Briefing note for MBC members

1. Introduction

1.1. Access to primary health care and other specialist services via general practice has been highlighted as a concern by councillors over an extended period of time. Concerns stem from residents' perceptions that current facilities are overburdened resulting in excessive waiting times for appointments and services that people are subsequently referred to and an anxiety that our population growth will exacerbate existing problems to the detriment of both current and future residents.

1.2. Members have been briefed about the first phase of work to create Local Care Hubs in West Kent. In August 2018 the CCG Governing Body agreed that there will be 3 Local care Hubs including one in Maidstone and two mini hubs. The second phase of this work is now underway and is focussed on identifying suitable sites.

1.3. The purpose of this report is to advise members about the national context and recent announcements along with the work being undertaken specifically focused around workload and workforce in general practice, capacity in estate and the associated challenges.

2. Background

2.1. The Health and Social Care Act places an obligation on NHS England to secure the provision of primary medical services for patients throughout England. The West Kent Clinical Commissioning Group took delegated responsibility for general medical service commissioning from NHS England from 1 April 2016. CCGs are clinically led statutory NHS bodies responsible for the planning and commissioning of healthcare services for their local area. CCG members include GPs and other clinicians, such as nurses and consultants.

2.2. The CCG is also responsible for strategic estate planning to ensure that buildings are fit for purpose, compliant and well utilised for commissioned services.

2.3. In 2017 the West Kent Clinical Commissioning Group adopted a Local Care Plan; it built on an earlier Primary Care Strategy produced through an exercise called Mapping the Future in 2013. Local Care is care not in a main hospital. It is about providing better access to care in people's communities. The Local Care Plan aligns to the national NHS Five Year Forward View and the General Practice Forward View and responds to the priorities set out in the 2017 NHS next Steps on Five Year Forward View .These are:

- to ensure that GP practices have the support that they need to deliver the quality of care that they want to provide
- that people with less severe conditions can access urgent care without attending A&E

- to improve prevention and care for people's mental and physical health through better integration of GP, community health, mental health and hospital services and more joined up working with home care and care homes.

2.4. Change is needed because our population is growing, the number of older people is growing as people live for longer and more people have long term conditions. As many as 4 in 10 emergency admissions in Kent and Medway could be avoided if the right care was available in the community. Everyday around 1000 people are in a hospital bed in Kent and Medway when they no longer need to be and there are challenges recruiting enough GPs and practice nurses.

2.5. The Kent and Medway Sustainability and Transformation Plan identified the following principles that the CCG's Local Care Plan responds to:

- Support the long-term provision of primary care services by scaling up practices to larger federations
- Educate the population in monitoring and improving their own health, making it easy for them to do so, and promote self-care
- Engage with the patient and provide the education and basic skills needed to allow them to manage their own care
- Coordinate and integrate health and social care services so that they provide care around a centrally held care plan in an efficient and holistic way
- Provide an easy to access service that patients can contact from their home, or via their GP to provide an alternative to what would otherwise be an A&E attendance
- Work across acute and primary care services to ensure a patient has the correct holistic care package in place and that this process begins upon their admission
- Provide the short term level of care needed immediately upon discharge to allow a patient to live independently in their place of residence
- Make it easier for a GP to get an opinion from a specialist in the community to avoid referral
- Position mental health staff consistently in all care settings to support and direct care for patients with mental health issues and reduce the risk of mental health issues developing especially among those with long-term physical health conditions

2.6. A priority identified across Kent and Medway was to develop more and better local care services, which bring together all the services that people currently get from their GP, as well as a range of additional services - bringing together primary, community, mental health and social services to offer joined up care in people's homes and communities. They recognised the need to increase capacity and that this was dependent on being able to attract and retain the right staff, having the right buildings and having in place excellent information technology and information management.

2.7. In the West Kent local care model the system is organised at four different levels-

- General Practice

- Clusters
- Local Care hubs
- West Kent wide services

2.8. General practitioners (GPs) are the first and most frequent point of contact with the National Health Service (NHS) for most people. They provide a range of primary medical care services to those who are registered with them and act as gatekeepers to most other NHS services, referring patients to specialist care where appropriate.

2.9. The public relies on general practice services for their health and wellbeing and that of their families but services are under increasing pressure both locally and across the country due to increased demand. This isn't just about the numbers of patients; the population's needs are more complex and people are living longer. GP workload has grown both in volume and complexity.

2.10. The increase in people with multiple long term conditions, frailty and complex social, emotional, medical and psychological problems can only be addressed by harnessing the holistic skills unique to a primary care team. To meet these challenges, primary care has to change. GPs need to work more closely with other professionals, leading multidisciplinary teams, managing patients who are more unwell and fostering joined up care.

2.11. Overview of general practice in the Maidstone Borough Council area of west Kent:

- There are **7 clusters** (groups) of general practices **in west Kent**; **3 of these clusters**, Maidstone Central, Maidstone Wide and Weald have practices that are **within the Maidstone Borough Council area.**
- There are **55 general practices** located in the CCG area; **19** of which are **within the MBC area**, this is as follows:
    - Maidstone Central Cluster – 8 practices, 7 of which are within MBC area
    - Maidstone Wide Cluster – 9 practices, all within the MBC area
    - Weald Cluster – 11 practices, 3 of which are within the MBC area
- The number of people **registered with a GP** in the west Kent area is **495,881** (at 1 October 2018); of this total **170,583** (34.39%) **people are registered with the clusters and practices within the MBC area set out above as follows**:
    - Maidstone Central Cluster – 83,784 people registered
    - Maidstone Wide Cluster – 68,895 people registered
    - Weald Cluster – 17,859 people registered
- General practices in west Kent operate out of **83 separate premises** including branch surgeries – **27** of these premises are **within the MBC area**.
- Across the CCG area there are **298 individual GPs**[1] registered to practices, however a number work on a part–time basis and therefore this equates to **206 full time equivalent GPs** working in the CCG area supported by GP registrars and locums; **88 individual GPs and 62.11 FTE GPs are within the 3 clusters and practices in the MBC**

[1] GPs excluding retainers, locums and registrars

area as set out above *(Source: NHS Digital General Practice Workforce (September 2018, published December 2018).*

- Within the MBC area the practice **list sizes range** from the **largest** with **19,494** patients to the **smallest,** where there are **2185** patients registered
- In the 2018 national GP Survey **86%** of people in west Kent rated their **overall experience of making appointment at their practice as very good or fairly good**.

2.12. **The main focus of this report is around General Practice**; Section 3 of this report provides a more detailed overview regarding the national context, including recent announcements regarding the new five year GP contract, work being undertaken at a Kent & Medway level and work underway in the Maidstone Borough Council area.

2.13. **Clusters** are groupings of general practices that are working together to co-operate, collaborate or combine regarding delivery of services for their registered populations. Clusters are critical to the integration of out of hospital care - forming a bridge between the services available at an individual GP practice and those available in local care hubs or secondary care. The benefit of clusters includes the ability to:

- realise improved access with more GP appointments until 8pm weekdays and weekends.
- enhance the primary care offer integrating teams of nurses and allied health professionals (multi-disciplinary teams); this supports co-ordinated care which relies on having scale larger than a single GP practice
- Utilise and share the skills and expertise of their member practices to offer a wider range of services than single practices.
- Achieve efficiencies in back office functions
- Support estates efficiencies both in terms of better utilisation and cost
- Support a sustainable and resilient general practice

2.14. A key component and 'way of working' for local care in west Kent was the establishment of new multi-disciplinary teams at cluster level; this was in line with the Kent and Medway priority for local care. These teams were established across all west Kent clusters between October 2017 and April 2018.

2.15. A multidisciplinary team (MDT) approach provides individuals with care and support needs with access to the right care when they need it. The MDT improves the care of complex conditions by making full use of the knowledge and skills of team members from multiple disciplines and service providers, including primary care, community health services, acute care, social care, and other specialist advice. The MDT approach also ensures that people with complex needs have access to expert advice.

2.16. The multi-disciplinary team comprise core disciplines including a health and social care coordinator, community nurses, complex care nurses, social services, GPs, mental health specialist, dementia nurses, pharmacist, Age UK and local hospice. A

MBC representative attends the Maidstone Central, Maidstone Wide and Weald Cluster MDT meetings.

2.17. Monthly MDT meetings provide a focus for the teams to meet regarding the people with more complex needs. GPs and other clinical staff can refer a case to the MDT meeting for a focused discussion around the individual needs of the patient and to develop an individualised care plan.

2.18. 48 hours prior to the meeting, a patient list is disseminated to the MDT to allow each agency to review the case list and identify which patients are known to what agency and what involvement they have had. The patients are discussed case by case and a multi-agency response can then be offered to ensure the patient has the correct services/support around them (making every contact count).

2.19. MBC's involvement in the MDT meetings commenced in September 2018. Prior to attending the MDT meeting MBC will establish whether any of the patients are known to the council via housing and health, Helping You Home (see below), housing advice, housing register or community safety and then, having participated in the MDT meeting complete the appropriate referral to the correct team.

2.20. In the period from September to December 2018 MBC has supported 24 patients in the community by providing housing-related support to prevent patients being admitted to hospital

2.21. Cluster MDT meetings have capacity for a defined number of referrals every month; the use of the capacity is improving as the MDT way of working continues to embed. Between June and September 2018 80% of the total capacity was utilised; this was an improvement of 17% compared to the previous 3 months.

2.22. Cluster MDTs are a way of working that will continue to evolve based on feedback of the cluster teams. In November 2018 a session was held with each cluster MDT focused on local arrangements for working together, communications and building relationships in order to continue to support the development of MDTs.

2.23. Another example of MDT working is within the hospital. A Hospital to Home scheme "Helping you Home" was introduced in September 2017 where MBC works collaboratively with Maidstone and Tunbridge Wells Trust to provide patients with a streamlined service to enable them to be discharged home. This is funded via the Better Care Fund and the Disabled Facilities Grant; it has received positive feedback from the hospital team not only for the positive impact for patients but also for the release of health professionals' time.

2.24. The MBC Helping You Home works with patients who have a housing-related need which could delay their discharge. Their need could relate to:

- installation of a key-safe to allow access for carers
- moving furniture to allow for hospital equipment or a micro-environment
- providing a deep clean of their property to reduce the risk of infection
- installation of lockable medicine cabinets

- sourcing move-on accommodation if their property is no longer suitable for them
- sourcing accommodation for discharge if they are homeless
- carrying out home safety checks to ensure their accommodation is safe and secure to return to
- referring for disabled facilities grants for larger adaptations at home such as stair lifts, flush floor showers or ramped access.

2.25. MBC support is not limited to the above as each referral is unique and tailored to the support needed by the patient or their next of kin. Depending on the type of referral there is a 4 hour target to acknowledge the referral and schedule in works with the handyman within 24 hours (where access allows). This ensures the patient is not 'bed-blocking' when they are medically fit for discharge.

2.26. Referrals are accepted from any NHS setting including community hospitals as long as the patient is a resident of the Maidstone Borough. In Year 1 of the programme, September 2017 – August 2018 MBC helped 336 patients return home or move to alternative accommodation. Between September 2018 to December 2018 182 patients were helped home. Every night not spent in hospital results in a nominal saving of £450 per patient.

2.27. A **local care hub** will be a building in the community enabling the delivery of a range of health, and care services that:

- Don't need to be delivered in a hospital setting but need to be delivered to a population bigger than cluster level.
- Deliver services around frailty and other needs which need a physical building.
- Are robustly linked to other community services, for example housing, so that a holistic approach can be taken to the health and well-being of our residents

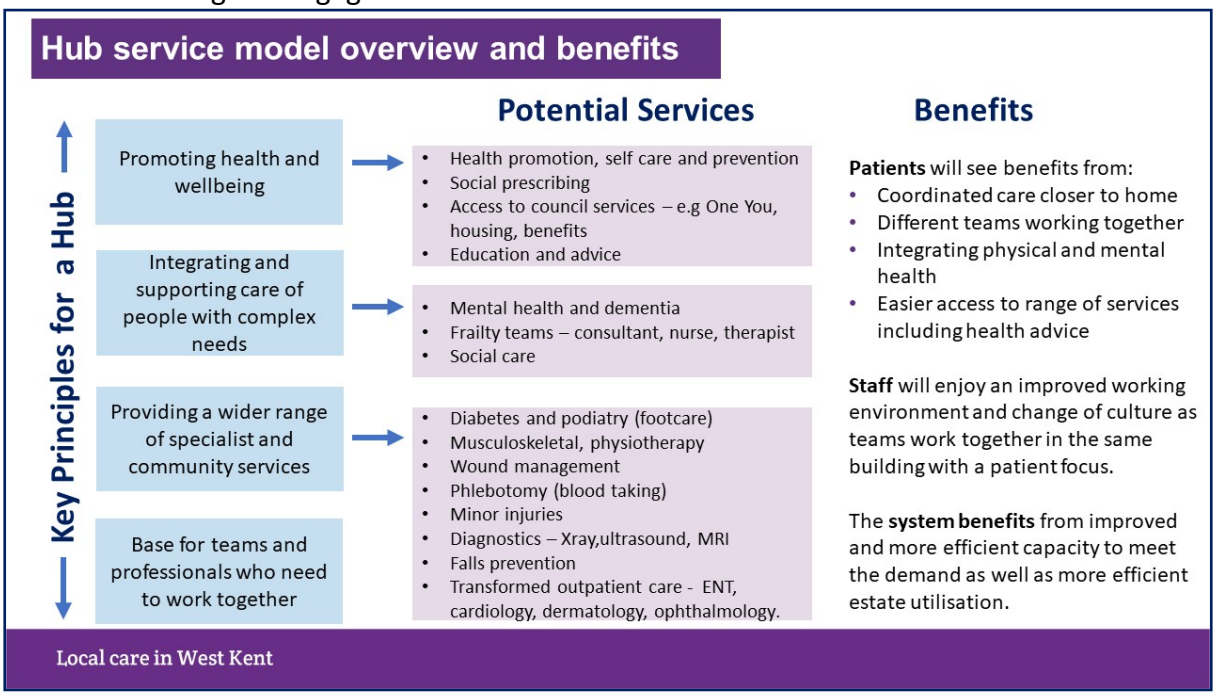
2.28. The CCG has led work to identify the services to be delivered from a hub and the optimum size and network of hubs across West Kent. Partners including health providers, social care and district councils have been engaged and contributed both their knowledge and expertise and to the joint approach for procuring analytical and modelling expertise to develop the strategic case.

2.29. Some of the key principles informing the hub development are to:

- enable delivery of a range of services in addition to the ones delivered at the cluster level and those that need not be delivered in a hospital setting.
- complement services delivered at practice and cluster level in delivering clinical pathways for different population segments.
- Co-location of accessible health, social care, voluntary sector and appropriate district council community services
- Services designed around pathways for vulnerable groups of people including people who are frail, and those with mental illness, long term conditions, dementia, as part of a patient pathway continuum from clusters into secondary care.

- An eventual shift in patient expectation, viewing the hub as the place to attend for their first line health needs, not always secondary care.
- Infrastructure utilisation for non-core hours to maximise use of the assets.
- Measurable shift and impact on Secondary care (i.e. reduced outpatients taking place inside a hospital

2.30. The below diagram provides a summary overview of the service model as used at the range of engagement events.



2.31. The next phase of the hub work will focus on identifying potential sites, including reviewing existing estate, in the localities identified in the strategic case. An options assessment will then be undertaken to inform the next steps.

2.32. There are some services that form part of local care but that will continue to be delivered at scale across the **west Kent area as a whole** – two key services are community beds and integrated urgent care services. Both of these services need to be delivered on a larger population basis to ensure a critical mass of safe and high quality services can be delivered round the clock on a cost effective and sustainable basis, specifically from a workforce perspective.

3. A focus on General Practice

National context

3.1. Primary care is fundamental to the delivery of health and wellbeing in Kent and Medway. For 90% of patients this is the first interaction that they will have with health services and early access to these services will have a significant impact on patient outcomes and their appropriate use of other health and care services. A key driver for access to services is the availability of primary care workforce, more

traditionally GPs, but also the wider clinical and professional workforce to support the workload. The predominant provision of primary care is through general practice.

3.2. The NHS Long Term Plan was published on 7 January 2019 and recognises that community health services and general practice face multiple challenges – with insufficient staff and capacity to meet rising patient need and complexity. GPs are retiring early and newly-qualified GPs are often working part-time. Use of locum GPs has increased and there is shortage of practice and district nurses. The traditional business model of the partnership is proving increasingly unattractive to early and mid-career GPs.

3.3. The NHS Long Term Plan details the commitment to increase investment in primary medical and community health services as a share of the total national NHS revenue spend across the five years from 2019/20 to 2023/24. This means spending on these services will be at least £4.5 billion higher in five years' time.

3.4. Linked to this investment a new five year contract for general practice was the first major pillar of the NHS Long Term Plan approved by NHS England on 31 January 2019. This will see billions of extra investment for improved access to general practice and expanded services. This is the biggest reform of GP services for 15 years and creates more certainty around funding and looks to reduce pressure and stabilise general practice

3.5. Through the extra investment 20,000 more staff will be recruited to help GP practices work together as part of a local primary care network. This will include pharmacists, physiotherapists, paramedics, physician associates and social prescribing support workers who will become a core part of primary care teams and will support GPs to free up time for the most complex patients.

3.6. This builds on the increase of 5,000 extra practice staff working with GPs over the past four years. Core funding increases will also support more practice nurses and GPs, with the number of young doctors choosing to train as GPs now at a record high.

3.7. Primary Care Networks are detailed in the NHS Long Term Plan - based on neighbouring GP practices that work together typically covering 30-50,000 people. Primary Care Networks are a continued development of the clusters in west Kent and continues provide an opportunity for general practice and other providers to share workforce and workload. In many areas, multiple networks (clusters) have come together to form GP federations – large groups of practices that form an organisational entity and are able to provide more economies of scale without losing the local focus of the individual networks. West Kent Health Limited was formed in 2018 as the GP federation in West Kent.

3.8. Details regarding the new GP contract can be found on the NHS England website – **https://www.england.nhs.uk/gp/gpfv/investment/gp-contract/** .A summary of the key parts of the contract is detailed on the website and for ease of reference is included in Appendix 1 of this briefing paper.

3.9. The workforce implementation plan detailed in the NHS Long Term Plan will build on the General Practice Forward View which is referred to in this briefing paper.

3.10. The following sections of the report provide context both at a Kent and Medway and West Kent level along with an operational focus around what's happening on the ground in west Kent general practice.

GP Partnership Review

3.11. The final report of an independent national review into the partnership model of general practice, as commissioned by the Secretary of State for Health and Social Care in 2018, was published on 15 January 2019.

3.12. The partnership model, wherein GPs operate as self-employed independent contractors, has underpinned general practice since before the establishment of the NHS. However, in recent years we also know that partnerships have become less popular with GPs.

3.13. The review was asked to consider and make recommendations on:

- the challenges currently facing partnerships within the context of general practice and the wider NHS, and how the current model of service delivery meets or exacerbates these
- the benefits and shortcomings of the partnership model for patients, partners, salaried GPs, locum GPs, broader practice staff, for example practice nurses, and the wider NHS
- how best to reinvigorate the partnership model to equip it to help the transformation of general practice, benefiting patients and staff including GPs

3.14. This final report makes recommendations to both the Secretary of State for Health and Social Care and the Chief Executive of NHS England to reinvigorate the partnership model to equip it for the future.

3.15. The report sets out:

- Sets out the challenges and issues which the review heard are currently dissuading people from working in general practice. These include workload burdens, workforce recruitment and retention difficulties, an increasing level of personal risk, and a feeling that general practice is not always valued as an important part of the wider health system.
- Describes the benefits and challenges of the partnership model, as identified by those who have engaged with the review.
- Proposes seven high level recommendations, including both 'quick wins' and longer-term projects which aim to address the challenges of risk and flexibility in the partnership model; workforce issues of recruitment, retention and education and training; workload, both clinical and administrative; the status and role of partnerships and primary care networks in their local health systems; and the emerging opportunities for primary care in terms of digital and technology.

3.16. The report states that the recommendations aim to be focused, affordable and practical. The new GP contract responds to some of the recommendations.

3.17. The full report can be accessed using the link below; for ease of reference a summary of the recommendations proposed by the review are detailed in Appendix 2. **https://www.gov.uk/government/publications/gp-partnership-review-final-report**

Kent & Medway Sustainability and Transformation Partnership (STP)

3.18. The position in Kent and Medway is worse for most staff groups than the national average – the GP FTE[2] workforce is down 3.3% (24) compared to 1.4% (402) nationally (between Sept 2017 and September 2018). 26% of GPs are 55 years and over and therefore nearing retirement.

3.19. In Kent and Medway:

- All CCGs have lower numbers of GPs when compared nationally - there would be 181 more GPs and five CCGs have lower numbers of practice nurses- 27 more practice nurses if we were at national average
- 12% of all GP posts are vacant, and 53% of these have been for at least a year, with all practice nurse vacancies having been vacant for more than 6 months – locum doctors make up 8% of the workforce.
- 26% of GPs are 55 years and over and therefore nearing retirement, the largest ageing GP workforce in England (19.4%
- a lack of growth in GP workforce (down 11% in Kent and Medway compared to 2% nationally)
- Limited number of trainees converting into GPs in Kent and Medway (around 40%)

3.20. The Kent and Medway Sustainability and Transformation Partnership (STP) have prioritised primary care as a key work stream. The Primary Care Board are currently developing a Primary Care Strategy for Kent and Medway, and the supporting Primary Care Workforce Group has developed a Primary Care workforce transformation plan which is summarised in this paper.

3.21. The Ambition is for Kent and Medway to be a great place to work, live and learn. To deliver the ambition and address critical workforce challenges it is intended that a Kent and Medway Academy for Health and Social Care be introduced working collectively to:

- ***Promote Kent and Medway*** as a great place to work
- ***Maximise supply*** of health and social care workforce
- Create ***lifelong careers*** in health and social care
- Develop our ***system leaders*** and encourage ***culture change***
- Improve ***workforce wellbeing, inclusion and workload*** to increase retention

3.22. Key deliverables for 2019/20 include:

[2] GPs excluding retainers, locums and registrars

- Undertaking a Kent and Medway and international GP and primary care recruitment campaign
- Developing GP and Advanced Practitioner portfolio careers and flexible working offers to support locum conversion and retention
- Supporting retention of the primary care workforce throughout their careers through the NextGen programme, careers counselling (First Five, Middle Five, Last Five programmes) and retirement planning
- Developing GP and primary care leaders through leadership programmes such as Practice Manager development, mentorship and coaching
- Developing virtual student and trainee networks and Communities of Practices across Kent and Medway
- Increasing supply of the primary care workforce through growth of new and enhanced roles and primary care placements in the Kent and Medway Medical School
- Supporting retention of the primary care workforce through workforce engagement, workforce redesign and high impact actions
- Supporting the development of new primary care integrated delivery i.e. GP Federations and Primary Care Networks
- Developing local workforce planning capability and capacity
- Growing the care navigation and social prescribing workforce
- Organisational Development support for the 37 Primary Care Networks in Kent and Medway including the rollout of the OD toolkit
- Esther coaching and training across primary care

Education Network

3.23. West Kent Education Network (WKEN) fulfils the nationally identified role of the Community Education Provider Network (CEPN) for the West Kent geography. The NHS 10 Point Plan described the establishment of 'Learning Hubs' throughout the UK, these are known in London, Kent, Surrey &Sussex geography as CEPNs.

3.24. Health Education Kent Surrey and Sussex describes the role & function of CEPNs as follows:

CEPNs have been identified as one of the key elements in supporting the workforce transformation necessary to sustain a robust primary care system which is an essential component to the ambition to deliver the integrated, place based systems of care being developed through the STPs.

Guiding principles of a CEPN;

1. Support for workforce planning and development to respond to local needs and enable the redesign of services within primary care and the community to better support general practice.

2. Improve education capability and capacity in primary and community settings through the development of multi-professional educators and the creation of additional learner placements.

3. Improve education quality and governance and act as a local coordinator of education and training for primary and community care to support general practice.

3.25. West Kent Education Network has defined its broad aims as being about 'Making West Kent a great place to work' with a focus on four key areas:

- **Recruit** – maximising the recruitment of Primary Care staff (including new disciplines) at all levels
- **Train** – ensuring the workforce is fit for purpose in an evolving NHS landscape
- **Refresh** – WKEN wants always to be sighted on the wellbeing of the workforce
- **Retain** – ensuring that the loss of workforce is minimised with staff encouraged in role development

3.26. The new five year GP contract announced on 31 January also detailed that NHS England would work with Health Education England to establish primary care training hubs from 2020/21. These will build on the existing CEPNs and enable more consistent provision of training and continuing professional development for primary care staff in the community.

3.27. West Kent Education Network works closely with the CCG, general practices, West Kent Health Federation and other system partners.

Building capacity and capability – workforce, workload and new care models

3.28. The General Practice Forward View (GPFV) was published by NHS England in April 2016 and focuses on improving care and access in general practice, including the wider primary care workforce to support GPs. As already detailed in this paper the workforce implementation plan detailed in the NHS Long Term Plan will build on the General Practice Forward View.

3.29. The GPFV is a development programme supported by investment and provides the support for practices to build the capacity and capabilities.

3.30. The key areas of focus being taken forward in line with the General Practice Forward View as part of the local care arrangements are:

- Primary care workforce and workload; including GPs and other healthcare professionals who make up general practice
- Care models and re-design; including different ways of working and widening the skills and responsibilities of existing practice teams, including nurses and receptionists.
- Digital technology including systems to improve the efficiency and effectiveness of GP services.
- GP estate i.e. the premises from which GP services are delivered

3.31. It is important to note that none of these areas of work are being taken forward in isolation; there are interdependencies across all of these areas.

3.32. National funding has specifically been made available to support:

- Transformation – supporting at scale service provision and the ten high impact changes.
- Resilience - to help practices that are struggling to become more sustainable
- Active signposting - training for receptionists and administrative staff to
- Releasing time for care - help practices work differently in order to free up GP time to spend more time seeing patients.
- Clinical pharmacists – funding for training and support and some initial costs of recruiting and employment.
- Online consultation systems

3.33. Some examples of work underway in West Kent, most of which is related to and different ways of working, are detailed below. Some of these schemes have been supported by the extra funding (GPFV or other funding) made available.

- **Improved access** - the practices in each cluster are working together to offer the additional appointments until 8pm Monday to Friday and Saturday and Sunday mornings. These appointments may not necessarily be with the patients regular GP and could be at another surgery in the cluster. Improved access started on 1 October 2018.
- **Care Navigation and Active Signposting programme**
  - Practice nurses and receptionists are being 'upskilled.' Patients ringing for an appointment may be requested by trained receptionists to give more detailed information so they can be directed to the most suitable professional. About 20 per cent of patients need non-medical help, and may be best helped by council or voluntary services. Many others can be helped by Advanced Clinical Nurse Practitioners – nurses with an additional level of training. Patients will always see a GP if required, and can always request to see a GP.
  - Phase 1 has been successfully delivered with 370 reception staff trained and practices now actively signposting to: IAPT, One You Kent, Live Well, Pharmacy First, Age Well & Health & Social Care Co-ordinators.
  - MBC has worked with the CCG to provide information and training to reception staff for this project for One You Kent.
  - KCC have also provided One You Kent GP packs to surgeries which include a number of materials promoting the service.
  - Phase 2 is due to begin in December 2018 where 6 more providers will engage with signposting initiative.

- **First Contact Physiotherapists (FCP)** - Maidstone Wide was the first cluster to go live in December 2018. FCPs can diagnose and treat (and many can prescribe) and see patients directly saving GP time and speeding up access for the patient.
- **Paramedics** - Maidstone Central has a cluster based paramedic to undertake Home Visits therefore helping to manage the GP workload.
- **Mental Health Nurse/coach –** soon to be based in the Maidstone Wide Cluster working with a cohort of patients in collaboration with GPs, complex care nurses and voluntary sector.
- **Pharmacists**. Clinical pharmacists are becoming increasingly important in surgeries in making medication decisions. Patients are reporting satisfaction and good attention to detail.
- **Patient Education Programme -** new programme in Maidstone Central to support patients with long term conditions through self-care to improve outcomes through empowerment and ownership.
- **Facilitated Cluster development** with a focus on sustaining general practice in rural areas
- **GP, Practice Nurse and Practice Manager Cluster lead roles** have been developed in order to support the cluster level working and planning.
- **Medical Assistant Training** (non-clinical workers taking on some of the administrative work that GPs undertake) - West Kent is a pilot site. Forty-four practices attended the launch events and now have well developed protocols for telephone triage & management of laboratory results.
- **Telephone advice -** Patients and GPs more frequently communicate by telephone with surgery appointments arranged as necessary.
- **Social Prescribing -**
    - The Involve Connect for Wellbeing Social Prescribing Bid was supported by the Department of Health towards the end of last year as one of 23 projects across England.
    - This is a 3 year project and is focusing on 5 GP practices; two of the practices are in the MBC area, Vine Medical Centre and Marden Medical Centre.
    - 5 link workers, supported by volunteers, will support 200 patients each (annually) to access activities and groups. Outcomes are expected to directly reduce GP appointments, A&E attendances and admissions to hospital.
    - The project will undertake research and outreach to map local activities and will also identify and develop smaller community led activities which may not have existing resources.
    - MBC is supporting this programme and has representation and input at the Social Prescribing Advisory Group and continue to support joint working, for

example by providing training opportunities for staff across both organisations such as motivational interviewing

3.34. In addition to the above collaboration between MBC and GP Practices/Clusters is established and growing; this includes delivery of the One You service and participation in the Multi-disciplinary team (MDT) model referred to previously.

3.35. **One You** is a national campaign and support service giving people the tools and techniques to make healthier lifestyle choices and change behaviours. It helps to make small, practical changes to fit in with everyday life.

- MBC's two One You officers deliver services in GP surgeries and work with a number of groups, including the Muscular Skeletal Alliance and Self Care and Prevention Group and have for example improved linkages between health and leisure services e.g. exercise on prescription.
- This service is commissioned and funded by KCC public health.

3.36. The general Practice Forward View includes expectations of local care transformation to deliver value for money and sustainable services for the future. This includes maximizing digital technology to facilitate patient care including

- Reducing the need for face to face consultations
- Better equipping patients to self-manage
- Enabling more preventative care
- Strengthening communication and collaboration between organisations
- Increasing remote and mobile working in order to reduce reliance on physical space
- Provision of confidential "hot-desks" to enable e-consultations and video conferencing into Multi-Disciplinary Teams and other clinically confidential meetings, for practice staff and for care professionals from other organisations
- WiFi connectivity throughout practice buildings, including provision of roaming WiFi access to support access for care professionals from other organisations
- Broadband connectivity (with resilience and appropriate service support) and local area network, provided to such a level such that it is not a barrier or constraint to the provision of digital technology solutions

General Practice Estate

3.37. The CCG has undertaken a thorough assessment of district and borough council local plans in order to understand future population growth, engaged with existing GP practices to establish appetite to grow in order to accommodate increased demand and identified priorities from a premises perspective in order to respond to growth.

3.38. This work has allowed the CCG to define, at cluster level, the priority areas for general practice premises development between 2018/19 and 2022/23 to ensure sufficient provision of primary medical services in West Kent. These priorities were

detailed in the GP Estates Strategy that was supported by the CCG Governing Body in November 2018.

3.39. The CCG's Local Care Plan details that investment in premises would be considered where merger or population growth would support a list over 8000 people; this is however a guide and in some cases may not still be considered a viable list size. It is not a resilient, safe, sustainable or attractive service model to commission new practices serving a small population; this is specifically in relation to workforce as locally and nationally there are significant pressures and challenges. The same principle applies to branch surgeries; practices are generally looking to expand service provision and existing premises to provide the most efficient operating model.

3.40. The growth analysis and premises development priorities will now further inform CCG and cluster based transformation plans around workforce, workload, care model/redesign and technology as part of the continued work to deliver the General Practice Forward view. These are all considered the key enabling strands of work that will support the delivery of the GP Estates Strategy – **it must however be recognised that estate as a single strand of work will not provide the solution to the challenges faced in general practice**. The wider context and challenges are set out earlier in the paper.

3.41. Plans to respond to growth in our population include both expanding existing premises and identification of the need for new premises. Alongside this is consideration of GP practice growth, merger and commissioning of new practice(s).

3.42. The assessment involved:

- a thorough analysis of current circumstances including premises information and patient list sizes
- baseline information has been collected about premises to provide a clear picture of suitability for the future including the potential for further expansions or internal reconfigurations.
- High level mapping has been undertaken to identify the closest practice along with all practice boundaries that cover any given development identified as an allocated site in the Local Plan.

3.43. Information has been shared and discussed with GP practices through a series of meetings in order to ensure engagement in planning for the future.

3.44. The meetings with practices were set in the context of the CCG's obligation to secure provision for primary medical services and focused on understanding the ambitions of existing general practices to expand to support the expected growth in population and the requirements from a premises perspective. Understanding the position of practices has been an important part of the discussions in order to understand whether the growth could be managed by existing practices or whether

the CCG will be required to commission additional primary medical services in specific areas.

3.45. **Maidstone Central** comprises eight GP practices, 7 in the MBC area and one in Tonbridge and Malling. The estimated population growth, as a result of housing development, for practices in this cluster is:

- 2018/19 – 2022/23 7,436 (6699 for 7 practices)
- 2023/24 – 2027/28 4,322 (2567 for 7 practices)
- Total for the planning period 11,758 (9266 for 7 practices)

3.46. Spatial analysis of the expected growth impacting on this cluster within Maidstone has concluded that growth would be expected to be spread across all practices. This does not take into account any sites that may be identified in the Local Plan Review. It is envisaged that growth in patient lists could be accommodated by:

- Ensuring maximum utilisation of the four newer purpose built premises in Maidstone town centre and aligning this with workforce and service strategy actions – this means that the available space should be used to support the individual GP practices and also services being developed by the cluster for which space is required.
- The College Practice have signalled an intention to support future growth in the area and will therefore produce a premises development plan in order to demonstrate how they could provide sustainable and resilient capacity. Two of the existing premises (main and one branch site) are not considered suitable for the long term as they have little capacity to support growth. Options include opportunities to co-locate with the Local Care Hub for the Maidstone area.
- The Shepway Medical Centre has signalled their intention to support future growth. This practice needs a premises plan for a new site for their branch surgery at Grove Green
- Headline growth figures indicate a requirement for a new general practice building within this cluster – this could be a building that is provided by an existing general practice as an extension to their current contract or through the commissioning of a new provider.

3.47. **Maidstone Wide** comprises 9 practices all of which fall within the borough although two practice boundaries (Headcorn and Len Valley) also draw patients from Ashford Borough Council area. The estimated population growth, as a result of housing development, for practices in this cluster is:

- 2018/19 – 2022/23 7,469
- 2023/24 – 2027/28 2,555
- Total for the planning period 10,024

3.48. The expected growth arising in Maidstone borough is spread across the cluster area; the CCG's spatial analysis has defined geographical areas which allow an indication of patient flows to specific practices. It is envisaged that growth in patient lists will be accommodated by:

- Development of new premises for Greensands Health Centre which it is expected will accommodate growth in Coxheath and immediately surrounding area
- Headcorn is expected to accommodate growth through utilisation of space not currently used; this may require re-configuration of existing space to ensure optimum use
- The Len valley practice will require a premises development plan in order to accommodate expected growth in the Lenham and Harrietsham area. Any plan should ensure maximum efficiency and utilisation working across both the main and branch sites
- A premises development plan is needed for the Langley (Sutton Road) area due to the significance of growth - -as this area is covered by more than one existing GP practice the CCG will work with interested practices to explore options.
- A plan to address the one poorer quality building (Grove Park Surgery) will be developed

3.49. The Weald comprises 11 practices, 3 of which are in Maidstone borough (Yalding, Marden and Staplehurst). The estimated population growth, as a result of housing development, for practices in this cluster is:

- 2018/19 – 2022/23 3,356 (2408 for the 3 practices)
- 2023/24 – 2027/28 1,048 (627 for the 3 practices)
- Total for the planning period 4,404 (3035 for the 3 practices)

3.50. The CCG mapping forecasts that development over the next 5 years will impact as follows Marden (427 dwellings), Staplehurst (450) and Yalding (152). It is envisaged that growth generated by this development will be accommodated by:

- Marden Medical Centre producing a premises plan to accommodate an additional 1000 patients Staplehurst health centre has capacity to accommodate growth due to the building not being fully utilised; consideration will be given to accommodating expanded GP services and cluster wide services
- Yalding surgery has capacity to accommodate the expected growth from the immediate area. Consideration will be given to the potential impact of growth from the Paddock Wood area
- The CCG has also identified that opportunities may exist through the next stage of the Local care Hub development in relation to a mini-hub in the Weald area. This will be explored in phase 2 of the Local care Hub programme.

3.51. To bring about new premises development proposals (as opposed to minor improvements to reconfigure or extend existing premises) the CCG has a three stage review and approval process:

- GP Contractors, under their contract, are required to provide suitable and compliant premises from which to deliver services from and are responsible for developing a business case and for sourcing the capital funding for the development.
- The revenue impact of general practice premises is the responsibility of the CCG through the re-imbursement of rent, business rates, water rates and clinical waste). To consider revenue impacts business cases must be considered through a robust process to determine if they are affordable within the budget and offer value for money to the NHS.

3.52. There are various sources of capital funding that practices can explore for new premises or significant refurbishment/extension to existing premises; this includes NHS capital where schemes have been prioritised as part of STP plans, NHS minor improvement grants, Section 106 and CIL, private finance and local authority funding to build premises for lease to General practice as part of a larger community facility or separate building and raising the funds through GP partners securing the borrowing.

3.53. With regard to S106 agreements and contributions already held by the borough council the CCG aims, through working with general practices, to utilise the funding within the required spend by dates. The CCG is aware of all funding contributions held by the council and those secured and the specific requirements of the S106 legal agreements.

3.54. The cluster based priorities detailed in the GP Estates strategy will inform and support the use of the S106 contributions. The CCG is already working with practices as follows to target use of contributions already held by MBC and other contributions expected to be triggered in the future:

- Coxheath - it is planned S106 contributions will contribute to the proposed new general practice premises in Coxheath.

- Marden –The practice is exploring the viability and options for an extension at the current premises and will seek to pool available S106 funds as a contribution towards this.

- Lenham/Harrietsham - The practice is aware of the S106 contributions and will, at the appropriate time, seek to develop premises plans that support expansion of existing premises.

- Langley area - there are a number of larger contributions that the CCG expects to pool towards new premises or extension/reconfiguration of existing premises in line with the priorities identified in the GP Estates Strategy.

- Other contributions may be used to upgrade existing practices, and in line with the S106 agreements, to increase capacity and support greater flexibility in the use of clinical space in existing premises.

3.55. The current S106 funding held by the council has been shared with all practices and the CCG will continue to work closely with practices to ensure opportunities are identified for use of S106 funding contributions.

3.56. The CCG and MBC Planning Technical Team are working closely together and meet on a regular basis to review S106 funding available and to discuss potential use of funding in line with S106 agreements.

3.57. With regards to CIL, the CCG GP Estates Strategy provides the strategic priorities that will now inform the Council's Infrastructure Delivery Plan (IDP). The CCG is actively engaged with the council regarding the refresh of the IDP.

3.58. It is however important to note that S106 contributions are treated as NHS Capital. In addition NHS General Medical Services – Premises Cost Directions 2013 set parameters regarding what can and can't be funded for premises improvements in general practices and the contribution can only fund up to a maximum of 66% of the total project costs. This means that GP contractors, as independent contractors, are required to fund the difference and this may not always be a priority or affordable to the practice. The Premises Cost Directions are expected to change in 2019 to support contributions over 66%.

3.59. From a revenue perspective there is a wider benefit to the NHS. Where a practice uses NHS Capital or S106/CIL contributions towards the cost of a premises project that creates additional space (i.e. the footprint of the practice for which rent is currently paid increases) the additional rent payable on the new space is abated linked to the contribution; depending on the value of the overall project abatements can be in place for 5, 10 or 15 years.

3.60. We will continue to work together to ensure that future S106 and CIL contributions align with the CCG's estates strategy.

Appendix 1

Details regarding the new GP contract can be found on the NHS England website – **https://www.england.nhs.uk/gp/gpfv/investment/gp-contract/**.

A short summary of key parts of the GP contract:

- Core general practice funding will increase by £978 million per year by 2023/24.
- A PCN contract will be introduced from 1 July 2019 as a Directed Enhanced Service (DES). It will ensure general practice plays a leading role in every PCN and mean much closer working between networks and their Integrated Care System. This will be supported by a PCN Development Programme which will be centrally funded and locally delivered.
- By 2023/24, the PCN contract is expected to invest £1.799 billion, or £1.47 million per typical network covering 50,000 people. This will include funding for around 20,000 more health professionals including additional clinical pharmacists, physician associates, first contact physiotherapists, community paramedics and social prescribing link workers. Bigger teams of health professionals will work across PCNs, as part of community teams, providing tailored care for patients and will allow GPs to focus more on patients with complex needs.
- A new shared savings scheme for PCNs so GPs benefit from their work to reduce avoidable A&E attendances, admissions and delayed discharge, and from reducing avoidable outpatient visits and over-medication through a pharmacy review.
- A new state backed indemnity scheme will start from April 2019 for all general practice staff including out-of-hours.
- Additional funding of IT which will allow both people and practices to benefit from the latest digital technologies. All patients will have the right to digital-first primary care, including web and video consultations by 2021. All practices will be offering repeat prescriptions electronically from April 2019 and patients will have digital access to their full records from 2020.
- A new primary care Fellowship Scheme will be introduced for newly qualifying nurses and GPs, as well as Training Hubs.
- Improvements to the Quality and Outcomes Framework (QOF) to bring in more clinically appropriate indicators such as diabetes, blood pressure control and cervical screening. There will also be reviews of heart failure, asthma and mental health. In addition there will be the introduction of quality improvement modules for prescribing safety and end of life care.
- Extra access funding of £30 million a year will expand extended hours provision across PCNs and from 2019 see GP practices taking same-day bookings direct from NHS 111 when clinically appropriate.

Appendix 2

GP Partnership Review - Summary of Recommendations

Recommendation 1: There are significant opportunities that should be taken forward to reduce the personal risk and unlimited liability currently associated with GP partnerships.
Recommendation 2: The number of General Practitioners who work in practices, and in roles that support the delivery of direct patient care, should be increased and funded.

Recommendation 3: The capacity and range of healthcare professionals available to support patients in the community should be increased, through services embedded in partnership with general practice.

Recommendation 4: Medical training should be refocused to increase the time spent in general practice, to develop a better understanding of the strengths and opportunities of primary care partnerships and how they fit into the wider health system.

Recommendation 5: Primary Care Networks should be established and operate in a way that makes constituent practices more sustainable and enables partners to address workload and safe working capacity, while continuing to support continuity of high quality, personalised, holistic care.

Recommendation 6: General practice must have a strong, consistent and fully representative voice at system level.

Recommendation 7: There are opportunities that should be taken to enable practices to use resources more efficiently by ensuring access to both essential IT equipment and innovative digital services.