NHS
Derby and Derbyshire
Integrated Care Board

Derby & Derbyshire ICB System-level Primary Care Access and Recovery Plan Update

Our plan sets out:

1. Introduction
2. Description of Derby and Derbyshire and our GP practices
3. National Context: Delivery Plan for Recovering Access to Primary Care
4. Our long-term vision for access in Derby & Derbyshire
5. How we will deliver the Primary Care Access and Recovery Plan
6. How we will organise ourselves to deliver and govern the plan
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9. How we will involve patients and communicate our work
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Introduction

The plan is a ‘work in progress’. It is not intended as a definitive final statement but is the summary of discussion to date and the starting point for further discussion with General Practice and other providers. The focus is on the immediate actions up to 31st March 2024, though work will continue beyond that.

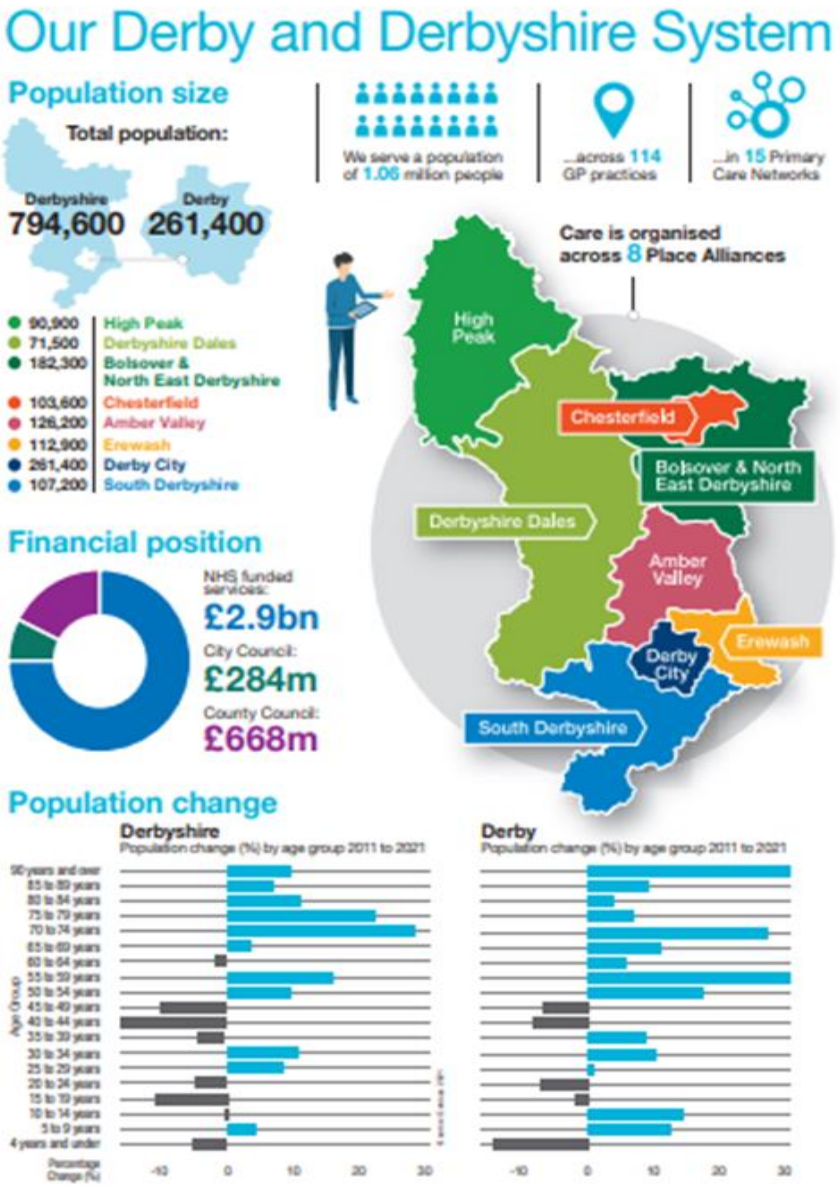
Our planning assumptions and outcomes have been aligned to and are interdependent with:

- Fuller Report
- Derby & Derbyshire ICB Joint Forward Plan
- Derby & Derbyshire ICB Integrated Care Strategy
- Derby & Derbyshire ICB Operational Plan 23/24
- Recovery Plan for Urgent & Emergency Care
- Recovery Plan for Planned Care

The primary interdependency is with the Primary Care Clinical Model for Derby & Derbyshire which is being developed by the GP Provider Board (GPPB).

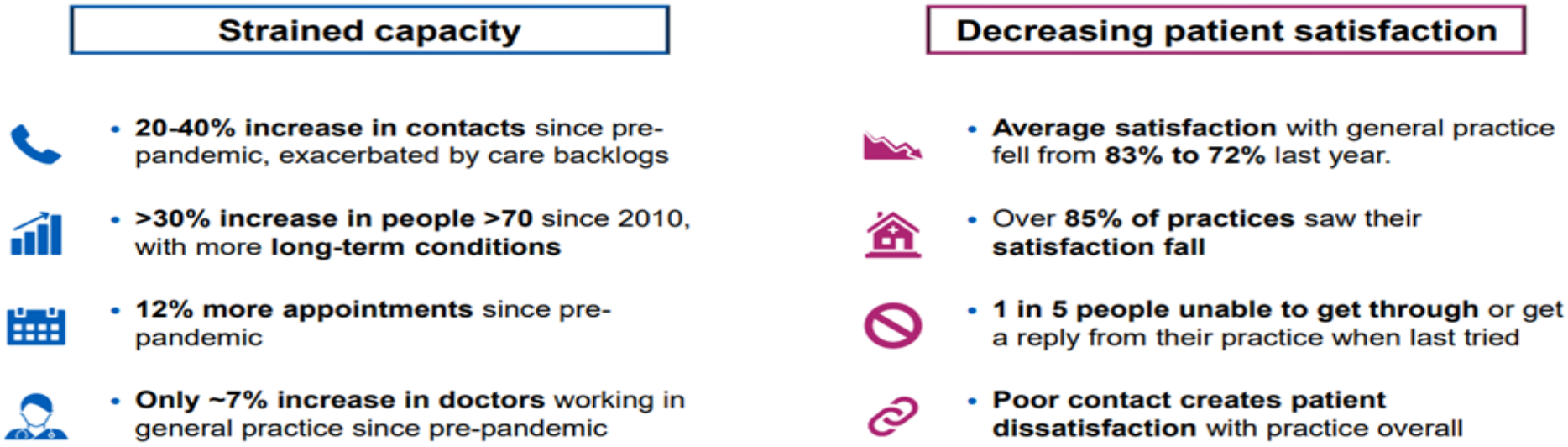
Derby & Derbyshire and our GP practices

- Derbyshire is a diverse county, with a population of over 1m people, 261,400 of which live in Derby. Our most deprived wards are largely in the city and the east of the county.
- We spend nearly £4b a year in health and social care and employ 53,000 people.
- There are 18 PCNs (113 practices) in Derby and Derbyshire, ranging in size from 32,000 – 100,000 population.
- The last three years have seen unprecedented demand on health and social care services. General Practices have had to make significant changes to the way they deliver services to adapt and respond to the COVID-19 pandemic.
- In 2022 we provided over 6.5 million appointments to our population.
- In January 2021 general practices provided 468,632 appointments increasing to 583,123 in January 2023, an increase of 24.4%.



National Context

Like many parts of the NHS, general practice is under intense pressure. Where demand is greater than capacity it means general practice cannot always be effective, and patient experience and access are negatively impacted. The diagram below describes the current situation for general practice:



National Context

The plan has two central ambitions:

- **1. To tackle the 8am rush and reduce the number of people struggling to contact their practice.** Patients should no longer be asked to call back another day to book an appointment, and we will invest in general practice to enable this.

- **2. For patients to know on the day they contact their practice how their request will be managed.**

a) If their need is clinically urgent it should be assessed on the same day by a telephone or face-to-face appointment. If the patient contacts their practice in the afternoon they may be assessed on the next day, where clinically appropriate.

b) If their need is not urgent, but it requires a telephone or face-to-face appointment, this should be scheduled within two weeks.

c) Where appropriate, patients will be signposted to self-care or other local services (e.g., community pharmacy or self-referral services).

National Context

The plan seeks to support recovery by focusing this year on four areas:

- **Empowering patients –** Empower patients to manage their own health including using the NHS App, self-referral pathways and through more services offered from community pharmacy. This will relieve pressure on general practice.
- **Implementing Modern General Practice Access –** This aims to tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another time. Patients will know on the day how their request will be handled.
- **Building capacity –** The national plan aims to build capacity to deliver more appointments from more staff than ever before and add flexibility to the types of staff recruited and how they are deployed.
- **Cutting bureaucracy –** Cut bureaucracy and reduce the workload across the interface between primary and secondary care, and the burden of medical evidence requests so practice have more time to meet the clinical needs of their patients. The aim is to give practice teams more time to focus on their patients' clinical needs.

Empowering patients

Improving information and NHS App functionality – All Practices to have enabled all four NHS App functions for patients.

- Ensure directly bookable appointments are available online by 31 July 2023
- Apply system changes or manually update patient settings to provide prospective record access to all patients by 31 October 2023
- Offer secure NHS App messaging to patients where practices have the technology to do so
- Encourage patients to order repeat medications via the App supported by comms toolkit

Increasing self-directed care where clinically appropriate – Expand self-referral routes for the following services by 30 September 2023: Falls services, Musculoskeletal services, Audiology for older people including loss of hearing aid provision, Weight management services, Community podiatry and Wheelchair and community equipment services.

Expanding Community pharmacy services – Build on the success of the increasing role of our pharmacies.

- Introduce a Pharmacy First service by the end of 2023 that enables pharmacists to supply prescription only medicines
- Expand blood pressure check and oral contraceptive services
- Invest to improve the IT system connectivity between community pharmacy and general practice

Implementing Modern General Practice

Better digital telephony – Enable all practices to move from analogue to digital telephony by 31 December 2023 and the remainder by 31 March 2024. We will achieve this by co-ordinating access to specialist procurement, agreeing a sensible approach to roll-out and use our peer networks and demonstrations with practices, Patient Participation Groups to help practices and PCNs adopt digital telephony.

Simpler online requests – Ensure that all practices are providing online access by working with practices and PCNs to decide which tools will best enable them to shift to the Modern General Practice Access model.

Faster navigation, assessment and response – Make it easier for people to contact their practice and normalise getting a same day response, so patients know how their request will be dealt with. We have asked all practices to nominate one staff member to attend the Care Navigation Training and share the learning with their practice, therefore generating a network of experts.

Building capacity

Larger Multi-Disciplinary Teams – Continue to grow the practice team, especially roles with responsibility for direct patient care which can be part of larger MDTs. We will support PCNs to use their full ARRS budget £26m by the end of March 2024.

More Doctors – We want to increase our number of new doctors in general practice by training more GPs and supporting other doctors to transition to general practice. We will work to address the pension challenges and make the GP Return to Practice and International Induction programmes easier to access and more attractive.

Retention and return of experienced GPs – Encourage GPs to return to general practice or to support services like NHS 111 in flexible roles where, for example, working from home is possible. We will encourage practices and PCNs to review and take up local offers for retention and maximise the funding we have available for these schemes.

Higher priority for primary care in housing developments – Ensure new developments are accompanied by primary care infrastructure, and that this is supported by the planning system. As part of normal planning processes, ICBs should work with local stakeholders and take account of areas where housing developments are putting pressure on existing services.

Cutting bureaucracy

Improving the primary to secondary care interface – ICB Chief Medical Officers will establish a local mechanism, to allow both general practice and consultant-led teams to raise local issues, jointly prioritise working with LMCs, and to tackle the high-priority issues. ICBs will also address the following four areas:

- Onward referrals – if a patient has been referred to secondary care and need another referral, for an immediate or related need, the secondary care provider should make this referral, rather than sending the patient back to General Practice
- Complete care (fit notes and discharge letters) – Trusts should ensure that on discharge or after an outpatient appointment, patients receive everything they need, rather than leaving the patients to return to their practice.
- Call & recall – NHS Trusts should establish their own call/recall systems for patients for follow-up test or appointments, eliminating the need for patients having to ask their practice to follow up on their behalf
- Clear point of contact – Ensure providers establish single routes for general practice and secondary care teams to communicate rapidly

Building on the Bureaucracy Busting Concordat – Reduce the demands on practice time from unnecessary or low value asks and improve processes for only the most important requests for medical evidence.

Our local long-term vision for access

GP Provider Board are working on developing a 'Sustainable Clinical Model for Primary Care in Derby & Derbyshire'. The core purpose of this document is to seek agreement to a new, sustainable clinical model for General Practice in Derby and Derbyshire. The aim is to give people hope, by demonstrating how we can mitigate the crisis facing primary care, through a shared vision for improving quality of care and staff working lives.

The vision would stratify our population into three broad categories: people with low complexity; people with rising or high complexity, and; people with extreme complexity. We will structure services differently for each of these groups.

- For people with low complexity, there will be a focus on digital and self-care, a lower skill mix and more emphasis on rapid access and less on continuity of care.
- For people with rising / high complexity this will look more like traditional General Practice, with smaller GP led teams working with a registered list with a focus on continuity of care.
- People with extremely complex needs will be served by multi-disciplinary, multi-agency teams working on a neighbourhood footprint.

Our local long-term vision for access

Stratification	Population group	Clinical Model	Continuity	Staff Mix	Escalation/de-escalation	Activity examples
Low Complexity	~60% of population People that are stable and healthy that have health conditions that can be easily managed.	Delivery at population level (large population registered list) Multiple locations.	Delivered around episodes of care and around information. Access to medical record.	ACPs, FCPs Clinical Pharmacists, HCAs, Nursing associates, GP oversight. Comm pharmacists. Optom	Escalation up where clinical need dictates. Eg persistent unexplained symptoms. Escalation for invx should stay in service.	Reactive illness service. FCP. Mental health. NHS health checks. CVD primary prevention. Smears. CPCS. etc
Rising/High Complexity	~35% of population. Chronic conditions that move in and out of stability. Increasing frailty. Persistent and/or uncontrolled symptoms.	Delivered at small registered sub lists based within a small number of distributed locations.	Focus on relational continuity with a small team.	GPs, Practice nurses, Clinical Pharmacists, ACPs	Seeks to de-escalate where possible back to low complexity. Eg Cancer patient that achieves cure.	Reactive illness service. Medication optimisation. Structured medication reviews. Long term condition management. Care planning.
Extreme Complexity	<5% of population. Heterogenous group. Multiple complex illness combined with significant psychosocial complexity. Would include EOL and severe frailty	Delivery at population utilising an integrated, multi-agency, multi disciplinary neighbourhood teams. Delivered in the location most appropriate to the needs of the patient.	Team based continuity.	GPs, ACPs, DNs, HCAs, Physio, OT, Social worker, MH, Clinical pharmacist. Specialist input where required.	Receives escalation where multi agency approach is required. De-escalated where possible eg super users.	Personalised anticipatory care planning. Reactive service to need. SMRs focused around frailty and polypharmacy.

Our local long-term vision for access

The new service model will incorporate the following key principles:

- Access will be multi-modal. We should not force people to online, telephone or face to face appointments, there will be a choice. We accept that people need and desire different access methods.
- Information gathered will include pre-existing data from medical records as well as information from the patient about the reason for their contact. The information will be gathered in a consistent way to support achieving a consistent outcome.
- Based on the information gathered a decision will be made as to who, when and where there is an appropriate appointment available. The decision will consider pressures within the system and manage the complex risk associated with triage and primary care.
- This decision will then be communicated to the professional along with the booking mechanism (including a waiting function) e.g., booking link, appointment time, warm transfer.

The key enablers to support the delivery of this model are Culture & Organisational Development, Leadership and Quality Management.

How we will deliver the national plan

We worked with our 18 PCNs to develop their Capacity & Access Improvement Plans earlier in the year. The plans incorporated all requirements of the PCARP with the ambition to achieve or work towards the target where appropriate.

National Capacity & Access Support Payment (CASP) 70% Payment	Local Capacity & Access Improvement Payment (CAIP) part or all of 30%
• The Capacity and Access Support Payment for the period 1 April 2023 to 31 March 2024 is calculated as £2.765 multiplied by the PCN's Adjusted Population. • This funding will be unconditionally paid to PCNs, proportionally to their Adjusted Population • Paid via PCSE **1 in 12 equal payments over the 2023/24 financial year**	• The maximum a PCN could earn is £1.185 multiplied by the PCN's Adjusted Population as of 1 January 2023. • The commissioner will instruct PCSE Online to make the appropriate payment to the Nominated Payee of the PCN by no later than **31 August 2024.**
DD total funding £3,061,941	**DD total funding £1,312,260**

The plans were signed off by the Access Working Group following feedback on the draft plans submitted.

We are holding mid-year reviews with PCNs to assess their progress and provide support where necessary.

How we will deliver the national plan

The key themes from the PCN plans are:

- Collaboration with Patient Participation Groups and work towards and improving against the five patient survey questions relating to access
- Develop bespoke in-house surveys to engage with patients to support the results of the patient survey
- Facilitate learning time for practices on care navigation and awareness of services to enable the ability to support getting people to the right place, first time
- Increase in onboarding and usage of Community Pharmacy Consultation Services
- Review of websites to ensure they are fit for purpose
- Development of hubs within PCN to deliver services from
- Segmentation of the population
- Triangulation of Cloud-based Telephony & online consultation data – addressing demand/capacity and staff management
- Integrated working with system partners and the voluntary sector

How we will deliver the national plan

Key deliverables from PCARP

Area	Progress & action
Cloud-based Telephony	Identified 34 practices as critical. We are working to agree a process to allocate funding across these critical practices, to enable migration.
NHS App	96.5% of practices were offering the book and cancel appointment's function and all practices are offering the repeat prescriptions within the app. Work is ongoing to ensure full functionality within the app, including secure app messaging.
Online Consultations	48 practices are achieving the Online Consultation Usage target of 260 per 1000 registered patients per annum. Engagement to encourage increased uptake is ongoing and will be discussed with PCNs during their PCARP mid-year review meetings.
General Practice Appointment Data (GPAD)	60 practices are seeing at least 85% patients within 14 days of booking an appointment, with more than half of these are seeing 90%+ patients within 14 days. Data is shared regularly with PCNs to support them to achieve the target and DDICB will continue to work with the practices who are outliers.

Area	Progress & action
Care Navigation Training	54 practices have signed up to participate in the national Care Navigation Training. We will continue to communicate to PCN Operation Managers to encourage uptake and will also be discussed at the PCARP mid-year review meetings.
General Practice Improvement Programme (NGPiP)	DDICB have 33 practices signed up to NGPiP and one PCN and will be ringfenced for Transition Funding. DDICB are agreeing an allocation of funding process for those practices who are implementing the Modern General Practice Model but not taking part in the NGPiP.
GP Community Pharmacy Consultation Service (GP-CPCS)	All practices are engaged with the GP-CPCS scheme. Locally, we have made the decision to include the scheme within the PCARP with the aim of increasing the number of referrals.
Support Level Framework (SLF)	We are recommending that practices take advantage of the SLF. A working group has been established focusing on uptake and our approach.
GP Registration Service	DDICB have the lowest sign-up rate, 9.7%. We are promoting all webinars and considering arranging a local webinar to encourage practice sign up.
Self-referral Pathway	DDICB have undertaken the initial national self-assessment, with a second self-assessment completed in late September. Our baseline figure for self-referrals is 1,100 and our target is 1,650. We are awaiting data so we can understand our position against the target. Once available, the data will be built into our community performance.

How we will organise ourselves

The Primary Care access recovery work is overseen by the Director of Primary Care (SRO). The ICB work collaboratively with other partners on this programme of work including, but not limited to the following:

- Primary Care Networks – this is with both Clinical Directors and PCN managers.
- GP Provider Board who provide a collaborative voice for developing the future of general practice provision within the Derby & Derbyshire health and care system.
- Derby & Derbyshire Local Medical Committee
- General Practice Task Force (GPTF) who now deliver the Training Hub for Derby & Derbyshire amongst many other things including System Development Fund schemes.

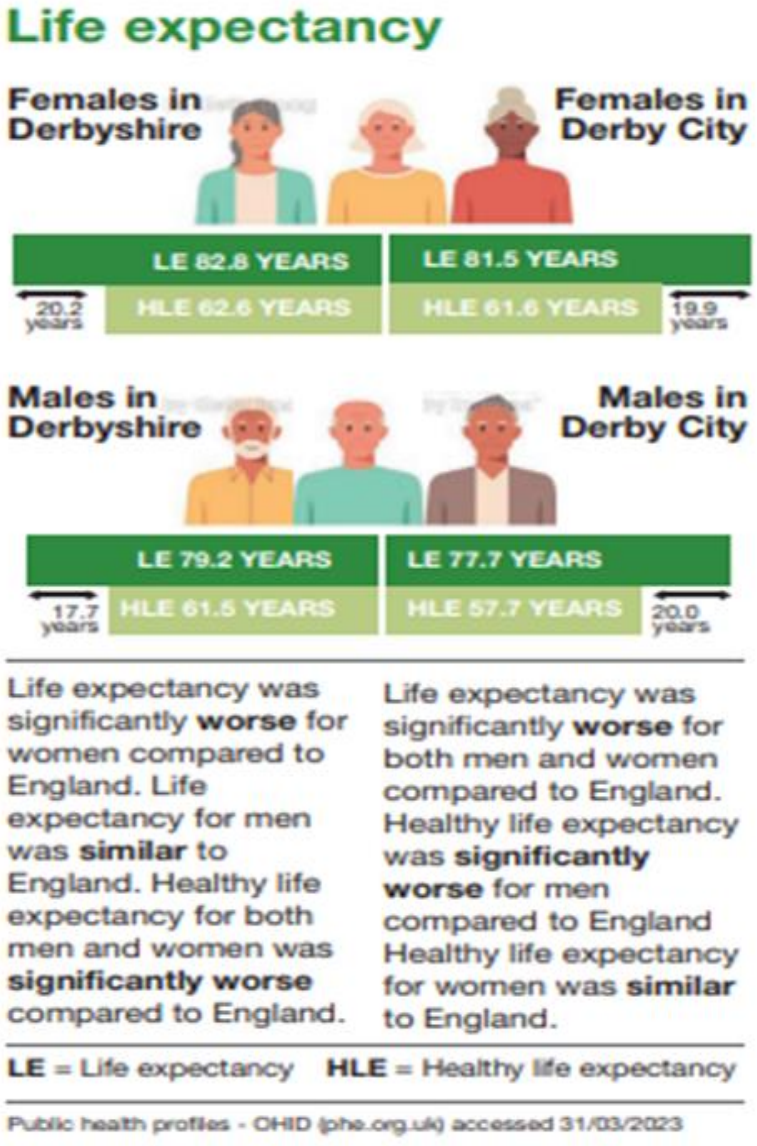
The programme of work is managed via the Access Working Group which is a subgroup of the Primary Care Network Delivery & Assurance Group, that oversees delivery of the PCN DES. The group has representation from the ICB, GP Provider Board, LMC & GPTF. The group meet monthly to discuss progress against the plan and advise on any issues/barriers that are being met.

Managing inequalities

Many people in Derby and Derbyshire live for a long time with long-term and often multiple conditions and there are stark differences in rates of healthy life expectancy between populations.

Similarly, there are also striking differences in life expectancy rates, when comparing the least and most deprived populations.

Work has been undertaken by JUCD System colleagues to develop a set of priority population outcomes and key indicators (known as Turning the Curve indicators) based upon the Derby and Derbyshire Joint Strategic Needs Assessments (JSNAs). These focus on increasing life expectancy, increasing healthy life expectancy, and reducing inequalities.



Managing inequalities

- **Start Well** - To improve outcomes and reduce inequalities in health, social, emotional, and physical development of children in the early years (0-5) via school readiness

- **Stay Well** - To improve prevention and early intervention of the 3 main clinical causes of ill health and early death in the JUCD population - circulatory disease, respiratory disease and cancer

- **Age/ Die Well** - To enable older people to live healthy, independent lives at their normal place of residence for as long as possible. Integrated and strength based services will prioritise health and wellbeing, help people in a crisis to remain at home where possible, and maximize a return to independence following escalations

How we will invest funding

The additional funding for primary care equates to £15.107m. We will ensure that funding is spent in year with practices and PCNs across Derbyshire, with deliverables being closely monitored against the funding allocations. Funding will be paid in a timely way, as per the ICBs agreement with providers, utilising payment mechanisms that are already in place and working well.

The funding has been split into the categories below providing assurance that the funding to support primary care is being used in addition to existing funding and for its intended purpose.

- Transition cover and transformation support funding
- Cloud based telephony transfer funding
- Digital 0.93p per weighted patient
- Capacity and access support payment (guaranteed element)
- Capacity and access improvement/ incentive payment (based on achievement of indicators)
- ARRS (additional value for 23/24 per allocation given)
- ARRS (funding required from ICB in line with contracts without national funding to support, high risk)

How we will involve patients

Engagement with patients, public & primary care workforce to deliver the PCARP is essential so that they can be part of the journey of transforming General Practice. Derby and Derbyshire ICB are adopting the following approach towards communications and engagement around the primary care recovery plan:

- **Amplifying national messaging –** We supported the national announcement of the primary care recovery plan by sharing key details through our stakeholder, staff and PCNs which included the development a local case study.
- **Informing and engaging local communities and stakeholders –** Primary care team leaders attended our “Derbyshire Dialogue” engagement forum in June to discuss the recovery plan and we presented at Healthwatch Derbyshire’s AGM in September, where we gained valuable insight from attendees.
- **Developing a locally specific communications campaign –** The local primary care access plan has been developed and was presented to/signed off by the ICB Public Board on 16th November 2023. A further update on progress will be taken in March 2024.
- **Supporting our winter campaign –** We have agreed a joint approach with our comms team and colleagues from the acute, mental health and community trusts, along with the provider of NHS111 and out of hours GP services. One element of this campaign will be to inform audiences about the range of primary care services available. This will mirror the national NHSE-led campaigns.

How we will manage risks to the plan

Key risks to the plan have been identified and mitigations will be agreed via the Access Working Group and other relevant forums. The main areas of concern are:

- Lack of agreement on some of the principles of “Modernising General Practice”
- Digital enhancements moving General Practice away from person centred holistic care and creating ‘infinite queues’, decreasing patient satisfaction even further
- Lack of workforce to support effective care navigation
- Senior and experienced clinicians moving into oversight roles when evidence suggests that they are needed on the ‘front-line’
- Plan will not be embedded or implemented in way that can support with winter pressures this year
- Demand still outweighs capacity
- Increased focus on ‘on-the-day’ care will have a detrimental impact on the management of long-term conditions and patients with high complexity
- The funding is not new and is being repurposed from the PCN DES

Derbyshire November 2023 Recovery Position

(When discussing post-pandemic recovery Glossop figures are not included because they were not part of Derbyshire in 2019. Including them would inflate our current position)

	Nov-19	Nov23 (not including Glossop)	Overall Derbyshire Totals Nov 23	Glossop Nov 23	Appt Different Nov23 - Nov19 (Not inc Glossop)	% increase / Decrease	% Increase / Decrease corrected for working days
Total Appointments	545896	593212	614165	20953	47316	8.7%	3.7%
Face-to-Face	446585	433262	448112	14850	-13323	-3.0%	-7.4%
Home Visit	4175	6224	6581	357	2049	49.1%	42.3%
Telephone	67643	111369	116679	5310	43726	64.6%	57.2%
Unknown	19329	21649	21928	279	2320	12.0%	
Video Conference/Online	8164	20708	20865	157	12544	153.7%	142.1%
Team UP Home Visitng Service			4941				
Same Day	204734	233732	241556	7824	28998	14.2%	9.0%

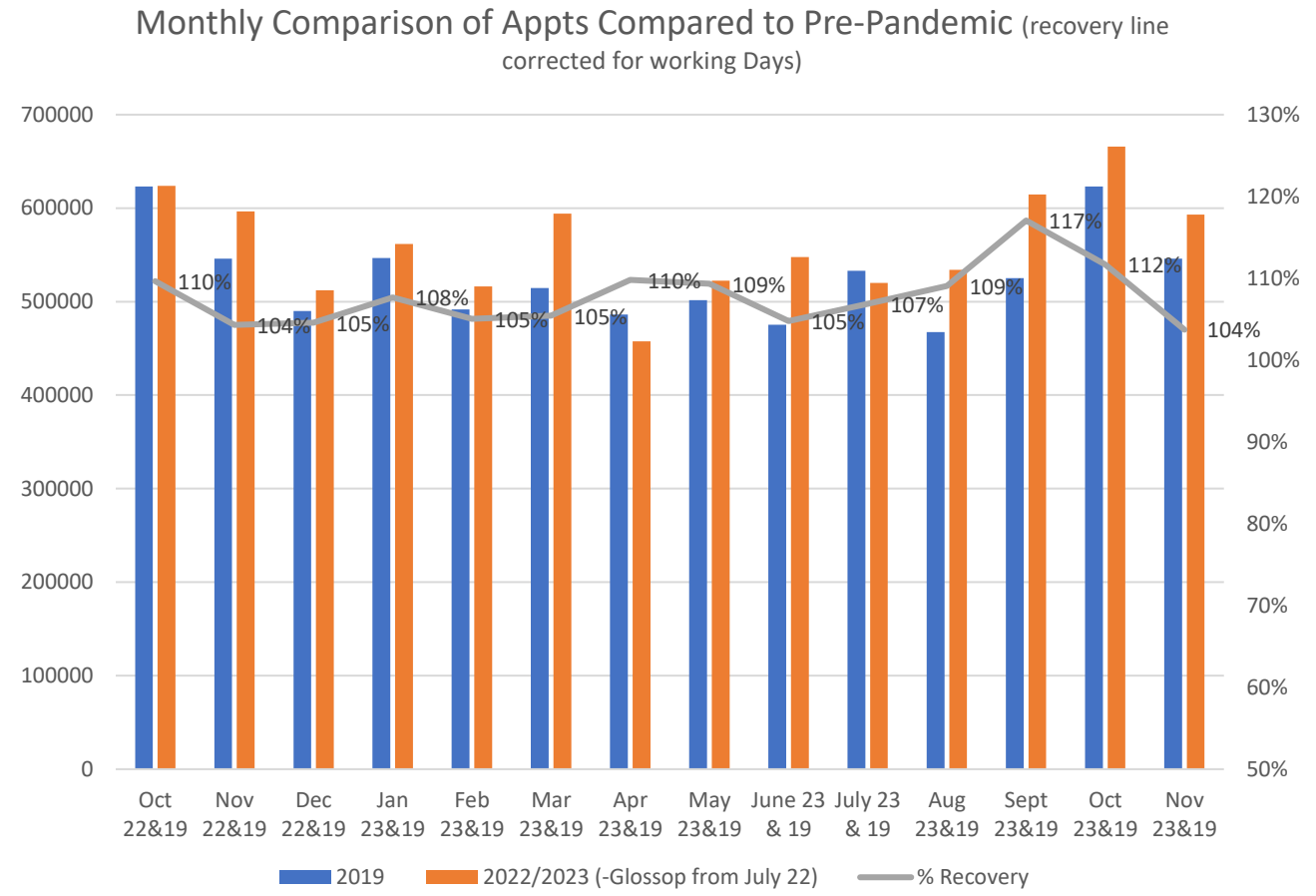
- Total number of appointments in November 23 has increased by 3.7% (corrected for working days) which is approx. 593,000 for the month (614,000 including Glossop). On top of the November 23 total there were 4941 home visits from the Aging Well Support Programme which relieves pressure in General Practice.
- The number of General Practice Face to face appointments in November 23 are down 7.4% compared with November19 (corrected for working days). They made up 73% of total appointments.
- Telephone appointments in November 23 are up 57% compared to November 19 (Corrected for Working Days). They made up 19% of appointments.
- Video/Online appointments are up 142% compared with November 2019 (corrected for working days), approx. 20,700 (not including Glossop) in total making up 3% of overall appointments.
- General Practice Same day appointments in November 23 are up 9% compared to November 19 making up 39% of appointments.

Derbyshire Total Appointments Delivered per month 2019 - 2023 comparison

November 2023 Derbyshire has recovered 104% compared with 2019 (corrected for working days).

The Primary Care team have been working with practices who regularly show lower levels of recovery to first of all establish if firstly it's a data issue and if not support is offered through talking through any issues, is there anything we can do to support

Targeted support is offered through the Accelerate programme and the newly released General Practice Improvement Programme which offers varying levels of support to practices to help improve access to patients.



Note:

- Glossop PCN joined from September 2022, so in order to compare figures for this PCN have not been included.

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