day.

The increased focus from the wider team on urgent care issues is releasing more capacity and enabling GPs to spend time managing more complex and long-term conditions.

Using digital tools to improve access to urgent care
Buckland Surgery, Newton Abbot

Buckland Surgery utilised funding from the Winter Access Fund implement a new digital triage system. The practice triaged all patients through their online consultation software, increasing their capacity to manage the demand and ensure people got the most appropriate care for their needs.

An increase of receptionists to answer the initial phone calls, and an increase in same-day urgent appointments and additional locum GP sessions also helped improve access.

The practice provided training for patients using online forms, improving their ability to access care this way, leading to a significant improvement in their clinical triage with patients receptive in accessing the practice digitally.

The practice can now better manage people's needs leading to a reduction in waiting times for urgent appointments, an improvement in patient experience, a reduction in complaints, and improved levels of staff sickness and morale.

6.4 Population Health Management (PHM)

The impact of the COVID-19 pandemic slowed our collective pace in the delivery of effective PHM so we will drive momentum as part of system wide reinvigoration. We can then understand and target underserved patient groups including children and young people and adults and children with mental health issues.

- The ICS will ensure any outstanding concerns regarding data governance and financial liability for data controllers are addressed
- ICS partners will work together to deliver in accordance with the NHS LTP and local policies
- PHM will identify gaps in care and the populations who will benefit most from a different approach to care
- Success will be measured by a decline in health inequalities
- Alignment to demonstrable patient need, PHM will help inform differential investment
- We will continually measure success and monitor outcomes to ensure investment is being made at the right time in the right place
- All practices signed up to the One Devon Data Set
- All PCNs achieving the requirements of the tackling health inequalities spec in the PCN DES
- All PCNs achieving step 3 on the PHM domain on the Maturity Matrix
- PHM fully embedded into PCNs, using data, working collaboratively with system partners, including the voluntary sector, at neighbourhood level. Develop new interventions to reduce inequity and improve patient heath and outcomes suitable and appropriate for the registered population.

Plant-based NHS lifestyle intervention
Coastal Primary Care Network, Dawlish and Teignmouth

The Coastal Primary Care Network is delivering one of the first plant-based lifestyle courses on the NHS. The intervention programme (Whole Life) is a 7-week online course for patients with the aim of supporting patients to live long and healthy lives through plant-based eating and daily activity.

The course supports people to change their eating habits and lifestyle and has seen improvements in blood pressure, weight and cholesterol in just 28 days.
www.wholelifeplantbased.com

6.5 Investment

Funding for Primary Medical Care (for delegated Primary Care commissioned services) is determined at ICB level through the use of a nationally calculated funding formula. This funding formula sets a needs-based target allocation for each ICB and where current funding levels differ from this target level a 'distance from target' value exists. NHS England then apply a pace of change adjustment to bring systems towards their target allocation over time, this adjustment is known as convergence.

For Primary Medical Care, the opening Devon ICB position for 2022/23 is that we receive less than our target allocation (based on population) by £8.1m (4%). In 2022 we received an additional £1.6m to being closing the gap by an initial 20% to £6.5m.

Although not yet confirmed we can reasonably assume that national allocations will continue at the same rate of change that will close the distance from target by 20% each year until the ICB is 2.5% away from target when is likely to be determined that we are close enough to target and no further adjustments will be made.

6.5.1 Funding principles

- Health inequalities will only reduce if we proactively support our services by investing equitably so we will differentially invest where there is greatest need
- We will use data such as deprivation scores to underpin any changes in how we will invest in General Practice.
- Workforce investment, training and development will be prioritised according to where recruitment and retention of staff is most challenging.
- The PCN estates toolkit will inform premises investment and, when available capital is made available, how the ICB will prioritise projects
- Working at scale across PCNs and with other health providers will be prioritised and ICS capital investment programmes will include supporting PCNs to work at scale.
- We will ensure rurality is part of differential investment especially as working at scale will be more challenging where PCNs operate across a large geographical area.
- We have committed to review Local Enhanced Services at LCP level to ensure what is commissioned meets the needs of our varied population and will be based on PHM identified needs.

7. Concluding remarks

"If General Practice fails, the whole NHS fails" - Roland and Everington

This Strategy reaffirms our priorities and ambitions as we embrace a major transition into an integrated system landscape. We are confident that we can effectively tackle the major barriers to progress and achieve our individual and collective ICS ambitions through collaboration and innovation.

Primary Care is the bedrock of healthcare provision in the NHS and General Practice has been described as the "jewel in the crown" of the NHS. Yet, perversely, it has locally been underfunded and criticised in comparison to other care providers. To some extent this reflects a failure to effectively showcase the activities and achievements of General Practice in a robust way, it is a fundamental flaw that the success of General Practice is not measured by its own achievements, but by the demand experienced in other parts of the health system.

Achieving our priorities in workforce, alongside our pivotal role within the ICS, will seek to repair this. General Practice has continued to function amidst unprecedented challenges including unmanageable demand, underinvestment, health inequalities and a workforce crisis, all of which were compounded by the pandemic. The remarkable adaptability of General Practice, exemplified by the pandemic, is a mammoth achievement and yet, at the time of writing, the national press coverage of General Practice reflects an underachieving service. In effect, General Practice has been 'busy surviving' a range of challenges for some years, preventing any time to stop, reflect and transform; we consider that now is the optimal time for a change in how we invest and work at scale.

The engagement work undertaken as part of this Strategy development showed that neither our General Practice community, nor our patients could give a unified response as to what it is that General Practice should look like or how it should be transformed. This demonstrates the range within General Practice as specialism and why this Strategy has identified key areas to address patient access and quality care.

As we enter this new phase, it is crucial to resolve this 'identity crisis' and be able to clearly define, in a united voice, what can reasonably be expected, as well as set out our expectations of our patients and system partners, underpinned by comprehensive literature reviews and national reports.

If we are to achieve General Practice that is sustainable and fit for the future, it will, alongside the whole health system, require a paradigm shift, for the benefit of its constituents, system partners and crucially, for our population. We look forward to working closely with our PCNs in the continued delivery of good General Practice and creating a sustainable model of care for the next 10 years.

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Glossary

AHP	Allied Health Professional
ARRS	Additional Roles and Reimbursement Scheme
BI	Business Intelligence
CCG	Clinical Commissioning Group
CCT	Certificate of Completion of Training
CHC	Continuing Health Care
CPD	Continuous Professional Development
CQC	Care Quality Commission
DES	Directed Enhanced Service
DCCR	Devon and Cornwall Care Record
EA	Extended Access
ED	Emergency Department
EHR	Electronic Health Record
ETTF	Estates and Technology Transformation Fund
FTE	Full-Time Equivalent
GP	General Practitioner
HEE	Health Education England
HOPE	Helping individuals Overcome Problems Effectively
ICB	Integrated Care Board
ICS	Integrated Care System
LCP	Local Care Partnership
LES	Locally Enhanced Service
LHCRE	Local integrated Health and Care Record
LDC	Local Dental Committee
LMC	Local Medical Committee
LOC	Local Optical Committee
LPC	Local Pharmaceutical Committee
LTC	Long Term Condition
LTP	Long Term Plan
MDT	Multi-Disciplinary Team
MECC	Making Every Contact Count
MIG	Medical Interoperability Gateway
MIG	Minor Improvement Grant
NWRS	National Workforce Reporting Service
NHSE	National Health Service England
PCN	Primary Care Network
PHM	Population Health Management
PM	Practice Manager
PMS	Primary Medical Services
PN	Practice Nurse
POD	Prescription Ordering Direct
PPG	Patient Participation Group
QEIA	Quality and Equality Impact Assessment
QOF	Quality and Outcomes Framework
SCR	Summary Care Record
SCR-AI	Summary Care Record – Additional Information
SLA	Service Level Agreement
STOMP	Stopping Over Medication of People
STP	Sustainability and Transformation Partnership
VTS	Vocational Training Scheme
WTE	Whole Time Equivalent

Appendix 1: List of Figures

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