NHS
North Durham
Clinical Commissioning Group

North Durham Primary Care Strategy Refresh

Refreshed July 2016

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Introduction

NHS North Durham Clinical Commissioning Group (CCG) was authorised as a statutory body with effect from 01 April 2013. North Durham CCG is a member practice organisation, made up of 31 GP practices and serves a population of about 253,086 spread across a large and diverse geographical area. Clinical commissioning means that local GPs are using their knowledge about healthcare to develop services that meet the needs of our patients. We commission services from one main acute provider and one mental health trust as well as commissioning additional primary care services from member general practices by way of a core contract and enhanced services.

The NHS Five Year Forward View (5YFV) was published in 2014 and sets out a new shared vision for the future of the NHS based around new models of care. North Durham CCG is working towards implementation of the 5YFV through the refresh of this strategy and to move as much care as possible out of hospital into the community. Consequently, general practice will grow and change as will other services such as community hospitals as we implement multi-speciality community provision.

Since April 2015 the CCG has new responsibilities for commissioning primary care which was previously commissioned by NHS England. Commissioning secondary, primary and community care allows North Durham CCG to develop services around the patient.

Due to rising demand on the NHS, rising expectations regarding greater accessibility over seven days and the NHS financial challenge NDCCG has to explore new ways of delivering primary care in the future. The General Practice Forward View which was published April 2016 sets out over the next 5 years the responsibilities and investment to undertake this transformation.

Our current model of general practice is the envy of the world. However, due to rising demand on the NHS, rising expectations regarding greater accessibility over seven days and the NHS financial challenge we have to explore new ways of delivering primary care in future. The General Practice Forward View was published in April 2016 and sets out the responsibilities and investment to undertake this transformation (over the next 5 years) https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

Primary care is the healthcare provided by general practitioners (GPs), nurses and other health care providers in general practice teams, as well as by opticians, dentists and pharmacists. It is typically the first, and most generalised, point of access to health care and can also have a coordinating role in a patient's care.

We strive for excellence in primary care in order to deliver the highest possible standards of healthcare for North Durham residents. This primary care strategy aims to drive forward health improvements for the entire population of North Durham CCG.

To deliver on the objectives within this primary care strategy, we believe that a stronger GP sector must have the following **key features**:

- maintains the strength of general practice in terms of personalised, continuity of care to a registered population, when necessary,
- builds organisational capacity within general practice at locality level and an infrastructure to enable cross practice working,
- is bigger, wider and integrated seamlessly with social and community services,
- is aligned and working in partnership with public health,
- enables patients to feel engaged and empowered in their care,
- provides a rewarding and enjoyable place to work, enabling adequate recruitment and retention for sustainable services.

Through North Durham CCG's vision of what primary care could look like five years in the future (2019/2020), a number of key characteristics have been emerged, which have guided the direction of this strategy:

- improved capability to respond to and manage demand,
- high standards of personal care,
- sustainability in working practices for primary care professionals,
- seven day and extended hours availability of primary care, with seamless transition between in-hours and out-of-hours care,
- federated, collaborative working that enables increased efficiency in primary care,
- movement of secondary care services into the primary care domain,
- wrapping of social care and community services around primary care,
- 'generalist-specialist' primary care clinicians,
- information sharing systems and a culture that promote patient-focused case management and timely access to information, reducing barriers to inter-agency working,
- access to effective and fast diagnostics, increasingly based in primary care investigation centres,
- pathways or protocols for specific disease/diagnosis, to guide consistently high quality care,
- speciality 'one stop' clinics, when appropriate with mobile equipment and teams,
- GPs as coordinators of care, with support from primary care teams
- specialist care teams (including Admiral Nurses)
- reduction of unnecessary admissions to Accident and Emergency.

Dr Neil O'Brien
Chief Clinical Officer

Executive Summary

What is the CCG Vision?

Better health for the people of North Durham

The Primary Care Strategy aligns with the four overarching priorities of the CCG:

- improving the health status of the population,
- addressing the needs of the changing age profile of the population,
- commissioning clinically effective, better quality services closer to home,
- making best use of public funds to ensure healthcare meets the needs of the patients and is safe and effective.

What is the CCG's Vision for Primary Care?

General Practice as partners leading healthcare for the people of North Durham

How will this strategy achieve this? – Our three objectives:

- to develop a fit for purpose workforce and primary care infrastructure to deliver care closer to home,
- to support general practice and federations to work together to deliver high quality cost effective primary care services for the population of North Durham CCG,
- to commission clinically effective planned and unplanned out of hospital care.

Our programmes of work to deliver these objectives (appendix 1) will form part of our Operating Model and Implementation Plan:

1. Develop a fit for purpose workforce and primary care infrastructure

North Durham CCG will:

- invest the Personal Medical Services premium over the next five years into the workforce within general practice,
- actively plan our workforce to look at future demand including population growth and other factors,
- work with GP and nurse tutors to develop a rolling programme to ensure that staff training needs are met,

- develop and support our existing primary care teams,
- address the need to use a multi-disciplinary model to support and develop the use of non-medical prescribers as part of the primary care team (nurses and pharmacists),
- develop a primary care estates plan and an investment plan which takes into account changes in population and changes in ways of working to ensure need is met,
- identify practice premises that are in greatest need and prioritise support to those,
- develop functionality to deliver mobile working and support the delivery of interoperability between systems across health and social care,
- work in partnership with health and social care across the County Durham and Darlington Footprint to achieve the ambition of paper-free at the point of care. It aims to identify how local health and care systems will work together to deploy and optimise digitally-enhanced capabilities to improve and transform practice, workflows and pathways.

2. Support general practice to work with each other and with local people and partners to deliver high quality, cost effective primary care

North Durham CCG will:

- encourage all practices to be part of three GP federations which we will support them to develop into successful primary care providers,
- facilitate and commission from trusts, other partners and primary care a Multi-Specialty Community Provider Model (MSCP) of care,
- effectively engage and consult with general practice and with our local community via a number of communication systems,
- continue to support general practice in terms of the implementation of the Friends and Family Test and ensure that quality is monitored and actively managed within primary care using national tools and supporting practices to develop.

3. Commission clinically effective planned and unplanned out of hospital care

North Durham CCG will:

- commission seven day primary care services tailored to those with the greatest health need,
- review and recommission out of hours services and extended primary care services,
- wrap community, social care and mental health services around primary care services to deliver an integrated service for patients,
- as a key partner and contributor to the health and wellbeing joint strategic needs assessment, ensure that public health priorities integrate through delivery of the three key objectives of the primary care strategy.

This plan sets out steps to future primary care delivery aligned to our priority health outcomes within NHS North Durham CCG.

'Delivering the Forward View' (published by NHS England) sets out steps to help local organisations to develop plans which will enable them to deliver a sustainable, transformed health service and to improve quality of care and wellbeing. This includes a new, dedicated Sustainability and Transformation Fund (STP) worth £2.1 billion in 2016/17 and rising to £3.4 billion in 2020/21. Within the STP there are nine 'must do' targets for 2016/17. These are:-

1. develop a high quality and agreed Sustainability and Transformation plans,
2. return the system to aggregate financial balance,
3. develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues,
4. get back on track with access standards for Accident and Emergency and ambulance waits,
5. improvement against, and maintenance of, the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice,
6. deliver the NHS Constitution 62-day cancer waiting standard, including by securing adequate diagnostic capacity; continue to deliver the constitutional two-week and 31-day cancer standards and make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission,

7. achieve and maintain two new mental health access standards [and] continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia,

8. deliver actions set out in local plans to transform care for people with learning disabilities,

9. develop and implement an affordable plan to make improvements in quality particularly for organisations in special measures.

Where the 'must do' targets impact on primary care we will strive to ensure that this strategy encompasses the CCG's ability to achieve these targets and to also answer the questions posed in the NHS Forward View Guidance 2016/17.

(hyperlink - https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf)

Joseph Chandy

Director of Primary Care (Non-Clinical)

Patrick Ojechi

Director of Primary Care (Clinical)

How does this fit with CCG and Health and Well Being Priorities?

The Health and Wellbeing Board (HWBB) vision is to:

Improve the health and wellbeing of the people of County Durham and reduce health inequalities

The key aims/programmes of work for North Durham CCG are aligned to the Health and Well Being Board priorities/strategic objectives which are:-

1. children and young people make healthy choices and have the best start in life,
2. reduce health inequalities and early deaths,
3. improve the quality of life, independence and care and support for people with long term conditions,
4. improve the mental and physical wellbeing of the population,
5. protect vulnerable people from harm,
6. support people to die in the place of their choice with the care and support that they need.

North Durham CCG's overall vision and vision for primary care aligns with the Joint Health and Well Being Strategy (JHWBS) and the CCG will continue to work closely with the HWBB to ensure all objectives are met.

Joint Strategic Needs Assessment (JSNA)

The Joint Strategic Needs Assessment (JSNA) provides a detailed overview of the current and future health and wellbeing needs of the people of County Durham. The data and key messages from this document provide the evidence base for the development of the Joint Health and Wellbeing Strategy 2016/19, the Children, Young People and Families Plan 2016/19 and Clinical Commissioning Group Commissioning Intentions.

The key messages are focussed around the demographics of the population of County Durham alongside their health and social care. For more detail on the JSNA's key messages please visit (hyperlink)
http://www.durham.gov.uk/media/9140/JSNA-2015-key-messages/pdf/CountyDurhamJSNAKeyMessages2015.pdf)

The CCG will work collaboratively with key stakeholders to ensure the key messages are disseminated and implemented within general practice.

Engagement and feedback on the Strategy Refresh

The North Durham primary care strategy was developed with input from and consultation with:-

- member practices,
- Council of Members,
- Patient Reference Groups,
- The CCG's Management Executive.

This primary care strategy underwent a programme of engagement which was aligned to the CCG's formal engagement process which included an interactive Patient Reference Group session and Patient Public and Carer Engagement (PPCE) Committee where memberships includes stakeholders representing carers, patients, voluntary sector and health watch.
In general the feedback was positive with key stakeholders endorsing the philosophy of transforming and strengthening primary care. In particular people were keen to ensure that access to primary care was enhanced and extended to ensure members of the public are seen within a timely manner and to avoid putting pressure on other key services.

The primary care strategy does not stand alone and links into key programmes of work for the CCG for example, diabetes, out of hours and frail elderly.

As part of the refresh of the strategy further consultation will take place with:-

- Patient Participation Groups,
- Healthwatch,
- the Overview and Scrutiny Committee,

- North Durham CCG's Governing Body,
- Area Action Partnerships
- County Durham and Darlington Local Medical Council
- Tees, Esk and Wear Valley Mental Health NHS Foundation Trust,
- County Durham and Darlington NHS Foundation Trust
- GP Federations,
- Health and Well-being Board,
- Durham County Council Public Health.

The primary care strategy is aligned to the 'Not in Hospital' workstream which forms part of the Better Health Programme (BHP) (5 year forward view). It mirrors the key principles and standards outlined as part of this clinically led transformation programme.

Context

There are many factors affecting the direction of travel for primary care services over the next five years, not least the growing financial pressure being placed on the NHS. There is a greater demand on services due to an ageing population with more complex health needs as well as increasing patient expectation and fewer resources available to deliver services. Indeed within the North Durham area there has been an increase in population size of 7.2% between 2001 and 2013.

It is estimated that general practice delivers around 90 per cent of NHS contacts meaning even a slight patient shift from primary to secondary care would put unmanageable pressure on the system *(NHS Employers, 2014).* Nationally there is a drive to move services into the community and closer to home where appropriate. *The Five Year Forward View* outlines new models of care which are centred on the ability of primary care to have the capacity and capability to deliver services at scale.

North Durham CCG has always had a role to play in driving up quality within primary care and now the CCG has responsibility for commissioning primary care medical services from general practice. This strategy will begin to identify the challenges now and in the future and outline the vision for ensuring successful and sustainable primary care is commissioned and delivered within North Durham. The primary care strategy will also need to be viewed in the context of other work programmes i.e. urgent care and frail elderly.

Case for Change

Workforce

The Health Education North East (HENE) *General Practice Workforce Report* December 2015 reported that there are 155 (head count) GPs within North Durham. Evidence is also emerging from the NHS Information Centre that the GP workforce is now shrinking rather than growing. Whilst the number of GPs per 100,000 head of population across England increased from 54 in 1995 to 62 in 2009, it remained relatively stable in North Durham with 61.8.

It is most concerning to note that nationally 54% of GPs over the age of 50 are intending to quit direct patient care within five years. A recent study within North Durham (2013) found that 40% of the primary care nursing workforce is due to retire in the next ten years, (NHS England Survey).

Quality

There are a variety of methods used to measure quality within primary care including; the Quality Outcomes Framework (QoF), Valued Based Commissioning Policy (VBCP), patient surveys, practice profiles, and the Friends and Family Test.

We can also measure the quality within general practice across North Durham by looking at the primary care outcomes tool. As an overview of the overall picture in terms of quality it outlines 18 achieving and 9 higher achieving practices. As a CCG we can identify (using this tool) areas which require further quality improvement. Some examples include the need to further increase the levels of identification for conditions such as Atrial Fibrillation (AF), Chronic Obstructive Pulmonary Disorder (COPD) and Coronary Heart Disease (CHD). Also the rate of emergency admissions for those with a long term condition is slightly above the NHS England average (57.39% and 58.88% respectively).

In the 2014/15 financial year North Durham practices achieved 98.0% attainment of the Quality Outcomes Framework (QoF) compared to the Durham, Darlington and Tees sub-region of 96.1%, Durham Dales Easington and Sedgefield CCG 96.8% and Darlington CCG got 98.3%.

The Friends and Family Test was introduced into general practice in 2014 and as at June 2016 76% of respondents were likely to recommend their GP practice to a friend or family member.

Our People and Place

Within North Durham there are 31 practices and the total registered list size for North Durham is 253,086 (Health and Social Care Information Centre (HSCIC), 2015/16). By using national figures, we can estimate that approximately 2400 people are seen every day in general practice within North Durham. The average payment made to general practice per patient across North Durham is £137.12 compared to a national average of £136.

Derwentside comprises a mixture of urban, semi-urban and rural areas with the population concentrated in Stanley and Consett. Durham and Chester-le-Street cover a mixture of rural and urban areas with two main population centres, Durham City and Chester-le-Street. The University in Durham is home to a large and internationally diverse student population. There are significant variations in health across these three areas.

People who live in the North Durham area have significant health challenges and problems. They are also more likely to die sooner than those living in other parts of the country. The main causes of early death include high levels of cancer, cardiovascular and cerebrovascular diseases.

With an ageing population, we will also experience greater demand for hospital services and an increase in illnesses related to older people such as stroke, long-term conditions and dementia. The large student population in Durham City results in a demand for sexual health, alcohol and harm reduction services.

Other key challenges facing North Durham include:

- reducing lifestyle risk factors such as smoking, alcohol, obesity,
- economic inequality related to unemployment and low incomes,
- people with disabilities have worse health than those without,
- children's health and lifestyles are poorer than elsewhere in the country.

The health of the population is not something that general practice can address alone. GPs have a unique and essential contribution to make in collaboration with public health, clinical commissioners and the community.

Population

Overall, the population of North Durham CCG (6.8%) has grown at a much quicker rate than County Durham (4.0%) or North East region (3.2%) over the last ten years. Specifically this can be seen in Durham (7.6%) and Derwentside (7.8%).

Life Expectancy

The healthy life expectancy for County Durham is significantly worse for both males (58.7) and females (59.4) than for England (63.4 and 64.1 respectively).

Health Inequalities

Health inequalities exist between County Durham and England. For example:
life expectancy for men living in County Durham is 1.3 years less than the England average. For women it is 1.5 years less than the England average (at birth 2010-12).

Premature Mortality

Premature mortality rates from all cardiovascular diseases (2010-12) in County Durham (92.4 per 100,000) are significantly higher than England (81.1 per 100,000).

Disease Prevalence

- CHD prevalence in County Durham (4.9%) is higher than England (3.3%)
- Diabetes prevalence in County Durham (6.8%) is higher than England (6%)
- COPD prevalence in County Durham (2.7%) is higher than England (1.7%)

Strategic Objectives

Our overall vision within the CCG is for better health for the people of North Durham. To ***'Improve the health of the population of North Durham'*** we need to understand how general practice contributes to this vision.

North Durham CCG has four strategic objectives; our primary care strategy is aligned to these in terms of how primary care will contribute to the delivery of the CCG's vision.

1. improving the health status of the population,
2. addressing the needs of the changing age profile of the population,
3. commissioning clinically effective, better quality services closer to home,
4. making best use of public funds to ensure healthcare meets the needs of patients and is safe and effective.

Aligned to these are North Durham CCG's primary care objectives which will be used to develop primary care to ensure its fit for purpose now and in the future:

- to develop a fit for purpose workforce and primary care infrastructure to deliver care closer to home,
- to support general practice to work with each other and with local people and partners to deliver high quality, cost effective primary care,
- to commission clinically effective planned and unplanned out of hospital care.

1. To develop a fit for purpose workforce and primary care infrastructure to deliver care close to home

1.1 Creating opportunities for the Primary Care Workforce

The CCG's Primary Care Steering Group will oversee initiatives.

Work with Health Education North East and the GP Federations to develop workforce plans for Practice Nurses and GPs in each locality, including a survey to understand the current situation and the position five years from now to identify risks and potential gaps.

Work is in progress for a CCG funded 'GP Career Start' scheme in conjunction with DDES CCG. Both CCGs aim to recruit up to 20 new GPs to the area to work in designated practices with GP mentor support. This is in addition to the continuing Career Start scheme for Practice Nurses which is an ongoing success at attracting more Practice Nurses onto a training and recruitment programme across Co. Durham.

Explore other potential initiatives with HENE and other CCGs for recruitment, retention and use of other primary care professionals for alternative access to care, e.g. Community Matrons and clinical pharmacists.

A Protected Learning Time (PLT) Steering Group with an approved budget has been set up, bringing together GP tutors, Practice Nurse tutors and locality representatives to develop a menu of education and training events that supports primary care professionals and their teams. This will include mandatory training such as safeguarding adults and children training events, and GP and Practice Nurse 'update' courses

Continuing Protected Learning Times (PLTs) for practices, but aligning them to the same 3rd Thursday afternoon each month across all localities. This provides protected time for practices and individuals to focus on key areas of education. The CCG will facilitate four PLTs a year as a whole North Durham event to engage with practices to take forward the primary care strategy.

2. Support general practice to work with each other and with local people and partners to deliver high quality, cost effective primary care

2.1 Building organisational capacity through GP Federations

In North Durham we have three GP Federations based around three distinct geographical localities; Chester-le-Street, Durham and Derwentside. Each of these areas are historically used to working well with each other.

They are currently supported and resourced by the CCG through contracts to:

- develop an organisational development plan to set up themselves as legal entities, establish governance arrangements, capacity and a business plan,
- set up a weekend on call service for the frail elderly,
- identify other 'examples' of cross practice working,
- deliver an example of multi-speciality care provision.

Progress update.

- all three organisations are now set up as legal entities,
- each has completed an organisational development plan to show progress after six months in existence, and beyond,
- the weekend service for vulnerable people has been up and running since October 2015.

Comments

- GP Federation development is still in its infancy although each shows potential,
- whilst gaining the support and credibility of their member practices it is also important for the CCG that the GP Federation become engaged with the objectives of the primary care strategy and that we have an early success in what they can deliver.

2.2 Driving up quality of primary care services and reducing variation

North Durham CCG is committed to supporting primary care professionals through the anticipated changes in the years ahead. The CCG also encourages local approaches and innovations to addressing challenges and improving outcomes. Over the past year, North Durham CCG has supported a number of schemes and projects, aimed at achieving the CCG's objectives, for example, the *Quality Improvement Scheme* and *Improving Outcomes in Primary Care*. Furthermore, the CCG provides on-going and informal support to primary care, such as through GP variation visits, engagement work in constituencies, and direct feedback mechanisms through constituency leads and deputies

Working with NHS England Cumbria and the North East to:

1. report primary quality using the primary care web tool,
2. improve reporting of serious incidents in primary care,
3. reduce variation of quality across primary care,
4. ensure dissemination and uptake of NICE guidelines,
5. implement a programme of audit work for quality improvement in specific areas,
6. review processes for improving quality in referral pathways,
7. improve use of GP Teamnet across North Durham as an information management tool to enable dissemination of :
    a. updates, information and diary events,
    b. NICE guidelines,
    c. clinical support information (CSI) guidelines,
    d. medicines optimisation guidelines and newsletters,
    e. GP appraisal documentation.

8. Improve quality of prescribing through the prescribing incentive scheme and the medicines optimisation programme.

9. Explore potential for re-instigating the Quality Improvement Scheme at practice level to re-engage Practices in areas of Quality Improvement.

(See quality improvement strategy update)

2.3 Introducing a systematic approach to health improvement

1. To work with Public Health and GP Federations to explore how primary care can work to contribute to the health improvement programme to provide solutions to reduce social isolation.

2. Work on lifestyle schemes to reduce:
    a. smoking,
    b. obesity,
    c. cardiovascular risk through patient health checks,
    d. low exercise rates,
    e. mental illness.

3. Improve self-management schemes for people with long term conditions.

4. Increasing screening and vaccination rates.

5. Reducing health inequalities and causes of ill health.

2.4 How will we know we have made a difference?

- There will be an increase in the primary care workforce and there will be fewer under-doctored areas within North Durham.
- There will be an increased proportion of commissioned services within the community compared to secondary care.

- Patient satisfaction (measured as part of the Friends and Family Test) has improved within primary care for North Durham.
- Tailored seven day services are in place.

3. Commission clinically effective planned and unplanned out of hospital care

3.1 Service Developments:

3.1.1 Moving towards 7 day working and extended access to Primary Care

Update

A review of urgent care services and out of hours services is underway with notice given to the existing provider (County Durham and Darlington Foundation Trust (CDDFT) of the CCG's plan to re-procure the out of hours element with an updated service specification. This will require a disaggregation of the contract between North and South Durham to identify the financial envelope to re-invest in a model going forward.

In line with Government policy, there is a drive to move towards 7 day working and extended weekday working as part of the core GP contract. The Prime Minister has recently announced a new 'voluntary' GP contract that will be in place by April 2017 that requires GP opening from 8am to 8pm during both weekdays and weekends. The detail of this is not yet available but it will be delivered and contracted for through GP Federations enabling new models of working across practices in geographical localities.

The timescale to define a new model of working and contract for its implementation is by April 2017 when the first examples of new models will go live.

In addition to this the North East Urgent Care Network has been successful in its bid to be a Vanguard site in the development of a model of care across the North East to address system pressures and improve quality of care and patient safety. Urgent care will be delivered, not just in hospitals, but also by GPs, pharmacists, community teams, ambulance services, NHS 111, social care and others, and through patients being given support and

education to manage their own conditions. Another aim is to break down boundaries between physical and mental health to improve the quality of care and experience for all.

The Urgent Care Strategy puts GP practices at the heart of the Urgent Care System, recognising their role in providing access to responsive primary and community care services 7 days a week.

For example:

- central data collection and monitoring of demand,
- better self care and education of use of services,
- future use of '111' as a point of access for urgent care or advice, including availability of GP appointments,
- integration with ambulance and paramedic services,
- fewer, but more specialised centres of Accident and Emergency care through new payment models,
- more accessible integrated care 'out of hospital service' at a locality level.

Next steps

1. There is a CCG working group set up to take forward the urgent care strategy which will co-ordinate its implementation going forward, anticipating the key role 'urgent care' will play in a wider 'not in hospital' strategy in each locality.

2. The CCG will work with each GP Federation (as part of their organisational development plan) to define a model of 7 day working for general practice in each locality which will describe aspects of how that service may be provided.

   Where, when, how, who

3. Consult with patients and the public about emerging models of access to 7 day services at locality level.

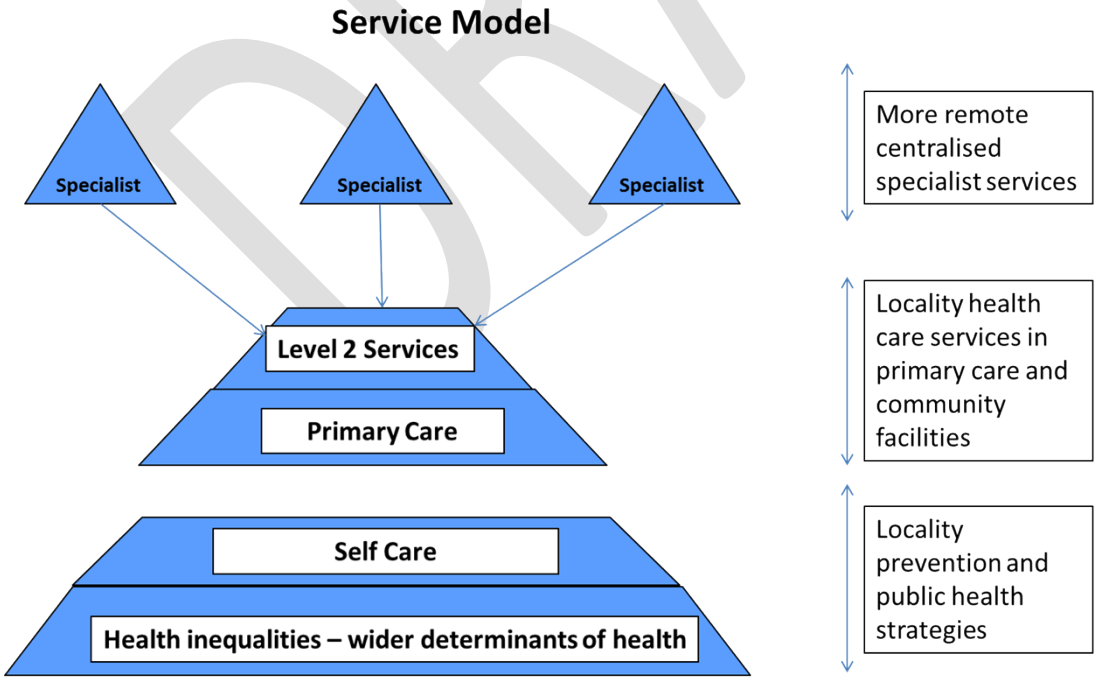
4. Work with other providers as to how this integrates with other 7 day working strategies eg Community Matrons, IC+ services, diagnostics, new consultant contracts, A&E services.

5. Understand the financial framework (from disaggregation of the out of hours contract) and new commissioning routes (new GP contract model, or Vanguard sites) that we can use to drive and implement new models of 7 day working.

6. Work with the local A&E Delivery Board previously known as System Resilience Group to understand the implications of the North East and Yorkshire Regional Vanguard initiatives.

7. Engagement with practices, GP Federations and the constituency leads is now paramount in how general practice will work within this model to find an effective solution.

3.1.2 Key features of a new operating model for 'Not in Hospital Care'



'Not in hospital care' will be delivered and co-ordinated at locality level.

Local practice teams will provide continuity to their registered population supported by aligned community services consisting of designated District Nurses and Community Matrons to each locality.

Hubs will be developed within each locality to provide supporting services across practices in each area.

This may consist of specialist clinical, specialist nursing, diagnostic, outreach, rehabilitation, out of hours services or even shared 'core' GP services.

Key elements at this level are:

- cross practice working e.g. out of hours services, weekend services,
- integration between social and community services, e.g. intermediate care plus (IC+) services,
- vertical integration between acute, community and general practice services e.g. diabetic clinics.

These hubs may be based at specified practices or community locations depending on the Primary Care and community estate or historical agreements at locality level, hence the importance of an estates strategy to follow the service strategy.

Continuity of information through effective IT solutions is imperative to enable access to a single patient record where possible and effective working across practices and community services.

A co-ordinated approach to improving health and wellbeing can be planned, contracted and integrated at practice or community level wherever is best accessible for patients.

GP Federations (or other models of scaled up General Practice at locality level) will be perfectly placed to take the lead for some, or all, of these services either providing them as a provider organisation themselves, or working with other organisations within a multi-speciality care provider model.

3.1.3 Implementing a new model of Care for Diabetes

Update

North Durham Clinical Commissioning Group wants to improve the quality of care for people living with diabetes, and to support them to manage their condition so they can stay healthy. Specialist clinicians are having to focus on managing the complications from diabetes, instead of preventing complications occurring. Historically there is not enough joined up working between primary care and acute care. Both patients and clinicians have fed back that they want a more joined up approach. 10% of the NHS budget is spent on diabetes, 1% of the whole NHS budget is spent on drugs to control blood sugar. Spend on diabetes drugs per patient is higher in County Durham and Darlington than the North East and is rising faster. Costs will continue to rise, becoming unaffordable if we do not change how we support people both at risk of diabetes and those who already have the condition.

A new model of care has been developed with input from patients, primary and secondary care clinicians and this will see:

- GPs and local hospitals working more closely together to give patients care closer to home,
- a shift from acute to primary and community services to support people with Type 2 Diabetes,
- a patient centred, integrated service for patients between primary and secondary care which ensures that future diabetes services are financially sustainable.

The new model promotes a keen focus on:

- diabetes prevention,
- individualised care planning and patient self-management,
- named specialist resources,
- consultants and Diabetes Specialist Nurses collaborating with groups of GP practices (based on local GP Federations) in newly formed ‘diabetes groups’ to upskill primary care and improve the level of care provided in practices,

- pursuing savings for reinvestment in diabetes care to ensure a financially sustainable service whilst also delivering quality care to our patients.

We have developed a training curriculum for primary care clinicians to ensure GPs and Practice Nurses are suitably qualified in diabetes care. In addition, County Durham is a demonstrator site for the new National Diabetes Programme. This will be rolled out across the County during summer 2016, initially focusing on areas where need is greatest (maybe due to deprivation or higher numbers of patients identified as being at high risk of diabetes), and we expect the first localised programme to start in early August 2016. Those referred will get tailored, personalised support to reduce their risk of Type 2 diabetes, including education on healthy eating and lifestyle, help to lose weight and bespoke exercise programmes, all of which together have been proven to reduce the risk of developing the disease.

3.1.4 Implementing integrated services for the Frail Elderly

Update

The model for the frail elderly has been developed at four different levels of care that together form an integrated pathway for the frail elderly patient. Its implantation is already well under way the elements of which will all be in place by early 2016.

Four levels of Care

1. Prevention and wellbeing

Public health and the Health and Wellbeing Board working on a strategy to reduce social isolation.

2. Practice level

Primary care identifying a register of people with frailty in each practice using agreed search criteria as a case finding tool. Each practice are contracted to assess all patients on this register in terms of frailty, risk of falls, cognitive assessment and medication review.

According to need, to provide targeted proactive and reactive care using a case management approach on a multidisciplinary team basis where required.

3. Locality based services

- at GP Federation level, working across practices to provide a weekend GP service to support those on the frailty register, and those in care homes, providing reactive and proactive care alongside Community Matrons, to keep this vulnerable cohort of patients out of hospital or facilitate discharge where necessary,
- by summer 2016 the team of community matrons will be fully integrated into primary care multi-disciplinary teams working with GPs and practice staff to care for their frail population,

- Community services and care home provision
    - District Nurses are now aligned to specific practices and specific care homes,
    - re-align named practices to specific care homes to complete a clinical support team of GP, District Nurse and Community Matron to each care home in a locality,
    - all care homes to have completed Emergency Health Care Plans for each resident (March 2016).

- After April 2016 onwards
  Full alignment of District Nurses to practices and care homes, providing a range of proactive and reactive care on a case management basis, with integration of Community Matrons working at practice level to a register of frail elderly patients both in care homes and at their own homes.

- Locality based Multidisciplinary Intermediate Care Services
  The IC+ 'Intermediate Care Plus'
    - integrated support from specialist nurses, rehab teams and access to carer support, provided from a Single Point of Access (SPA),

- this is now in place, allowing urgent intervention in a co-ordinated approach. This can arise from either a step up referral including crisis response from the community, or a step down referral from hospital to support discharge,
- the service provides rapid access to an appropriate level of support to keep people out of hospital or facilitate discharge,
- it is available 7 days a week, 24 hours per day.

4. Linking with specialised elderly care services

- Rapid assessment clinics
  - daily clinics Monday to Friday to provide same day / next day appointments for urgent medical assessments,
  - access via Single Point of Access service,
  - locations at Shotley Bridge and Chester-le-Street Community Hospitals,
  - providing full elderly assessment, access to diagnostics, therapy, medical opinion and onward referral if necessary.

- Consultant advice lines – Daily 12.00 – 2.00 pm

- Proposed front of house service – working alongside Accident and Emergency at University Hospital North Durham (UHND) to provide a consultant led service, providing urgent assessment to the frail elderly attending A&E, including diagnostics, access to therapy and IC+ services.
  This will be integrated with other community support services described above through shared access to community service and Social Service IT systems.

Appendix 1

Operational Plan

Objective 1 **To develop a fit for purpose workforce and primary care infrastructure to deliver care closer to home**
Workforce and Training
Invest the Personal Medical Services premium over the next five years into workforce within general practice such as GP posts e.g. joint posts within urgent care and diabetes, primary care nursing, career start for GPs as well as nursing, extending the role of nurses and training.
Actively plan our workforce to look at future demand including population growth and other factor such as working patterns and retirement and plan for this demand.
Promote North Durham CCG practices as a great place to work and we will link into universities to attract the newly qualified workforce.
Work with GP and nurse tutors to develop a rolling programme to ensure that staff training needs are met and to enhance workforce skills particularly in relation to long term conditions. We will align this programme to CCG commissioning priorities.
Develop primary care teams as CCG leaders
Work with Health Education North East to maximise the impact of any workforce related programmes.
Develop and support our existing primary care teams, e.g. via Protected Learning Time
Address the need to use a multidisciplinary model to support and develop the use of non-medical prescribers as part of the primary care team (nurses and pharmacists). In particular we will identify the associated challenges such as training and work with HENE to mitigate against these.
Premises
Develop a primary care estates plan which takes into account changes in population and changes in ways of working
Develop an investment plan in line with the national capital programme for primary care premises to ensure need is met.
Identify practice premises that are in greatest need and prioritise support to those.
Informatics
Develop functionality to deliver mobile working.
Support the delivery of interoperability between systems across health and social care.
Further develop the utilisation and effectiveness of a central communication system.

Objective 2 **Support general practice to work with each other and with local people and partners to deliver high quality, cost effective primary care**
Federated working
By the end of 2015-16 all practices within North Durham will be working as part of a federated model
The CCG will support federations to set up and develop into successful primary care provider organisations.
The CCG will work with federations on an ongoing basis to share ideas and ensure two way communication is in place
In line with the Five Year Forward View, the preferred model for primary care to be part of is Multi-Speciality Community Providers (MCP). North Durham CCG will facilitate and commission from trusts, other partners and primary care organisations that develop these new models of care by the end of 2016-17.
Engagement
Effectively engage and consult with general practice via a variety of means including the constituency lead model, the Director of Primary Care role and through the central communication system as well as formal Council of Members meetings.
Play an active role in supporting the Protected Learning Time (PLT) work programme which will include time dedicated to them as commissioners.
Ensure that our member practices are involved in the priority setting process.
Strive to ensure that member practices think of the commissioning organisation as “our CCG”.
Engage with our local community about primary care services through our engagement model including Patient Reference Groups and the Patient, Public and Carer Engagement Committee.
Patient safety, experience and quality
Continue to support general practice in terms of the implementation of the Friends and Family Test, and specifically in relation to the patient experience kiosks.
Ensure that quality is monitored and actively managed within primary care using national tools and supporting practices to develop. The aim is to reduce variation, NICE guidance implementation and to ensure patient safety, experience and effectiveness of care is delivered. We will support GP practices through the CQC process.

Objective 3 Commission clinically effective planned and unplanned out of hospital care
Review the out of hours specification and recommission a service to meet the demand and needs of unplanned care provision. The service will also support patients to be cared for in their own home.
Commission seven day primary care services tailored to those with the greatest health need
Support primary care services to manage long term conditions such as diabetes, mental health, palliative care and cancer, with the aim of moving more care closer to home.
Engage with public health to support the delivery of the prevention agenda through primary care.
Evaluate the primary care outcomes scheme and commission those schemes as part of the mainstream commissioning agenda which have made an impact. Such services will be commissioned across the CCG area.
Wrap community, social care and mental services around primary care services to deliver an integrated service for patients.