Appendix 2

A Primary Care Strategy for DDES - discussion document

DRAFT

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Foreword

Last summer, NHS England's Deputy Medical Director Dr Mike Bewick launched the national Call to Action for General Practice. This engagement programme was NHS England's response to the challenges general practice faced from an ageing population with growing levels of comorbidity, increasing patient expectations, workforce pressures, persistent inequalities in access and quality, and increasing financial pressure.

General practice in the Durham Dales, Easington and Sedgefield CCG (DDES CCG) faces all these national challenges, along with further local challenges based on our geography and socio-economic make-up of our communities.

In DDES CCG we are very fortunate to have strong general practice provision which has a long track record of delivering high quality care, that responds to the needs of our local populations and that our patients value. We do need to recognise that general practice does not operate in isolation however and the role, scope and range of services offered in primary care and how they interact with our community, hospital and social care services is critical for meeting the challenges facing the wider health and social care system.

There is a huge opportunity for primary care in DDES to provide additional services that meet our patients' needs and reduce the reliance on hospital care. As our population ages, more and more people will have one, two or more long term conditions . Primary care, working closely with community and social care services is best placed to support patients to manage these conditions. General practice may also be better placed to provide more accessible services for our communities, particularly for our more rural communities where traditional hospital based services are inconvenient or feel out-of-reach.

We also understand however that there is a reluctance within general practice to take on more work against a backdrop of chasing targets, diminishing resource and increasing statutory and professional regulation. We know that GPs carry out 90% of patient contacts in the NHS for only 9% of the overall NHS budget and are struggling to cope with day to day pressures.

To meet these challenges, build on our strengths and maximize our opportunities, primary care needs to change.

If we are to develop a more sustainable health service that helps to keep people healthy, there needs to be a significant shift of resources from acute services to out-of-hospital care.

The Better Care Fund(CF) - a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities - will provide significant opportunities for CCGs and local authorities to work together to effect this change.

In addition to our BCF plan we will be working to develop, support and grow an even stronger and more resilient, sustainable primary care service in DDES. This strategy outlines the case for change for general practice, what we feel the main components of a stronger primary care sector may look like and how we will bring about the changes necessary to deliver them.

Once agreed, we will work with commissioning partners in Durham County Council and NHS England, with our clinicians and current providers in general practice and the other services that general practice interacts with to implement our strategy to deliver a primary care service our patients deserve.

Dr Stewart Findlay

Chief Accountable Officer
Durham Dales, Easington and Sedgefield Clinical Commissioning Group

Introduction

The CCG's Primary Care Strategy endeavours to ensure that the direction of travel proposed for the next two years reflects the CCG's vision and identifies what is required to offer a high quality primary care service that reflects the needs of the population. For the purpose of this strategy Primary Care is defined as General Practice (NHS England will develop national and local strategies for Dentistry, Optometry and Pharmacy which will receive our input).

Good primary care can be regarded as the hub of a wider system of care. Consequently, developing and delivering a robust strategy for high quality primary care has important interfaces and interdependencies across the whole health system, including but not limited to, planned and unplanned use of secondary care, prevention and health promotion, mental health care, social care and end of life care.

In March 2014 NHS England published the emerging findings that stemmed from the national Call to Action for General Practice. These findings listed 5 ambitions.

- Ambition one: **proactive, coordinated care:** anticipating rather than reacting to need and being accountable for overseeing your care, particularly if you have a long-term condition.
- Ambition two: **holistic, person-centred care:** addressing your physical health, mental health and social care needs in the round and making shared decisions with patients and carers.
- Ambition three: **fast, responsive access to care:** giving you the confidence that you will get the right support at the right time, including much greater use of telephone, email and video consultations.
- Ambition four: **health-promoting care:** intervening early to keep you healthy and ensure timely diagnosis of illness - engaging differently with communities to improve health outcomes and reduce inequalities.
- Ambition five: **consistently high-quality care:**

These findings are consistent with our local strategy and overall vision for primary care for the patients of DDES. This strategy has some common themes with the Urgent Care Strategy, as much urgent care takes place in, or in collaboration with, primary care. The ongoing Community Nursing Review will align vital community services with the proposals contained within our Better Care Fund (pooled budget integrating Health and Local Authority funds) plan.

Finally, this strategy will address many of the challenges outlined in our Joint Strategic Needs Assessment (JSNA) and contribute to the delivery of the Health and Wellbeing Strategy for County Durham as agreed at the local Health and Wellbeing Board.

Strategic Vision

Our strategic vision is
Investing In a General Practice for a modern, patient centred integrated service
Sustainable care closer to home and out of hospital where appropriate
Accessible General Practice with personalisation and continuity of care
Reducing inequality improving health focusing on outcomes and best evidence

Based on our understanding of the challenges outlined in our JSNA , local activity and workforce analysis and engagement with practices and patients, to achieve this vision we must deliver these **strategic objectives**:

- To have a high quality core service supporting 7 day working with the additional capacity to support an out-of-hospital strategy
- To have a service that strengthens prevention, management of long term conditions and ambulatory care sensitive conditions
- To have a service that co-ordinates care for the elderly care

To deliver these objectives we believe that stronger general practice sector must have the following **key features**:

- Is bigger, wider and integrates seamlessly with social and community care and other primary care professions
- Works in partnership with, and is aligned to, the County Durham Wellbeing Service
- Enables patients to feel fully engaged in their care and responds to their feedback
- Provides a rewarding and enjoyable place for our primary care professionals to work, both in terms of the quality of estate they work out of and the job satisfaction they receive

To help bring about the changes necessary to reflect these features we will focus on the following **strategic initiatives**:

- To encourage, support and incentivise the development of GP Federations
- Creating opportunities for, and getting the most out of, the primary care workforce
- Introduce a systematic approach to supporting the frail elderly
- Seamless Primary Care any day of the week
- Establish a systematic approach to driving up quality in primary care
- Introduce a systematic approach to health improvement in primary care

We will support these strategic initiatives by carrying out these pieces of **enabling work**:

- Introduce technology solutions that make services more accessible and that are more joined up
- Develop an aligned primary care estates strategy that makes the most out of our current estate
- Create an environment that develops a research culture in general practice

The case for change

This primary care strategy has been written to address the specific challenges faced by general practice in DDES. The key drivers for change are:

Demography

Changes in the demography will mean more pressures on general practice:

The population growth of 4% experienced in County Durham between 2001 and 2011 has been absorbed by healthcare facilities. The population of County Durham is projected to increase by 5.2% by 2021 (to 539,900 people), rising to 560,700 people by 2030, (a 9.3% increase from 2011). This will place substantial pressure on existing community and primary care infrastructure. There is limited capacity within the health sector to fund new infrastructure projects. A further consideration is the workforce impact of population growth, ensuring sufficient clinical staff will be available to meet patient need.

County Durham has an increasingly ageing population and the proportion of the county's population aged 65 or over will increase from almost one in five people (18%, 2011) to nearly one in four people (23.8%) by 2030.

Health status

In DDES emergency admissions for CHD, COPD, Stroke and MI are higher than the England average in many MSOAs:

- 69% of MSOAs in Easington locality display elective CHD admissions higher than England; 36% (13) of DDES MSOAs display greater than expected emergency CHD, MI and COPD admissions compared to England;
- 81% (29) MSOAs display high MI admissions compared to England; 72% (26) display high emergency COPD admissions compared to England;
- 64% (23) display high emergency CHD admissions compared to the England average. 28%(10) MSOAs display high elective CHD admissions compared to England;
- however, 44% (16) display low elective CHD admissions compared to England; 53% (19) display high emergency stroke admissions compared to England.[4]

Health and social inequalities

[4] Public Health England. 2012 Local Health.

DDES CCG has some of the most deprived areas in England. 60% of DDES lower super output areas (LSOAs) are in the most deprived 30% nationally, 20% are in the most deprived 10% in England.[2]

Around 19% of DDES CCG population (around 69,000 people) live in low income (or income deprived) families reliant on means tested benefits. DDES CCG experiences higher levels of income deprivation (19.4%) compared to County Durham (16.9%).

Compared to County Durham, DDES CCG displays generally higher levels of income deprivation, children in poverty and older people in deprivation, although there is variation across MSOAs. 33% of MSOA's (12) display deprivation levels higher than County Durham across all three indicators.

Geography

The geography of DDES is unique:
The Durham Dales locality is rural and therefore travelling to access services is challenging.
DDES does not have an Acute Hospital or Emergency Department in its geography.
From East Durham to the Upper Dales the CCG geography covers half of the country coast to coast.
The diversity of the population with post-industrial health problems with severe socio –economic deprivation

Demands on secondary care

A significant amount of secondary care activity in our local hospital providers is driven by patients from DDES:

- 7460 number of non-elective admissions in local trusts came about because our patients with ambulatory sensitive conditions were admitted in 2013/14

- 94,845 attendances at urgent care walk in or minor injury services in 2013/14 in local trusts came from patients from DDES
- number of review outpatient appointments in local trusts in 2013/14 could have been potentially been seen in primary care

Review OP appointments	323,581
Review OP appointments cancelled	24,814

Workforce

[2] Index of deprivation (ID2010), DCLG

We have conducted a local practice survey to which 57.5% of practices responded. This found:

- There are localised difficulties with recruitment
- 78% of practices had tried to recruit new GP(s) in the last 3 years, and of these over 50% had experienced difficulties.
- Confirmation of national data showing GP workforce is older than other areas of the country
- Lower than average involvement with teaching/training (specifically the Foundation Programme and Vocational Training Scheme)

Quality

As defined by the national General Practice Outcome Standards, there variation in the quality of service offered by general practices in DDES. In particular this document shows variation in

- Attainment of clinical standards and practice for clinical outcomes for patients
- access to primary care is variable (from GP survey) and utilisation of A&E and Urgent Care Centres differ
- Patient experience of primary care is variable but DDES CCG is above average (from GP survey)

In summary

These drivers for change mean that if primary care needs to change to cope with a likely further increase in demand on general practices that are already under pressure, to meet the changing needs of patients with a wider range of health and social care needs and to support the management of future increases demand onto the hospital sector which is itself already nearer fully capacity.

The full underpinning analysis across all these areas that supports this strategy can be found in the DDES Primary Care Strategy Case For Change – Technical Document.

Findings from engagement with practices and the public in DDES

In developing this strategy, DDES CCG sought to engage widely with patients, the public and key stakeholders, to ensure that our strategic direction reflected the views of people who use, and work in, health services in DDES. We worked with patients and members of the public, as well as other stakeholders to co-produce the strategic objectives of the strategy, and inform our vision of how services should be developed over the next five years.

We held an open event for patients, the public and interested stakeholders including the voluntary sector on 13 December 2014 at Spennymoor Town Hall focusing on some key questions.

Throughout January the locality PRGs hosted Call to Action where we asked *'What would the Future of Primary Care look like"?* The feedback we received was:

- Agreement of moving services closer to home. Acknowledgement that this has to be sustainable and not every service could be in every village or GP surgery
- One Stop Shop/ mini cottage hospital - acknowledgement that one GP surgery might act as a specialist hub for other practices. Can we include Opticians and Dentists ?
- There was also agreement to the CCG direction to support Federations
- Greater understanding of how the 'named/accountable GP' will work but agree GP is the co-ordinator and Integrating primary and community care with joint assessments
- Better access to General Practice and different ways of communicating with the practice
- Consultants and Specialist nurses in Community Hospitals or Hubs with spoke arrangements in practices
- How do we attach Mental Health to the practices
- To integrate with Local Authority, Housing and Public Health

Each GP Practice held their own Call to Action events and we have engaged the member practices at locality meetings. This feedback has also informed the strategy.

Strategic initiatives

We have reviewed and prioritised a range of initiatives that will each contribute to the delivery of one or more of our objectives.

1. Support the development of GP Federations

Alliances and federations are broad terms used to describe collective arrangements between two or more parties. They are often established to maximise effective working in the pursuit of one or more common aims. A Federation is exactly what a group of practices want it to be, it can be a loose arrangement with a number of like-minded practices or it can be an organisation that has formed a legal entity.

There is a push to wrap community services around practices and in the future, federations should be in a position to bid to provide community services that suit the way GPs work and make sure that the practice team is able to deliver a high-quality service to the practice's patients. For small practices, this will only be delivered though federated working. In future it should also be possible to move many outpatient services and the hospital specialists that run those services into the community.

In DDES we aim to have:

- 3 GP Federations established by October 2014
- 99% of practices belonging to a GP Federation
- By April 2015 created the capacity for Federations to collaborate and competitively tender for new pathways that support their registered patients.

To achieve this, the CCG will offer support packages to emerging GP Federations which includes:

- Resource them to develop their Organisational Development plan and Governance.
- support the development of specialist GPs who may either rotate across practices or work from a hub practices with other practices referring patients in to them
- work with GP Federations to develop community services and work with social care services in a cohesive and seamless way

The new capacity and more effective business process that will come with GP federations will enable:

- high quality management of long term conditions
- Shifting planned pathways from Acute hospitals to Primary and Community Care

- and the diagnosis and treatment of those with ambulatory emergency conditions in the community when appropriate.

2. Creating opportunities for, and getting the most out of, the primary care workforce

This strategic initiative will ensure that there is the workforce necessary to deliver more services in primary care and a more accessible service to patients throughout the week.

To ensure we have a sustainable workforce we propose the development of workforce positive schemes in partnership with HENE and interested Acute Trusts:

- **DDES Big Project –** Increase the number of GP's working in DDES
- **Golden Hello Scheme-** We will use the recruitment survey to target practice recruitment hotspots and target those practices in the lowest 30% Lowest Super Output Area. A steering group will define the criteria.
- **Encouraging GPs to stay in the profession and keep up to date -** Reducing professional isolation by developing an action learning group for GPs nearing retirement age.

To develop highly trained/skilled staff

- **Developing innovative posts with Secondary Care –** Development of 3 year posts with an acute Trust to split work between Hospital acute care and General Practice providing educational supervision and appraisal provided in both settings
- **Portfolio roles –** Look to create a programme for newly qualified GPs that would lead to a Masters In General Practice.
- **Nursing and Health Care Assistants –** fund training not covered by Regional arrangements eg Clinical Skills, Long Term conditions and non-medical prescribing. Expand local Career Start scheme.

To provide support to practices to have time to learn:

- **Continue Time Outs –** Provide protected time for general practice to focus on key topics that support the development of practice staff
- **Training Budget –** re-introduce a training budget for General Practice
- **Support for GPs, Practice Nurses, Practice manager and administration staff to develop skills –** We will propose to fund an education fund for the CCG.

To develop clinical leaders:

- **Support for clinical champions -** Eight of the eleven high priority clinical areas identified by the CCG have appointed Clinical champions. Locality Prescribing groups now have their own designated GP leads.
- **NELA Clinical Leader programme -** The NELA Clinical Leaders Programme is a tailored leadership development programme to support senior clinicians in leading services and transformation. The CCG has already supported two clinicians through this programme and we will continue this over the next 2 years. In addition we propose to support each clinician to shadow existing leaders to get practical experience in leading an organisation.

3. Introduce a systematic approach to supporting the frail elderly

"Care needs to be just as important as treatment. Older people should be properly valued
and listened to, and treated with compassion, dignity and respect at all times. They need to
be cared for by skilled staff who are engaged, understand the particular needs of older
people and have time to care."

'Hard Truths, the Journey to Putting Patients First',
Government response to the Francis Report, November 2013

The CCG wishes to see the bulk of care for the frail elderly delivered more locally within the community. This will mean that patients will only attend hospital when their condition means that they cannot receive care closer to their home and they will be able to be discharged more quickly because local services will be better equipped to support patients to recuperate at home.

By introducing a well co-ordinated care where the patient is at the centre and receives the right care at the right time we aim to:

- Reduce the number of admissions to institutional care
- Reduce the spend on acute care in order to invest in preventative solutions based in the community
- Have patients report that they feel they more choice and control over how their care is delivered

To achieve this, the CCG will:

- Reduce complexity of services
- Wrap services around primary care, so that groups of practices are supported by staff they are familiar with and with whom they can develop shared ways of working

- Build multi-disciplinary teams for people with complex needs, including social care, mental health, urgent care and other services
- Develop these teams to have specialist medical input and redesigned approaches to consultants services, particularly for older people and those with chronic conditions
- Create services that offer an alternative to hospital stay
- Build an infrastructure to support the new model, including much better ways to measure and pay for services
- Develop the capability of the wider community including the 3rd sector

4.Seamless care any day of the week

Extract from NHS England Blog by Dr David Geddes, NHS England's Head of Primary Care Commissioning: abridged

Arguably, the current model of primary care is no longer fit for a modern NHS. We know increasing numbers of patients are presenting in general practice with multiple long term conditions, working days are longer and retirement is getting later. For many of the population, (myself included) they never see their surgery open. At one event, the chief executive of a local hospital told how a consultant had to cancel his entire clinic, so that he could see his own GP.

Now, with the highly systematic use of IT in primary care; we should be in a better position to provide coordination of care across the seven day week.

Where is the additional human and financial resource to deliver this care? There won't be a single solution. The challenges facing rural communities are far different to those facing inner city general practices, and resource issues will differ.

However, I believe that this challenge offers us an opportunity to stop and reflect on our current way of practice. We should not see this as an additional 40 per cent of work, but a chance to re-distribute our working week, and to ask how we can do things differently and more effectively as a consequence.

Working across seven days will give many practices opportunities to work together in a different way, I believe this will reduce silo working professional isolation, and increase opportunities to collaborate in new and different ways which means that general practice truly will be able to play an even stronger role at the heart of a more integrated out-of-hospital service.

In December 2013 County Durham and Darlington (CDD) was accepted as one of thirteen national pilots to progress seven day services.

The national programme is governed by 'NHS Improving Quality' and aims to identify best practice and inform future policy.

The CDD proposal was to prioritise:

Frail elderly care
Unscheduled care
Diagnostics in a forward programme.

The initial plan focusses on:

- Development of 'multi-disciplinary' teams in support of frail elderly and long-term conditions
- Extended GP practice opening times and service provision and
- Progress of County Durham and Darlington NHS Foundation Trust towards the ten national clinical standards for emergency care.

The CCG is now exploring how GP practices can extend opening hours.

Independent staticians at Whitehall are estimating that 812,000 patients nationally went to A&E last year because they were unable to get an appointment.

Develop 7 day working models – Our Aims over the next 5 years
The ESH and Intrahealth Federation bids for the Prime Minister Challenge were unsuccessful. However, they began to explore how we make practices more accessible beyond 6.30pm and weekends. We are particularly interested to improve opening beyond 6.30pm on weekdays and would be interested to hear from practices who wish to trial this.

In the first 18 months we will work with Federations to trial weekend opening and demonstrate a shift of work from Urgent Care Centres back to General Practice and improve continuity.

With the introduction of the Friends and Family Test in December 2014, the CCG and NHS England will be looking at the patient satisfaction and accessibility. We would like GP practices and Federations to look at other models of access where there is issues highlighted by patients. Below are some examples.

Online access
The digital platform WebGP, from the Hurley Group (practice of the Past RCGP Chair), funnels access to clinical services through an online platform, where patients use online diagnostic tools to determine if they should see a doctor, and are then taken through a simple online consultation process. The doctor assesses their needs based on the online forms and can then make necessary appointments or referrals
.
Patient Access / Doctor First

In surgeries that use these models patients are able to access same-day care from the GP of their choice.

5.Establish a systematic approach to driving up quality in primary care

CCGs have a duty to improve quality in primary care. Supporting NHS England Area Team our aims are to:

- reduce variation in GPOS outliers
- Support General Practice with the development of their action plans
- Improve the reporting of serious incidents in primary care
- Resource innovative pathway development that improves patient experience and outcomes.

6. Introduce a systematic approach to health improvement in primary care

Primary health care, in particular GP practices are an ideal setting for health improvement. We know that focusing solely on the most disadvantaged will not reduce health inequalities sufficiently; actions need to be universal but with scale and intensity that is proportionate to the level of disadvantage. There is much potential to commission health improvement interventions within local community venues. Evidence based lifestyle activities and mental wellbeing programmes can achieve as much health gain as medical interventions if delivered through quality assured programmes.

Our focus in DDES over the next 5 years is:

- More patients managing their own conditions - Patients with long-term conditions are now managing their own health care - which reduces pressure on staff and services, and boosts patients' quality of life.
- Improve screening and vaccinations rates
- Social Prescribing relating mental health issues to reduce reliance on medical and pharmacological therapies.
- Contribute to reducing health inequality both in access to services and life expectancy

Patients managing their own conditions

By commissioning a range of self-management programmes for people at risk of CVD, low level anxiety and depression as well as more specialised lifestyle

interventions, such as exercise referral, the health of the population can be improved and preventable hospital admissions reduced.

Screening & Vaccinations

We will work with Public Health and NHS England to improve in this area to use primary care as the vehicle to increase cancer screening rates and improve the uptake of vaccinations. We will increase the use of Federations to monitor individual practice performance and reduce inequalities.

Mental health in primary care

The CCG wishes to commission an integrated primary care mental health services. Currently there is little integration between Tier 1 services including Social Prescribing, Counselling, Psychology and Psychological Therapies.
We will work with practices to develop a new integrated service that is personal and local for patients and allows patients to access the right service at the right time through their General Practice.

Reducing health inequality

Currently managing the performance of primary care and patient outcomes is challenging. For the NHS England or the CCG there are 40 practices who provide services for the population.

A tool called “Health Equity Audit” which allows commissioners and service providers to analyse the way in which services are accessed, in order to consider whether uptake by different population groups is in proportion to health need. As a result of this work, a service may be able to adapt or change the way in which it is delivered to address any inequities in service uptake. Our outcome data is already showing that the access to the new NHS Health Checks is variable. Commissioning to improve collaboration between GP practices and community health check providers is important to increase rates of detection of atrial fibrillation and to initiate appropriate management of atrial fibrillation in line with NICE guidance.

Enabling activities

In order to support our key strategic initiatives we will undertake the following enabling activities:

1. Introduce technology solutions that make services more accessible and that are more joined up
2. Develop an aligned primary care estates strategy that makes the most out of our current estate
3. Create an environment that develops a research culture in general practice

1. Information Management & Technology

As a CCG, our four initiatives for 2014-2016 that will support the delivery of this strategy are:

- GP Migrations to a web based system
- Transfer of patient records electronically from GP practice to GP Practice
- Electronic prescribing
- Explore scope of Portals with partner organisations
- Improve utilisation of GPteamnet CCG Intranet

Moving to a single system

The CCG support system of choice (GPSOC). IT also supports all practices moving to a web based system. The predecessor PCT left us a legacy system. All the community staff are on System one. The Urgent Care Centres are on System One. The Endocrinology department of our local Foundation Trust is on System One. Both with Federated working and integration of Primary and Community providers The CCG has made significant investment to support migrations to both System One and EMIS.

Partner Organisations and Patient Records
We will work with our local authority and Acute Trust providers to create a record that is visible at the point of contact for the professional involved in the patient care. Our partner organisations are developing portals that will allow us to share records at the interface where a professional requires records from all providers in the patient pathway.

As a CCG we are keen to explore these developments.

GP to GP transfer

For the transfer of information between EMIS and System one practices the GP to GP record transfer process is deisgned to automatically retrieve the patient's record safely, securely and quickly from the previous GP practice where the clinical systems are different. It will include:

- Full patient electronic health record available for the first appointment
- Allergies, adverse reactions, medications visible for new patients
- Safer prescribing
- Test results available

E-prescribing

The CCG will roll out the EPS pilot for a roll out which will support practice by;

- Less time signing prescriptions
- Greater control of the prescription
- Less time dealing with prescription queries
- Standardised prescription information will reduce queries from dispensers.
- Improved prescription accuracy leads to a reduction in the likelihood of patients receiving the wrong medication.
- Electronic prescriptions cannot be lost, reducing the risk of duplicate prescriptions being generated.

GP TEAMNET

GP Teamnet was purchased in December 2012. This tool is a key strand for communication between the CCG and its member practices. However, feedback has told us that implementation of this communication system can improve. We have looked at other products on the market. We have realised it is not sufficient to pay the licence fee alone. We have a refreshed approach to implementing GP teamnet across DDES. We realise that it requires project support to enable the product to embed within General Practice. Therefore, we have appointed a project manager to work part time to assist with implementation and training. GP Team net have matched this resource to support DDES with this project. We have identified 2 champions in each locality who will work with our project manager.

2. Premises and estate

To have clean fit for purpose premises to support quality primary care by establishing a baseline of existing General Practice provision including:

- The condition of current premises
- Under-utilised capacity that can be used to provide new/extended services

- Premises that are not fit for purpose
- Exploration future funding options

We would also like to agree with General Practice a set of parameters to influence premises funding decisions in the future to consider:

- how we help deliver the vision through innovative premises solutions
- What key criteria we might want to use for making premises investment decisions (recognising national tools need to be adapted to local circumstances and rurality)
- Key strategic locations and how we maximise utilisation of these sites and drive out efficiencies
- Condition survey work and CQC/Statutory / regulatory issues
- Opportunities for partnership / joint developments working across communities / public sector
- Impact of federated working and premises partnerships
- 7 day working and extending the use beyond office hours and how can General Practice change to facilitate this
- Under-utilisation of existing community and LIFT premises

3. Supporting research in primary care

To developing a culture that encourages GP Practices to participate in Research and Development we will:

- Support practices in the attainment and maintenance of research ready status and good clinical practice training
- Promote sign up to the research collaborative.

The CCG will work with the Local Clinical Research Network (LCRN) also funds research manager, facilitator and nurse to work with research practices and others to increase opportunities for DDES to get involved in research at both feasibility and delivery stages for commercial and non-commercial research for the benefit of DDES patients

- Independent contractors in primary care will decide of their own accord to participate in research, like other providers in acute, community and mental health care. Whatever their feelings about direct participation in research, they will need support and advice when making decisions Patients are now more commonly empowered to request participation in research, and moreover, may be recruited in another health care setting, but may still require the collection of data from primary care sources.

Communications and engagement

We are fully committed to ensuring patients are engaged and help lead the development and implementation of our primary care strategy and in the ongoing monitoring and evaluation of its effectiveness once established.

We will do this by:

- Developing the strategy around the feedback received from Call to Action engagement
- Development engagement tools in the practice
- Using our involvement groups, Practice and Locality Patient Reference Groups.
- Introducing the Friends and Family Test in general practice by November 2014
- Investing in Elephant Kiosks in all practices who agree to participate. These kiosks will give us a flexible patient engagement solution offering a real time patient feedback.

What will happen next.

Once we agree a plan for Primary Care we have to be able to afford it. The practices as commissioning members control our expenditure. There will be significant challenges in 2014/15. We can not afford this strategy and the cost of the Better Care Fund and maintain the same expenditure in hospital. Therefore, we need to deliver more out of hospital and ensure our hosptials specialise with more acute hi tech medicine.

DDES CCG will work closely with the Health and Wellbeing Board (HWBB) which has been established by the Local Authority. The role of the HWBB is to work with key partners focusing on improving the health and wellbeing of DDES's population.

This strategy has some common themes with :

- DDES's Urgent Care Strategy, as much urgent care takes place in, or in collaboration with, primary care.
- The Community Nursing Review which should align to our approach delivered through the The Better Care Fund (BCF- pooled budget integrating Health and Local Authority funds)