APPENDIX 2

NHS

Durham Dales, Easington and Sedgefield
Clinical Commissioning Group

A Refreshed Primary Care Strategy for DDES

2016-2018

Joseph Chandy

May 2016

Contents Page

Contents

Introduction

Durham Dales, Easington and Sedgefield Clinical Commissioning Group (DDES CCG) is a member practice organisation made up of 40 GP practices with 14 branch surgeries. For the purpose of this Strategy, the term *Primary Care* refers to General Practice, although technically, it covers Pharmacy, Optometry and General Dental Services as well. We commission services from three main acute care providers, two mental health providers as well as commissioning additional primary care services from member general practices by way of core contract and Enhanced Services.

The NHS Five Year Forward View (5YFV) was published on 23 October 2014 and sets out a new shared vision for the future of the NHS based around the new models of care. This was published by the NHS Chief Executive Simon Stevens. We are working towards implementation of the 5YFV through the development of this strategy 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-specialty 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 the CCG to develop services around the patient journey. When the NHS was founded in 1948, 48 per cent of the population died before the age of 65; that figure has now fallen to 14 per cent. Life expectancy at 65 is now 21 years for women and 19 years for men, and the number of people over 85 has doubled in the past three decades. DDES CCG also has some of the most deprived areas in England and premature mortality rates (under 75) for the biggest killers (heart disease, cancer, stroke) across County Durham are higher than the rest of England.

Given current pressures, commissioners must strive, wherever possible, to shift the curve of care from high cost, reactive and bed-based to preventative, proactive care, based closer to home and focus as much on wellness as on responding to illness.

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 has been published in April 2016 and sets out over the next 5 years the responsibilities and investment to undertake this transformation https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

The model of GP Practice created with the NHS in 1948 is by and large the same model. However, this is not sustainable for the future, with workforce, financial

challenges and our ambition to reduce health inequality, it needs to move forwards with radical models of change.

General Practice services look after the health and wellbeing of people in their local community who are on their registered list. Their core contract requires them to provide services for those who have or believe themselves to:

- Be ill with something from which recovery is generally expected
- Have a long term condition
- Be terminally ill'

General practice is organised into individual surgeries, some of whom have 'branch' surgeries. These are all of varying sizes depending on the size of the population they serve. Many branch surgeries are small, part time services but allow GPs to deliver some services at the heart of smaller, more isolated communities and to increase patient choice by offering more than one practice in a village. Core opening hours for general practice are 8-6, however; the CCG has commissioned additional opening hours, both during the week and on Saturday mornings, to offer flexibility and to accommodate patient need. Sunday morning surgeries were commissioned in line with central strategic direction initially but the demand for this was so low that the CCG re-invested the money where the demand was highest. This includes the ability for the NHS 111 service to book patients who ring when their practice is open directly into their practice, which helps patients receive the most appropriate care first time.

General practice is central to primary health care services in the UK. Primary health care services also include pharmacies and ophthalmologists plus a range of community services provided by Foundation Trusts.

The key attributes of primary care are:

- First point of contact for most health care needs.
- Continuity of care over a lifetime and, in many cases, across generations.
- Comprehensive service that ensures either the provision of general services, or referral on to specialist services.

Practices also offer a range of other services commissioned by the CCG and Public Health (Durham County Council) which reflect the needs of their local community. For example;

- Smoking cessation
- Near patient testing
- Sexual health
- Health Checks

General Practice core contracts are detailed at the link in Appendix A.

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.

The CCGs primary care strategy reflects the development of good primary care as the hub of wider health system that co-ordinates patients within a continuum of prevention, self-care, diagnostics, treatment, disease management, acute care and end of life.

To meet these challenges, we will build on our strengths and maximise our opportunities to develop *a modern, accessible, patient centred General Practice in DDES.*

Dr Stewart Findlay

Chief Clinical Officer

Executive Summary

What is the CCG Vision

Improve the physical and mental wellbeing of the people of DDES and reduce health inequalities

The Primary Care Strategy aligns with the three overarching priorities for the CCG:

- To drive up the quality of commissioned services
- To ensure full engagement and participation of patients, clinicians and stakeholders
- To deliver our five key aims within the CCG's allocated budget

What is the CCG Vision for Primary Care?

A modern, accessible, patient centred General Practice in DDES

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

- Developing 7 day services that meet the needs of our vulnerable population
- Sustainable Care closer to Home and out of Hospital
- Focusing on Population Health
- Wrapping services around General Practice

Our programmes of work to deliver these objectives will form part of our Operating Model and implementation plan:

1. Developing 7 day services that meet the needs of our vulnerable population

1.1 We will develop Primary Care services from 8am-8pm weekdays from April 2017.

1.2 We will build upon the CCG's successful GP Practice Weekend working pilot for Saturdays and expand over the weekend for vulnerable patients. The means that support is available for vulnerable patients outside of normal GP Practice Core Hours

1.3 Workforce is essential to deliver 7 day services. We will continue our initiative for attracting GPs in the form of Career Start Scheme, extend the Nursing Career Start Scheme and develop Pharmacists in General Practice.

1.4 Driving up Quality will underpin our approach to strengthening Primary Care.

1.5 Ensuring that all Practices have robust Business Continuity plans so that service continuity is assured.

2. Sustainable Care Closer to Home and out of Hospital

2.1 We are piloting a disease specific pathway for integration of services and budgets developed in line with the 5YFV new models. Diabetes has been chosen and will require a pooling of health and Local Authority budgets and creating centres of excellence in primary care that will increase prevention and management in the community.

2.2 In 2014 the CCG created a new set of Local Enhanced Services. From 2016, we will evaluate the use of Direct and Local Enhanced Services and the Quality and Outcomes Framework (QOF) to improve patient outcomes and reduce duplication of services and targets.

2.3 CCG will develop Practice Based Budgets and support a Demand Management programme to align clinical and financial responsibility and optimise our use of secondary care.

2.4 The CCG will create a programme for Supporting Struggling Practices and develop a Federation approach.

3. Focusing on Population Health using new models of delivery

3.1 We will use a robust evidence base to demonstrate The Case for Change for population health and reducing health inequalities.

3.2 Build upon the current development of Federations to develop at scale models outlined in the 5 Year Vision and develop the concept of Primary Care Home

3.3 Ensure that our primary care premises and community hospitals are optimally utilised to benefit services grouped around local populations.

3.4 The CCG will continue to develop learning opportunities for Primary Care staff and develop learning sets as part of the organisation culture to becoming a learning organisation.

4. Wrapping services around the patient

4.1 Progress the development of the Integration of Primary and Community Care Nurses to wrap around practice and patients to avoid duplication.

4.2 We will ensure that the Primary Care Information technology structure supports patient care and greater accessibility by healthcare professionals and patients alike.

This plan sets out our approach to future Primary Care delivery aligned to our priority health outcomes within NHS Durham Dales, Easington and Sedgefield CCG.

'Delivering the Forward View' 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 A&E 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's 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, Partnerships and Engagement

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

The Health and Wellbeing Board vision is:

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

The key aims/programmes of work for DDES 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
4. Long term conditions independence and care and support for people with
5. Improve the mental and physical wellbeing of the population
6. Protect vulnerable people from harm
7. Support people to die in the place of their choice with the care and support that they need

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)

Many of the initiatives in the primary care strategy address these key messages. In particular smoking cessation, NHS Health checks, aligning mental health workers to general practice and integration of services.

Engagement and feedback on the Strategy Refresh

Before commencing this strategy refresh we had discussions with key stakeholders. In November 2015 we have consulted specifically with the following groups;

- Member Practices
- Council of members
- Patient Reference Groups
- Area Action Partnerships
- Local Medical Committee

The engagement proforma document relating to this process is available at Appendix B.

All members of the above committees have been given a pro-forma to complete the feedback. On this pro-forma we asked if the vision and objectives need to change and if so for some suggestions or ideas as to what they should change too. We also asked if respondents agreed with the way forward and for any additional comments or ideas. The comments we have had include;

- Doctors should come out at night and over the weekend
- The vision and objectives would be achievable with proper resources but may not be deliverable in the current climate.
- Proper and effective engagement is the number one objective (both with patients and with partners). Engagement has been undertaken before and ignored.
- We have lost the experience in management to effectively deliver primary care.
- Primary care is failing in a number of areas;
    - 7 day week not resourced
    - Shortage of doctors
    - Failing services in rural areas
    - Demise of volunteer support services
    - No proper emergency cover by consultants at weekends
- Need to demonstrate you are listening to communities and value their input.

Member Practice Engagement
We have also sought feedback specifically on this strategy refresh and received the following comments;

The draft Strategy refresh was discussed at the Council of Members and at the DDES-wide and Locality Group meetings prior to being circulated to all practice staff to seek their views. The main themes from the Council of Members were;

- GP workforce
    - Concerns about the aging profile of the current GP workforce
    - Desire to increase the skill mix and include wider skill base in this
    - Concerns about the increasing demands on primary care
- Premises
    - Use of void space across the health economy
    - Need to make use of the void space in secondary care premises too
- General Practice at scale
    - Continue support for Federations
    - Ensure increased work in Primary Care is appropriately funded
    - Concerns that 8-8 and 7 day working are not deliverable due to workforce issues

There was general consensus that the vision, objectives and way forward were correct although there was some individual disagreement.

Other issues were also discussed, but the above are the main themes which were raised. These other issues included whether 7 day working was required as Sunday opening has been tried in the CCG and was not utilised by patients. Practices could trial a step process to GP access whereby patients are seen by other members of the clinical team initially before being referred to a GP only when necessary. There could also be a 'home visit squad' who undertake all home visit requests for a group of practices or perhaps for a federation.

Stakeholder feedback
Finally feedback was also requested on this strategy refresh for our colleagues and partners in the local Acute and Mental Health Secondary Care Foundation Trusts and Primary Care beyond the Council of Members. The main themes from these stakeholders were:-

- To see a further focus on the 9 musts do's from the Sustainability and Transformation Plans and where primary care fits into this process
- Detail on the efficiencies to deliver admission avoidance and timely discharge from the acute sector
- The role of Pharmacy as part of the whole systems approach
- Welcomed the alignment and inclusion to the Health and Well Being Board Objectives
- Links required to the Joint Strategic Needs Assessment
- Reference to multi-disciplinary and integrated working
- To identify vacant space and utilisation of space within primary care premises
- GP workforce specifically relating to recruitment issues and the ability to build capacity to ensure it can cope with the increasing volume of work.
- The future size of GP practices/hub arrangements.

What does this Strategy build on?

This Primary Care Strategy builds upon the 2013-15 strategy. This has, in the main, been delivered. The strategic vision and objectives for the 2013-15 strategy were:

- **Strategic vision;**
  - Investing in 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
- **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

What did this Strategy achieve?
In two years there has been significant transformation of Primary Care. This has been achieved even before becoming direct commissioners of Primary Care through:-

- The development of access to healthcare services seven days a week (we are doing this by improving the availability of patient appointments) and wrapping services around the patient; The CCG commissioned a scheme to enable practices to offer extended opening hours every Saturday. Originally introduced in November 2013, the scheme improved access to GP appointments and was extended by the CCG until the end of March 2015. The scheme was extremely successful and saw thousands of patients every weekend in primary care. From June 2015 the scheme has been given greater flexibilities and appointments can be booked via 11, the impact can be seen in the table below. The information below includes 25% of interventions/contacts from the VAWAS nurses. These nurses look after our vulnerable patients and prevent them from being admitted to hospital.

- Total interventions seen in Primary Care to from June 2015 – March 2016:

Federation	**Target patient contact**	**Actual Interventions**
Intrahealth	1755	3799
DDHF	3926	5104
SDH	9200	15792
Total	**14881**	**24695**

- Improving services for frail and vulnerable patients, being visited by an appropriate professional from a common care plan which may reduce multiple visits by multiple professionals. In DDES CCG all 41 practices signed up to the Unplanned Admissions Direct Enhanced Service (DES) (14/15) to identify a minimum of 2% of registered adult patients (18 years and over) at risk of unplanned admission to hospital. The percentage figure is agreed with NHS England across the country as being the most optimal population for effective intervention. The DDES CCG Vulnerable Adults Wrap Around Service (VAWAS) specification is a further enhancement to the DES. This cohort of patients were those who the VAWAS service initially focused on, however additional services must also wrap around those patients as identified in the specification/contract. Having identified the patient list practices developed care plans for patients as part of proactive case management working with this additional resource of nurses.

- Encouraging GP practices to work together. GPs have traditionally worked separately yet there is a growing realisation that general practice has to work at a larger scale to extend access beyond core hours and compete for community based services as they move out of hospital. In 2013 the practices grouped together to form three Federations i.e. Practices coming together in a separate commercial entity to provide services at scale for a greater population and to compete in the healthcare market. These Federations have made massive strides already despite being new organisations. Two of our Federations provide Anti-coagulation services and are part of a new national pilot for employing pharmacies in General Practice. All three Federations provide weekend working, Advanced Nurse Practitioner and wrap around nurse schemes are in place to ensure extra services for patients and increase capacity in Primary and Community Care. One of our Federations also provides Rapid Testing status for a new model of Primary Care delivery called Primary Care Home.

- Our member GP practices were facing GP recruitment and retention issues. Many GPs are taking early retirement and new GPs are choosing to become agency locums as an alternative career/lifestyle choice. In addition, DDES is a very deprived population with high levels of morbidity that increases the work burden on General Practice. Geographically the area does not offer the same economic or lifestyle choices that other parts of the North East offer a GP and their family when making a life commitment to a workplace. With the support of Health Education England we committed to reverse this downward spiral by launching 'Career Start'. By offering newly qualified GPs the opportunity of guaranteed continuing education and a minimum guarantee of salary we have recruited seven new GPs. 15 Practices highlighted vacancies and this programme has begun to make inroads.

- The CCG committed to investing in General Practice and have more services delivered out of hospital. There was a legacy of some additional or enhanced services commissioned by predecessor commissioning organisations. However, this was different in each locality and this causes inequity of access for patients and inequity of funding for practices. For 2014-16 the CCG successfully reviewed and re-launched 5 new enhanced services which focused on Gynaecology Minor Injuries, Dressings, Near Patient Testing and Shared care treatment.

- The CCGs has a statutory role in driving up quality in Primary Care. Since 2013, the CCG has commissioned a quality incentive scheme. This requires General Practice to look at consolidating some of their existing good practice by additional audits which allows them to learn from current patient experience and improve outcomes. This scheme also assisted the CCG in pump priming the development of Federations.

- The CCG works with our Local Authority partners to deliver on our Health and Well Being priorities. Screening, smoking cessation and Health Checks are the main services commissioned from General Practice. The CCG has worked with the Local Authority to move practices to the new programme for Health Checks called 'Checks for Life'.

- In conjunction with our Information Technology Strategy, all Practices in the CCG have been moved to a new system that stores patient data in warehouses as opposed to being in the individual practice computer. This web based system has now enabled patients to access their records at many more points of care than just their General Practice. However, this requires patient consent.

The following is a summary of the main aims and objectives from that strategy and how we have delivered on them;

2013-15 strategy	**Delivery**
Workforce – GP Career start scheme	5 GPs on the career start scheme with a further 3 coming on board
7 day working and weekend opening	GP services open on Saturdays across DDES
Frail Elderly – Vulnerable Adults Wrap Around Service (VAWAS)	VAWAS services operating 7 days a week
Quality Incentive Scheme (QIS)	QIS in place in practices
Investment – Enhanced Services	Enhanced Services Commissioned from General Practice and investment increased
Primary Care at Scale – Federation development	3 fully operational Federations with pump priming for three years
Information – Migration to web based systems	Migration complete
Premises – condition and utilisation of void space	6 facet survey and utilisation survey undertaken.
Prevention – Change for Life	Change for Life roll out underway
Research and Innovation – R&I collaborative	CCG actively involved in developing a research network of practices
Patient Engagement	Developments are being undertaken with our locality Patient Reference Groups to align patient champions to provide objective advice on key transformation areas such as Diabetes, Urgent Care etc.

1 Developing 7 day services that meet the needs of our vulnerable population

1.1 We will develop in Primary Care services from 8am-8pm weekdays from April 2017.

There are many routes available to patients for accessing Primary Care routine and urgent care during the day. In addition to General Practice there are also Urgent Care Centres and Accident and Emergency. These different centres are often used inappropriately in place of General Practice and sometimes accessed all together causing a duplication of services despite supporting patient choice. Currently General Practice closes at 6pm in DDES CCG.

There is a region wide Urgent Care Strategy covering Durham and Darlington. The Urgent Care Strategy identifies eight high impact interventions which were developed by NHS England following the Keogh review of urgent and emergency care in 2014. The main one pertaining to this Primary Care Strategy is that;

No patient should have to attend A&E as a walk in because they have been unable to secure an urgent appointment with a GP. This means having robust services from GP surgeries in hours, in conjunction with comprehensive out of hours services.

The Out of Hospital strategy developed across Durham, Darlington and Tees as part of the Better Health Programme also requires a responsive General Practice as one of its standards to prevent unnecessary admissions and emergency attendances. This standard was recommended in March 2016.

These interventions are parallel to the direction of travel within Primary Care to ensure patients are seen in the right place first time and to develop services and capacity in primary care by moving as much as is safely possible out of hospital.

Last year the Prime Minister created a Challenge Fund to allow General Practice to explore widening access. An independent evaluation on the first wave of the Prime Minister's GP Access Fund (formerly Challenge Fund) pilots has now been published.

The first report on the national evaluation of the programme looks at how the first twenty pilots have delivered on their key objectives to provide more GP appointments, expand the types of patient appointments and improve patient and staff satisfaction in GP access.

The wave one pilots will use the results of the evaluation to work with their local CCGs and assess how the most successful aspects of their local pilot can be incorporated into future services. A second evaluation report will be published in the coming months which will present data over a longer period of time compared to the first wave of the pilot.

What is the CCG doing?
Currently we have created slots with 111 for them to book directly into General Practice during the day. This offers an alternative to sending all patients to Urgent Care.

Direct Enhanced Services (DES) for extended hours access
The intended outcome of the Direct Extended Hours Access Scheme (DES) is an increase in patients' access to primary medical services, though face to face appointments with a health care professional at times outside practices' current core contracted hours, in line with any known patient preferences, and utilised at an acceptable rate. Appointments may be booked ahead or booked at the last minute.

As we develop 7 day services in DDES we need to look at the current take up of this DES which is not universal and how this investment can support access for vulnerable patients till 8pm weekdays across the CCG.

Key deliverables

- Commence a consultation on day time urgent care as part of the DDES wide urgent care strategy development
- Explore pilots for 6-8pm opening for vulnerable patients
- Review the DES for extended hours
- Negotiate for pathology and diagnostics to be more accessible between 6-8pm.
- Explore current ease of access for urgent and routine appointments in General Practice and whether capacity is meeting demand.

1.2 We will build upon the CCG successful GP Practice Weekend working pilot for Saturdays and expand over the weekend for vulnerable patients

The CCG commissioned a scheme to enable practices to offer extended opening hours every Saturday. Originally introduced in November 2013, the scheme improves access to GP appointments and was extended by the CCG until the end of March 2015. A number of practices ran the scheme together, giving patients a choice of:

- pre-bookable Saturday appointments;
- urgent appointments booked on Saturdays via NHS 111;
- urgent walk in appointments on Saturdays.

The scheme was extremely successful and saw thousands of patients every weekend in primary care. Due to the introduction of this service Urgent Care activity has dropped by 8% in Seaham, Peterlee and Bishop Auckland, whereas a 23% reduction has been reported from the Walk in Centre at the Healthworks, Easington.

The introduction of the CCG extended opening in primary care offers choice and alternatives for patients who might otherwise attend A&E, Urgent Care Centres and Walk in Centres.

Extending opening for GPs also supports the interaction with other services working outside of normal hours for example District Nursing, Intermediate Care plus and VAWAS services and much needed support to our care homes. This all contributes to the reduction of unnecessary admissions and provides care for patients closer to home.

From 1st June 2015 the new extended opening service now offers the following;

- GP extended opening on Saturday mornings for same day appointments/111 diverts and walk ins and telephone advice;
- GP priority appointments and advice to care homes/residential homes/ ANPs/111 and support triage on a Saturday morning;
- ANP advice to care homes/residential homes/ 111 and support triage on a Saturday and Sunday;
- Extend the current VAWAS model to offer home visits for house bound and care homes over the weekend;

The scheme aims to reduce the pressure on hospital accident and emergency departments, allowing them to concentrate on more urgent cases, and evaluation of this will inform future commissioning of extended opening.

Urgent and Community Care Networks
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.

Key deliverables

- Evaluate the use of VAWAS nurses until 8pm weekdays and weekends
- Extent GP Practices opening Sundays, appointments are required alongside out of hours arrangements

1.3 Workforce is essential to deliver 7 day services. We will continue our initiative for attracting GPs in the form of Career Start, extend the Nursing Career Start and develop Pharmacists in General Practice.

NHS England, Health Education England, RCGP and the BMA GP Committee are working together to ensure that we have a skilled, trained and motivated workforce in general practice.

All four organisations have jointly developed a new GP workforce action Action plan which sets out a range of initiatives to expand the general practice workforce. The broad themes are:

- **recruit newly trained doctors into general practice**
- **to retain GPs**
- **to encourage doctors to return to general practice**

There is a critical workforce problem given the relative shortage of new GPs who want to work in the North of England. As a CCG we have locally developed an initiative to recruit newly trained GPs in to the area with our Career Start scheme.

Building capacity in general practice

GP Career start
The GP Career start scheme (which was initiated through the previous Primary Care Strategy) was considered as a one-off scheme. By attracting seven new GPs into the DDES CCG area, which will improve chances of retaining these individuals in the longer-term, the scheme has proved to be a success. These GPs have formed a CCG-based peer set. When the occasion presents, we are taking this peer set to Durham University Queens Campus Stockton and extending the training to ST3 students. These are students in their last year of GP training and at the end of their training they will be looking for permanent jobs. In order to develop this scheme into a regular recruitment campaign we are widening the peer set to include ST3s who will pay per session to attend. Immediately we will be selling our area with a strong learning culture.

Pharmacy Pilot
By testing new ways of working across professional boundaries, we are taking another step forward to relieving some of the pressure that GPs are clearly under and ensuring that patients see the health professional that best suits their needs. In 2015, the government announced a pilot with funding of £15m to incentivise general practice to employ pharmacists. Two of our Federations have been successful in this bid for this pilot which will see 10 practices locally employing pharmacists alongside their clinical staff.

Recruitment and retention of the clinical and medical workforce has been one of the major themes in the feedback received. The main concern is that there is a huge

expectation in terms of primary care development in coming years. This expectation will not be achieved with the current workforce and more needs to be done to try to recruit not only GPs, but also nurses and Health Care Assistants alongside developing the skill mix with the wider workforce such as Pharmacists, Advanced Nurse Practitioners and Allied Health Professionals.

Key Deliverables

- Continued development of the Career start GP scheme built upon Phase I of the scheme which now has seven new GPs in post. Phase II will be the development of GPs with additional interests, by providing access and support to development/courses in areas of interest. These are recognised as being key development areas, especially for delivery of care in an out of hospital setting. For example, care of the elderly, which has been highlighted as an area of interest and priority to provide enhanced care for the frail elderly in their own homes and dealing with multi-morbidity. We are currently working with HENE and our local acute trusts to develop this.
- Promote the career start scheme as an employment route for aspirant/trainee GPs who are in their final stages (ST3).
- Explore portfolio opportunities with other providers as part of the GP career start development.
- HENE is developing schemes for return to practice and near retirement GPs.
- Expand a career start programme for practice nurses. This will help the transition of nurses working in the secondary care setting who wish to work in primary care. This expansion will include Sedgefield for the first time and therefore benefit all localities.
- Access to clinical leadership programmes for GPs. This will include building on the existing clinical leadership programmes, where these are appropriate. However, it may also require access to additional training. Two of our GPs (Dr Satinder Sanghera and Dr Jonathan Smith) have previously attended the North East Leadership Academy (NELA) Clinical Fellowship Programme.
- Developing the pharmacy workforce by working with the HENE Pharmacy Sub Group to ensure appropriate development of the pharmacy workforce in primary care. This will be in addition to the national pilot for expanding the pharmacy workforce in primary care.
- Work actively with NHS England to introduce a capping of locum costs.

Driving up Quality will underpin our approach to strengthening primary care

We will use local and national frameworks to assist us. Local schemes include the CCG Quality Incentive Scheme and Prescribing Incentive Scheme. National Performance frameworks include the Friends and Family test, Care Quality Commission and the Primary Care Web tool.

CCG approach to quality

A comprehensive programme of quality improvement activity has been introduced across the CCG member practices supported by the locality quality leads.

The activity includes a focus on improving the processes for safeguarding children, improving diagnosis rates for Dementia, improving the diagnosis of Cancer, reporting of incidents and improving the care for those who are on the end of life / palliative care registers.

Locality Prescribing Groups now have their own designated GP Prescribing Lead and there is a clinical champion and locality representation on the CCG Research and Innovation Group.

DDES CCG is also involved in contributing to the development of the NHS England approach to Clinical Quality Review, helping to oversee provider quality in secondary care and supporting the development of how primary care services will be monitored in the future.

Quality Incentive Scheme and Prescribing Incentive Scheme
The CCG has, since 2012, worked with practices on evidence-based improvements for patients that would be an enhanced over their day to day work. The aim of these schemes is to reduce health inequality and ensure that the quality of care and prescribing patients currently receive is delivered to an even higher standard.

Patient Experience (FFT)
The Friends and Family Test (FFT) was introduced in England in April 2013 and initially established in all NHS inpatient and A&E departments. In December 2014, it was rolled out across Primary Care organisations. The FFT is an important feedback tool that supports the principle that people who use NHS services should have the opportunity to provide feedback on their experience. For example, it asks people if they would recommend the NHS services they have used. The FFT provides a mechanism to highlight both good and poor patient experience (NHS England, 2014).

DDES CCG is working with NHS England to analyse the submissions from the FFT in order to identify areas of improvement within primary care based on patient experience. We are also working with our Patient Reference Groups to analyse the responses. Patient Reference Groups are made up representatives from each GP practice Patient Participation Group and they meet monthly, by locality supported by the CCG.

Constitutional Indicators
The CCG also has responsibilities set out in the NHS constitution which are delivered in Primary care; namely cancer diagnosis and end of life care.

Cancer Diagnosis
To address improved survival, evidence strongly advocates for earlier diagnosis, and timely access to treatment (Foot and Harrison, 2011). GPs have been suggested as pivotal in this arena, and survival rates have been highlighted as a key index of the effectiveness of Primary Care in cancer management locally (Abdel-Rahman et al, 2009).

Looking to the future, the overall picture for cancer survival is positive. However, in the short term, inequalities still exist. In 2015 DDES CCG introduced a Quality Incentive Scheme (QIS) which included an element that specifically looked to address issues with cancer diagnosis. In the scheme GP Practices are asked to:-

- Complete an audit on' Improving diagnosis of cancer'
- Evaluate the effectiveness of action plans in place following a previous audit
- Develop a second action plan where issues are still apparent

These actions will be monitored via the QIS process.

End of Life Care
The first national End of Life Care Strategy (2008) generated significant momentum to reverse the upward trend of people dying in hospital. However, there is still much to build on.

The Quality Standard for End of Life Care (NICE, 2011) provides a comprehensive picture of what high quality end of life care should look like. Taking into account the current needs of the population and the changing health and social care landscape, NHS England (2014) has developed a 5 year vision for end of life care beyond 2015. This strategy focuses on 'dying well', wherever it occurs, with Primary Care being identified as a key stakeholder.

As with Cancer the DDES QIS included an element that specifically looked to address issues with End of Life Care. Within the scheme GP Practices are asked to:-

- Identify a practice End of Life Care Lead
- Engage with the CCG Cancer/End of Life Care Lead and hold regular Multi-Disciplinary Team Meetings
- Demonstrate continued improvements in End of Life and Palliative Care using the Gold Standards Framework
- Increase the number of patients on the End of Life/Palliative Care registers

Learning Disabilities
CCGs need to give particular consideration to commissioning services for people with learning disabilities because they experience poorer health than the general population. These differences are to a large extent avoidable and thus represent health inequalities. Some health inequalities relate to barriers people with learning disabilities face in access health care and health screening.

People with learning disabilities often have difficulty in recognising illness, communicating their needs and using health services. Research shows that regular health checks for people with learning disabilities often uncovers treatable health conditions. Most of these are simple to treat while sometimes serious illness such as cancer is found at an early stage when they can be treated. The Annual Health check is also a chance for the person to get used to their GP practice, which reduces their fear of going at other times.

In order to drive up the quality of services for people with a learning disability and to aim to reduce the inequalities specific measures have been added to the 2016/17 Quality Incentive Scheme. These measures will include GP practices:-

- Increasing flu and pneumo vaccinations including those in care homes
- Increasing health checks (including eye checks), including those in care homes
- Supporting practices to carry out death reviews for people with a learning disability

Key Deliverables:

- We will continue in 2016 with a QIS and Prescribing Incentive Scheme (PIS)
- Constitutional indicators will be included in the QIS scheme so that General Practices are able to support achievement.
- A Primary Care Macmillan service is commissioned to support practices improve screening rates and support newly diagnosed patients.
- We will develop a dashboard to monitor practice achievement against Friends and Family test, Care Quality Commission inspections, QOF and the Primary Care Web tool. We will also use the developing trigger tool within RAIDR that draws upon practice data to identify untreated patients.
- The QIS will include new targets for improving Learning Disability health

1.4 Ensuring that all Practices have robust Business Continuity plans so that service continuity is assured.

Primary care is an essential service that is relied on by the community. Planning ahead for how to continue to provide services during any circumstance is essential; whether it be a disruption to a single practice (such as a fire) or a wider-scale event that impacts on a whole region (such as an earthquake).

In addition, primary care may experience an increased demand for their services during emergency events, and find they are faced with providing services beyond their 'business as usual'.

From 2015 our responsibility as a level 3 Commissioner of Primary Care means that we require assurance that all practices have these plans in place. An example of a business continuity plan is included in our Operating Framework.

Additionally, the CCG as commissioner has to be able foresee any bottle necks or problems around the corner that may result in individual practices moving to a challenging position. This is covered under section 2.4.

In line with managing day time urgent care a six level escalation plan within the North East Escalation Plan (NEEP) framework has been adopted by General Practice through the Federations. For the first time this allows us to have an up to date position on practice capability at any given time.

Key Deliverables

- Practices to lodge business continuity plans with the CCG by March 2016.
- The CCG to create an escalation flow chart for incidents that affect business continuity and require escalation outside the practice.
- CCG continues to monitor the NEEP framework to establish patterns of service challenge.

2 Sustainable Care Closer to Home and Not in Hospital

2.1 We are piloting disease specific pathways for integration of services and budgets developed in line with the 5 year Forward View new models

The above objective demonstrates how the CCG is moving in the same direction of travel as set out by Simon Stevens in the 5 Year Forward View which was published in October 2014. This sets out the direction of travel for the NHS over the subsequent five year period up to 2019. The document argues that in order to ensure the sustainability of the NHS in the longer term a radical upgrade in prevention and public health in required as part of a radical over hall in the structure of how NHS services are delivered to patients.

Better Health Services
Commissioners and clinicians are three years into a programme of work that considers the future needs of patients and the health services they will need in Darlington, Durham and Tees.

Phase 1 was known as the 'Acute Service Quality Legacy project' which focused on how we deliver clinically agreed standards of care for best patient outcomes and then addressing how finance and workforce constraints impact on this. During this phase clinicians agreed clinical standard aspirations for:

- Acute Paediatrics, Maternity and Neonatology
- Acute medicine, surgery and intensive care, and
- End of life

Phase 2 was Securing Quality in Health commissioned external experts to analyse the feasibility of implementing the recommendations.

The current phase is known as the 'Better Health Programme' and is focussing on the pre-engagement, public consultation and implementation of the agreed standards. Implementation is due to take place between April 2017 and March 2020.

One element of the Better Health programme is 'Not in Hospital' Care. To date the standards that have been developed have been embedded in the 'In-Hospital' services and therefore a similar approach needs to be used for the 'Not in Hospital' element. 'Not in Hospital' Care can be delivered from the following groups:-

- Primary Care
- Health Services
- Social Care
- Community services
- Voluntary and Third sectors organisations

The aim of this element of the Better Health Programme is to ensure that patients only go to hospitals for appropriate care, and on other occasions are treated closer to home.

New Models of Care
This CCG is committed to developing new models of care for the following areas;

- Diabetes,
- Mental health,
- Community nursing

Diabetes
The current model is not financially sustainable for County Durham and Darlington (CD&D) as Diabetes prevalence rises. If we 'Do Nothing' it will require finding an **additional £7-9m per year** by 2025 to fund Diabetes care in County Durham and Darlington. In DDES this is an extra £1.7 million by 2019/20. Depending on the level of CCG investment there will be a shift in management of patients from secondary care to primary care, by upskilling GP practices and supporting patients to take more control of their condition.

Future diabetes services in County Durham and Darlington will see primary care and secondary care working together with commissioners to develop new ways of working, and indeed commissioning – with the introduction of a programme budget and an outcome based service. The new model of care has three underpinning principles:

- Patient centred care
- An integrated service
- Financially sustainable

We have developed an alternative model of delivery for diabetes services following clinical consensus between primary and secondary care that services needed to change. We are creating a pooled budget for diabetes care with clinicians across primary and secondary care plus the Local Authority focussed on transforming care using an outcome based commissioning approach. We are working with NHS England to explore the potential to pool/align their related budgets into this model to develop a truly system wide approach to diabetes care. We plan to expand this approach to other chronic diseases over the next three years.

The vision of the new integrated community based model of care for diabetes in County Durham and Darlington is to provide a seamless service for adult patients living with type 1 and type 2 diabetes, with a strong focus on prevention and education. This will include implementation of the National Diabetes Prevention Programme

The current service is financially unsustainable in the face of rising prevalence and increased costs of treating diabetes. The service is fragmented, particularly between primary and secondary care, there is significant variation across County Durham and Darlington, and health outcomes are at best, average, and in some cases worse than the UK average.

Clinicians in County Durham and Darlington (CD&D) have developed a model that will see clinicians from secondary care and primary care working together in diabetes groups with shared responsibility for health and system outcomes. The system will be supported by overarching enablers including a joint governance model, aligned incentives, information sharing and organisational development.

The new model will be flexible to accommodate the needs of each local group, with improved access for patients, who will receive the majority of their care from their local GP practice or community clinics. Practices will be supported by specialists in secondary care, providing education and continued professional development so primary care clinicians feel confident and able to manage more complex cases outside of a hospital setting.

The aim is:

- to reduce the prevalence of diabetes by identifying people most at risk of developing Type 2 diabetes and referring them into evidence-based lifestyle interventions
- to reduce the incidence of avoidable complications in patients with existing diabetes, by assertive management of glycaemic control
- to assist patients to self-manage their condition, by providing education, support and encouragement through individualised care plans that reflect the patient's personal circumstances
- to see a reduction in unnecessary hospital admissions, particularly for avoidable complications such as amputations, renal failure and retinopathy, and continued reductions in outpatient appointments
- to achieve a financially sustainable model of care. If we do nothing it will cost Durham Dales, Easington and Sedgefield CCG at least a further £1.76m per year by 2020.

'Diabetes Groups' will be formed where clinicians from primary and secondary care share responsibility for health and system outcomes for a defined cohort of patients. The new model will achieve high quality care through a new focus on enabling patient self-management via longer *individualised care planning* conversations in primary care. Every patient with diabetes will receive a jointly agreed individual care plan, as well as the core care processes (i.e. Urinary Albumin, Eye Screening, Foot Exam, Smoking Review, Body Mass Index (BMI), Cholesterol, Blood Creatinine, HbA1c and Blood Pressure). More patients will be managed in primary care or in the community, reducing the need for referrals into secondary care. As the model matures there will be a phased discharge of patients from secondary care and Tier 2 into primary care.

Community nursing

Our current approach to ensure effective care for both the general population and the frail elderly means services are delivered in both primary and community care by multiple providers. Therefore the patient can have their care delivered by a number

of practitioners in the same day and quite often, in an emergency, there is no co-ordination which often results in an emergency admission to hospital. Community services and primary care are natural partners; the opportunity exists through a new model to combine the wide range of primary and community care professionals, generalists and specialists, aiming to play to the strengths of each, while feeling like a single service from the patient perspective. This collaborative working, based around populations on GPs registered lists, is at the heart of the emerging multispecialty community provider and primary and acute care system models. DDES CCG is currently developing this model under the 'Primary and Community Nursing' Model.

Mental Health

Mental Health is a high priority for DDES CCG. There are a large number of services provided by Tees Esk and Wear Valley Foundation Trust (TEWV), Voluntary and Community Sector Organisations plus some private providers. It is therefore difficult when a patient presents at General Practice for the practitioner to have knowledge of all available and services and this results in some patients not being referred into the most appropriate service for their needs first time.

To aim to address this issue DDES CCG has proposed working with TEWV and the DDES GP Federations to develop a service model that would see Community Psychiatric Nurses (CPN's) aligned to work in and alongside General Practice. To ensure the smooth running of this proposal a Partnership Agreement has been developed which proposes a joint working arrangement between TEWV and the DDES GP Federations.

The CCG is also committed to continuing to work to deliver the actions associated with the Crisis Care Concordat, of which it is a signatory, and to work with the Mental Health Partnership Board to improve joint working with partners in the delivery of mental health services.

Multispecialty community providers

The FYFV sets out an ambition for new models of delivery. One of these models is Multi-speciality Community Providers. The principles of this model are forming the basis of our disease area transformations. We are not being prescriptive with our providers on the shape of this model.

2.2 In 2014 the CCG created a new set of Local Enhanced Services. From 2016, we will evaluate the use of Direct and Local Enhanced services and the QOF to improve patient outcomes and reduce duplication of services and targets.

Local Enhanced Services
The CCG commissions a number of Enhanced Services from practices which are detailed in the operating model. This is the contracting vehicle we use to move care out of hospitals into the primary care setting.

The aim of Enhanced Services is to meet the needs of the local population, recognising and addressing gaps in the core services in order to reduce the necessity for admission to secondary care. In the past, these services have been commissioned via an add-on (enhancement) service to the GP contract. However, increasingly this is done via a tendering process which means GPs have a contract for the treatment of their registered list and the old Enhanced Services are now commissioned under a standard NHS contract. These services are also key to the implementation of other CCG Strategies, such as the Urgent Care Strategy.

- DDES CCG currently has 5 locally agreed Enhanced Services in place which began in 2014. These are:-
    - Community Gynaecology Services
    - Near Patient Testing and Shared Care
    - Minor Injuries
    - Innovation and Transformation
    - Basket of Services

- Each service comes with its own aims and objectives. The Community Gynaecology specification is paid for on activity relating to the number of Vaginal Ring Pessary's fitted, monitoring, checking and removal of LNG-IUSs as appropriate in the management of menorrhagia within primary care. The other services were paid for on a block basis from the practices raw lists size on the 1st April 2015.

Direct Enhanced Services (DES) for extended hours access
The intended outcome of the Extended Hours Access Scheme DES is an increase in patients' access to primary medical services, though face to face appointments with a health care professional at times outside practices' current core contracted hours, in line with any known patient preferences, and utilised at an acceptable rate. Appointments may be booked ahead or booked at the last minute.

As we develop 7 days services in DDES we need to look at the current take up of this DES which is not universal and how this investment can support access to vulnerable patients till 8pm weekdays across the CCG.

Quality and Outcomes framework
Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results.

It rewards practices for the provision of quality care and helps standardise improvement in the delivery of primary medical services.

It is a voluntary process for all surgeries in England and was introduced as part of the GP contract in 2004. The indicators for the QOF change annually, with new measures and indicators being retired. The QOF awards practices' achievement points for:

- managing some of the most common chronic diseases, e.g. asthma, diabetes
- managing major public health concerns, e.g. smoking, obesity
- implementing preventative measures, e.g. regular blood pressure checks

In 2016, the CCG clinical champions, who are local GPs with special disease interests that advise the CCG, will look at the QOF and whether the measures are appropriate for us to achieve our desired local outcomes. This will be particularly relevant with Chronic Obstructive Pulmonary Disease (COPD) and Diabetes where we are working with Primary, Community and Acute care to improve outcomes for patients with an integrated pathway closer to home.

Practice Based Community Contracts

- Individual GP practices also provide a range of Community Contracts, details as follows:
    - Anti-Coagulation
    - Deep Vein Thrombosis
    - Minor Skin Surgery
    - Physiotherapy
    - Vasectomy

Key Deliverables

- The CCG will evaluate local enhanced services before re-commissioning in 2016
- The Clinical Champions group will review QOF indicators in line with our Out of Hospital Strategy
- The CCG will review the DES for extended opening in line with the Urgent care Strategy.

2.3 The CCG will develop Practice Based Budgets and support a Demand Management programme to align clinical and financial responsibility and optimise our use of secondary care.

The government announced a forecast position of NHS nationally (£30bn pressure by 2020) during its public consultation 'A Call to Action'. Against this backdrop we expect minimal financial growth locally. Extra services in Primary Care must be funded from existing funds. Increasing activity and costs in secondary care will use up all available funds unless current trends are slowed/reversed. GP practices have a key role to play as significant expenditure committed at the point of the GP's decision to refer into a secondary care setting. If the CCG does not achieve financial balance then funding for additional services in Primary Care will not be available. We wish General Practices to take control of budgets from April 2016 and have agreement from our member practices on an apportionment methodology of our entire budget.

To support future budget monitoring and variation we will support General Practice with our Demand Management Programme. This is the analysis and discussion of how, where and when patients are referred from their GP to secondary care. GPs, with the support of specialists within the CCG, look at this data analysis to ensure that patients are referred at the right time within their care pathway to the right place in order to optimise treatment outcomes.

Primary Care Federations are involved in our demand management programme and play a key role in management of referrals and peer comparison across practices to understand variation in referral rates. This is part of the CCG's wider approach to demand management.

The main monitoring tool is the referrals dashboard, which is produced every two months by Business Intelligence. The dashboards allow practices to see how their current referral levels for the top 3 referred to specialties compare to the same period last year, minus the 1% referral target. In effect it shows what level of action is required to achieve the 1% reduction target.

Key Deliverables

In 2016:

- We will give member practices their delegated budgets and create rules for re-investment of efficiency saving into improving patient services.
- We will continue to support practices with their demand/variation management

2.4 The CCG will create a programme for Supporting Struggling Practices and develop a Federation approach.

Support for struggling GP practices
The vision presented by the 5YFV is about releasing the potential of general practice in primary care.

There are many positive examples of general practice redesigning their services and programmes of work are being aligned to support improvement and change management to deliver primary care at scale envisaged under the 5YFV.

However, we are increasingly concerned about the resilience of a number of GP practices to respond to current pressures on general practice, let alone begin a journey of change around new ways of working that will improve services for their patients. These pressures are well known (if not fully articulated) and relate to:

- Increasing and more complex workload
- Recruitment problems and understaffing
- Complexity of annual contractual requirements.

Much focus has been placed on the individual needs of GPs, such as risk of burn out and stress which clearly relate to, and impact on, practice resilience. Options for individual occupational health support are being considered separately by NHS England.

GP practices as independent contractors are responsible for, and control the running of, their business including the planning and allocation of resources to meet service demands and pressures. Under the new Primary Medical Services (PMS) the impact of a move to equitable funding can present as pressure if practices fail to plan even with a pace of change and respond accordingly to local changes or if external factors (such as GP recruitment) impact on the cost of delivery.

There is increasing anecdotal evidence nationally that the number of practices that are struggling and are vulnerable are on the increase, presenting as practice closures or as adverse impact on patient services.

More worryingly around 150,000 patients across England were displaced as a result of 58 practice closures between April 2013 and April 2015 (Source: Pulse report based on Freedom of Information returns from our regional teams). Practices can also seek to unilaterally close their practice lists temporarily to new patients.
CQC ratings are currently finding 4% of inspected practices inadequate and 12% as requiring improvement. However the standard of Primary Care in DDES is high and we do not expect this. We are aiming not to have any practices rated as inadequate.

Locally two practices are in discussion with the CCG regarding closing their list to stop any further new patient registrations. The introduction of the CQC inspection

regime has highlighted a number of practices in difficulty nationally and the importance of practices being well-led. However, with the nature of general practice operating as small independent units, there is a risk that even high performing practices can quickly fall into difficulty e.g. with the loss of one or two critical personnel. We have seen this happen in DDES CCG.

DDES CCG will create local capacity to support struggling practices by investing in Specialist Practice Managers who will be available at least one day per week to be placed in practices who are identified as requiring support.

We want to support all general practices to realise their potential and that means ensuring struggling and vulnerable practices are supported too. Commissioners must have due regard for procurement principles and ensure providers and potential providers are not unfairly treated.

The Secretary of State for Health confirmed in his 'new deal' speech that NHS England had identified funds of £10m from the 2015/16 Primary Care Infrastructure Fund (PCIF) to develop a support programme for struggling practices. A submission is currently being prepared on future PCIF investment plans for the next three years and proposes this investment for struggling practices should continue to 2018/19. The beneficiaries of the 'turnaround' fund – pledged as part of health secretary Jeremy Hunt's 'new deal' - will have to be identified by January 28 2016.

This flexibility will prioritise practices with a high ratio of patients to GPs, but it will also give funding to practices with higher than average referral and prescribing rates.

Any practices receiving funds will have to match any investment 50:50, and the specification that will come out states that it must align with "CCG plans for primary care locally".

Key deliverables

1. Support access to the Royal College of General Practitioners peer support pilot programme for practices in CQC special measures using the Vulnerable Practices fund. NHS England will fund 50% and the Practice will match fund.

2. Key elements of support services to struggling practices include:

    - Offer of diagnostics – development of action plan
    - Targeted approach – time limited interventions
    - 'Whole practice 360 appraisal'
    - Specialist advice and guidance – e.g. HR, IT, Management, Finance
    - Support for merging / federations
    - Coaching / supervision / mentorship
    - Short term clinical or practice management capacity
    - Intensive support from a specialist manager

3. Create Specialist Practice Managers who will work in practices identified requiring support. This will be done in conjunction with Federations.

4. Create a risk register which aligns practices highlighted as having quality or workforce issues.

5. Work with partners to develop a suite of offerings to practices that extend their options at an identified time of vulnerability to support recruitment, premises or financial viability.

3. Focusing on Population Health using new models of delivery

3.1 We will use a robust evidence base to demonstrate the Case for Change for population health and reducing health inequalities.

The case for change
We know that focusing solely on the most disadvantaged will not reduce health inequalities sufficiently; actions need to be universal but with a scale and intensity that is proportionate to the level of disadvantage. Evidence based lifestyle activities and mental wellbeing programmes can achieve as much health gain as medical interventions if delivered through quality assured programmes. By working in partnership with public health to ensure commissioning of 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.

Commissioning for Health Prevention

Primary care and population health
The aim of this section of the primary care strategy is to stimulate greater engagement of general practice with improving the health of the population and reducing the gap in health inequalities.

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

This is not something new. Population health has always been an important element of primary care. However, there has always been the tension in general practice between treating those who are unwell, managing patients who are at a high risk of becoming unwell and giving sufficient attention to the general population to improve their health and well-being to prevent them becoming unwell.

“The profession has a minority of doctors who seek to conserve health in populations rather than restore it in sick individuals; but they are at the periphery, and have never been encouraged to combine the functions of prevention and cure.” (Tudor Hart, 1981, p.871)

There is a growing consensus around the view that general practice could, and probably should, do more to improve health and well-being in its population. Following a review of the quality of general practice, the King's Fund concluded that:

“General practice is regarded as uniquely well placed not just to provide medical care, but also to promote the health and well-being of the practice population and to address health inequalities.”

In general, practices in more deprived areas are under greater pressure to deal with a rising demand for the management of people with long-term conditions leaving little time for prevention programmes. This will contribute to a widening of health inequalities.

Key Deliverables

1. All practices should invite a sufficient number of eligible patients for an NHS Health Check to ensure coverage of 20% of the eligible practice population using the check for life programme. Any practices not wishing to provide this will consider this being done by another provider or Federation.
2. Every practice should provide level 2 stop smoking services based on the recommendations in the guidance document, brief interventions and referral for smoking cessation in primary care and other settings. (NICE, 2006a)
3. Practices should routinely use the general practitioner physical activity questionnaire (GPPAQ), to identify inactive individuals and act on the recommendations in the guidance document. Commonly used methods to increase physical activity are: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling.(NICE, 2006b)
4. Practices should agree to include alcohol brief interventions as an intervention based on the guidance document; Alcohol- use disorders: preventing harmful drinking, (NICE, 2010) when offered in next year’s public health agreement.
5. Every practice remains part of a Federation and supports our commissioner approach to wrapping services around groups of populations. We will be encouraging practices to work closely together so that those who have demonstrated successful delivery of services (such as smoking cessation) can share their learning and best practice with others.
6. improving the uptake of vaccinations, immunisations and screening. This includes childhood immunisations, influenza and pneumococcal uptake and cancer screening including cervical, breast and bowel and non cancer screening including Triple A screening and diabetic retinopathy screening

3.2 Build upon the current development of Federations to develop at scale models outlined in the 5 year Vision and develop the concept of Primary Care Home

GP Federations
We introduced a quality improvement scheme that incentivised the setting up of GP Federations (GP practices coming together in collaborative models). From this, three federations have evolved - South Durham Health, Intrahealth and Durham Dales Health. These organisations have clinical leaders in place and have now been commissioned to deliver new services to support patient care.

- The benefits to patients:
  - Services closer to home - every patient has access to a local, flexible and enhanced service that is delivered by their own GP Practice or a group of practices from a hub.

- For practices
  - Allows them to deliver primary care services at scale and creates an opportunity for practices to share staff skills and other back office functions.
  - Allows their patients to access services even if they are unable to provide them at the practice level.

Our population of 280,000 is currently served three established Federations.

The Federations are as follows:

Durham Dales Health	12	104,052
South Durham Health	24	169,670
Intrahealth Ltd	4	27,470

Primary Care Federated Service Delivery
Since supporting the development of Federations they now deliver the following services:

July 2014 – Primary Care (PC) federations started delivering weekend opening services for the entire DDES population. In July 2015 this service was modified to ensure that there was a focus on the frail elderly population including those in care homes by providing additional support throughout the weekend.

Urgent care attendances have decreased by 12% on a Saturday morning following the introduction of PC Federated weekend opening.

July 2014 – Primary Care Federations started delivering pro actives support in the form of wrap around services for frail elderly patients

June 2014 – Primary Care Federations started delivering emergency admission avoidance services (reactive services) to prevent admission to hospital

In July 2015 these services were merged in recognition of the fact that the two services often supported the same cohort of patients, just at different times in their care pathway

DDES CCG now has three fully operational GP federations. They have been working with the CCG to develop their capabilities as providers. The CCG hold monthly meetings with each Federation Management team individually to discuss progress with each service and to develop improvement plans where these may be required. The CCG will continue to support Federations and their development for the duration of this strategy. We are unable to offer a longer commitment than this due to the constantly changing political landscape within which the NHS functions. The CCG would encourage Federations to support practices in any way they can, for example, bulk purchasing consumables in order to achieve cost reductions could be one way the Federation is able to support General Practice where the CCG cannot. Federations are also in a position to be able to co-ordinate the delivery of care across specific areas without the need for all practices to offer every service.

What is the Primary Care Home (PCH) model?
The PCH is a form of multispecialty community provider (MCP) model. Its key features are:

- provision of care to a defined, registered population of between 30,000 and 50,000;
- aligned clinical financial drivers through a unified, capitated budget with appropriate shared risks and rewards
- an integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care; and
- a combined focus on personalisation of care with improvements in population health outcomes.

What is unique about the PCH model?
The PCH and MCP model share some of the same goals, such as better outcomes for patients, at lower cost, based on greater integration between primary and secondary care. However, the PCH model, in particular, focuses efforts on the 'make or buy' decisions within care provision through the accountability of independently managing a capitated budget for a registered population of between 30,000 and 50,000. It can strengthen organisational relationships, with multi-disciplinary clinical and social care teams working collectively through networked arrangements. The PCH model will be based within modernised community healthcare premises, with access to diagnostics on site and fully integrated IT systems.

What are the benefits of the PCH model for patients?
The key benefits for patients are a single integrated and multidisciplinary team, working to provide comprehensive and personalised care to individuals. Working at

this scale ensures everyone within the team knows everyone else and the patient has a more consistent experience of care, similar to having a named GP.

What is the PCH workforce model?
The PCH model enables primary care, community health and social care professionals to work in partnership with specialists to provide out of hospital care. The workforce model should reflect the size and needs of the registered population, which may result in exploring opportunities to design and develop the roles of nursing, pharmacy and allied health professionals. The scale of the population for the PCH model is intended to drive a workforce model that ensures patients have a consistent and personalised experience of care.

What next?
The South Durham Federation has been successful in its bid with the National Association of Primary Care (NAPC) to be a rapid test site. DDES CCG in parallel will ask Federations to identify further groups of practices who wish to pioneer a population based approach to Primary Care. There are two pieces of work that fit with these sites will be well positioned if organised to consider the new contract that is being offered in April 2016 based on this approach.

Key Deliverables

1. Practices to remain in a Federation.
2. Federations and other providers work with the CCG to develop new models piloting Primary Care Home and disease specific models in line with the FYFV.
3. Federations play a more active role to support struggling practices or practices who are not meeting quality indicators on enhanced services.
4. Federations work with the CCG to integrate General Practice teams with community staff wrapped around the patient.

3.3 Ensure that our primary care premises and community hospitals are optimally utilised to benefit services grouped around local populations.

We are carrying out a review of premises and estates across DDES to ensure best use of clinical space. We have a number of minor elective procedures that could be carried out in a community setting to provide alternative options hospital and care closer to home. The review includes potential space in GP practices and Primary Care Centres across the CCG patch. As Primary Care Commissioners, we now have responsibility for primary care estate and, as such, need to work with General Practice to ensure that all premises are fit for purpose and utilised to maximum capacity. This includes utilising some estate beyond office hours to accommodate 8-8 opening hours and 7 day working.

Future primary care premises strategy has to align to:

- The CCG vision for Primary Care
- "Local Estates Strategies - A Framework for Commissioners" ;DH June 2015
- What key criteria we might want to use for making premises investment decisions (recognising national tools need to be adapted to local circumstances)
- Key strategic locations and how we maximise utilisation of these sites and drive out efficiencies
- Horizon scanning / current hot spots
- Condition survey work and CQC/Statutory / regulatory issues
- Opportunities for partnership / joint developments working across communities / public sector

NHS guidance states that to be considered for development, practices have to identify that they meet two of the four criteria to for new premises:

1. That there is a known current or future geographical gap in primary medical care service provision.
2. That any of the GP Contractor's practice premises are currently 50% undersized (utilising the size criteria contained in the Principles of Best Practice).
3. That the surgery is unsatisfactory in terms of functionality and/or condition.
4. There is a need to respond to an emergency situation e.g. fire; flood which requires a temporary solution.

Additional sources of investment will need to be sought to support the development of Primary Care estate. The next phase of NHS England's £1billion **Primary Care Transformation Fund** promises to deliver GP premises fit for the future so patients can access more services out of hospital and in their local communities.

Proposed schemes can now span more than one year. This means bigger, more ambitious projects will be possible that will help address rising demand on GP services that account for 90% of all patient contact with the NHS.

The first year of the four year investment made £250m available to help GP practices to make much needed improvements in premises and technology. The fund will now also be able to support more ambitious longer term plans to improve out-of-hospital health services, helping ensure general practice remains at the heart of NHS care as services adapt to meet future challenges.

From 2016/17 we plan and fund the majority of local health services and will lead proposals for how funding will be invested, working with GPs locally. This will ensure investment supports long-term plans for delivering the best, joined-up services for patients in their local communities, while reducing reliance on hospitals.

CCGs will work with GP practices to identify opportunities for developing existing premises, relocating services to new or existing buildings to provide a wider range of services and better use of existing premises.

The recommendations will need to demonstrate that they meet one or more of the criteria set out below:

- increased capacity for primary care services out of hospital;
- commitment to a wider range of services as set out in the CCG commissioning intentions to reduce unplanned admissions to hospital;
- improving seven day access to effective care;
- increased training capacity;
- Commitment to utilise community hospitals for services such as IC+

Key Deliverables

1. We will invite new bids and re-appraise previous premises bids with approval in principle to re-apply to the Challenge fund if they meet the criteria set out above.
2. We will continue to encourage practices to meet the statutory and regulatory frameworks for GP premises and offer NHS England Improvement grant scheme.
3. We will explore with General Practice how empty sessional space already covered by notional rent can be optimised.
4. Work with practices to ensure that their current sites are fit for purpose and that services are sustainable based on future workforce requirements and clinical good practice.

3.4 The CCG will continue to develop learning opportunities for Primary Care staff and develop learning sets as part of the organisation culture to becoming a learning organisation

Developing a Learning Culture amongst GPs
People learn in different ways. Currently, the CCG operates Time-In and Time-Out sessions regularly throughout the year where external trainers are invited to run sessions for GPs to attend to update their skills in both mandatory and voluntary training. This does not take account of different people's individuals training needs. The Time-In and Time-Out model will continue but we will develop action learning sets of specific groups of GPs who could support each other and offer peer support.

Our current example of learning sets has been with our Career Start GPs. These are GPs who completed the Vocational Training Scheme and took jobs in GP Practices in DDES. Twice a month the GPs meet with Dr Martin Jones as their group facilitator to share experiences, learning and to provide support to each other. We now wish to extend this concept with other primary care professionals.

Why action learning sets?
Principles of Adult Education - Traditional teaching methods in medicine are gradually being replaced by those based on principles of good practice and effectiveness in the wider world of adult education. Brookfield (1986) and Knowles (1975) described some of the fundamental principles of adult education.

Adults learn best when they:

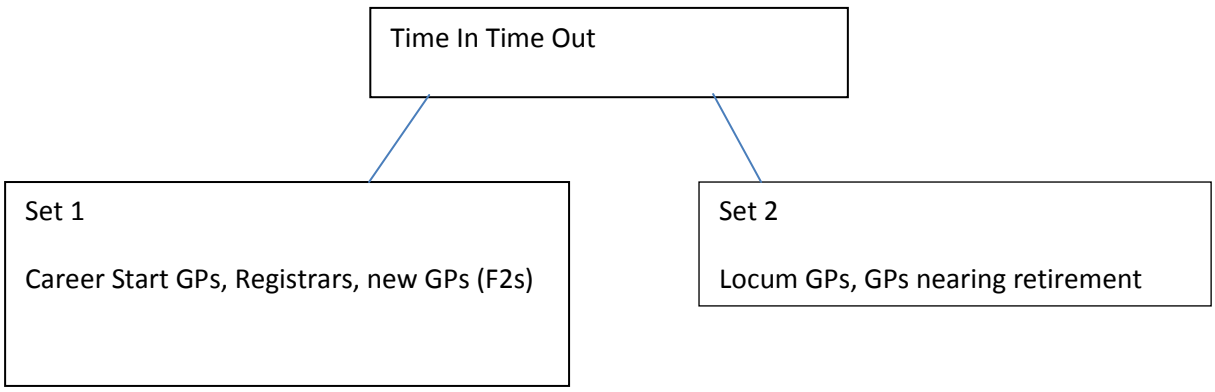
- Are helped reflect on their practice
- Identify strengths and weaknesses
- Resolve conflict between educational wants and needs
- Negotiate their learning objectives
- Articulate learning outcomes for themselves
- Analyse how they have learned
- Agree plans for further development.

Self-directed learning can be defined as
A process that involves taking the initiative with or without the help of others in diagnosing learning needs, identifying resources for learning, choosing and implementing appropriate learning strategies, and evaluating learning outcomes. The process of learning can be illustrated as a cycle:

The CCG will create a support network, led by a DDES GP Tutor. It will focus on the educational needs identified by the GPs in this group and develop as an action learning set. Between the action learning meetings the GPs will continue self-directed learning in line with their PDP and approach to appraisal and revalidation.

Set 1 would consist of GPs at the start of their practicing career and the aim of the group would be to attract new GPs into the CCG area. Set 2 will be aimed at GPs who do not practice here regularly or who are nearing retirement (this latter group would be self-selecting) as these two groups are often identified as struggling to keep abreast of the frequent changes made to pathways, referral methods and other regularly changing aspects of practice.

Diagrammatically, it would look like this;



These groups will meet twice a year as a minimum but could meet more regularly as required by members.

Key Deliverables

1. Expand Career start learning sessions to include and sponsor Medical School GP trainees (ST3s) periodically
2. Work with a GP Tutor to develop the Peer sets for locum GPs and GPs nearing retirement
3. The CCG to build on the Time-In/Time-outs

4. Wrapping services around the patient

4.1 Progress the development of the Integration of Primary and Community Care Nurses to wrap around practice and patients to avoid duplication.

Following successful delivery of services by Primary Care Federations we have looked to strengthen collaboration between providers. Three of the key delivery projects for 15/16 are:

To develop coordinated of care services to include our district nursing, practice nursing, Advanced Nurse Practitioners and Vulnerable Adults Wrap Around Service resources into an aligned provision in phase 1. These services will be based around general practice, improve communication, reduce duplication (which will also avoid the potential of patients falling through the gap) and support a seamless patient centred journey.

Once the first stage of this work is competed we will be working to integrate with other services such as the Specialist Nurses, Intermediate Care service, Macmillan services etc.

We are developing a service model with TEWVFT and PC Federations with Community Psychiatric Nurses (CPN's) aligned to and working in an integrated way with primary care services. The aim is to ensure a coordinated pathway of care is in place, with the aim of ensuring patients are referred to the most appropriate service first in order to meet their needs effectively. The service will also provide care closer to home and improve access for hard to reach patients.

Key Deliverables

- Reduce in hours and out of hours avoidable admissions by 3.5% from 01/09/14 to 31/08/16 and all other targets within line with the Better Care Fund plan.
- Upskill and work in partnership with Federations and Care homes to reduce avoidable admissions.
- Ensure that the Vulnerable Adults Wrap Around Service team integrates with Primary and Community Nursing. Every Practice to know their named nurses in the community and operate regular multi-disciplinary meetings looking at the top 2% vulnerable adults in their practice.

4.2 We will ensure that the Primary Care Information technology structure supports patient care and greater accessibility by healthcare professionals and patients alike.

To enable this, we align our Five Year Informatics Strategy to delivering the needs of the FYFV and Personalised Health and Care 2020. These drivers for change ensure that we look at how our citizens are traveling through care pathways and we will review and implement, at pace, change for the better.

We will use information and Informatics solutions to enhance patient experience and drive a step change towards patients being informed prior to any consultation, enabling patients and carers to participate as partners in their own healthcare.

We will use technology to deliver the paper free agenda, pushing forward with the 2020 vision of having fully interoperable electronic health records in place, so that patients' records are paperless at the point of care. The paper-free agenda is supported further through the delivery of projects such as electronic prescribing, this enables prescriptions to be sent electronically to the pharmacy of choice; this not only reduces paper flow but gives further flexibility for patients.

Building on providing further flexibility for patients we are providing extended hours of access to primary care services, this will ensure that patients have greater choice and accessibility in seeing health care professionals.

Key Deliverables

- Working with ICT and Information Governance colleagues we will provide safe and secure access to solutions as e-consultation, WIFI and patient online access, which gives improved access to services, ensuring the patient is at the centre of their own care.
- We will continue to ensure that all providers of care in the vulnerable patient pathway are able to access the patient record with permission of the patient
- We will work towards a standardised care template for key clinical data for vulnerable patients so that the record is able to be shared.
- We will continue to build on the success of national solutions such as patient online, which gives patients direct online interaction with their GP enabling them to book appointments, book repeat prescriptions and view their own medical record reducing the need to travel to the practice
- Intra-Practice and CCG communication will continue through our intranet product GP TeamNet. This is also our platform for sharing and disseminating clinical guidelines via the Clinical Support Information module.

Appendices

Appendix A - General Practice Core Contracts

https://www.england.nhs.uk/commissioning/gp-contract/

Appendix B – Engagement Documentation

Please see next page.

Appendix C – GP Forward View

https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

Contributors

Durham Dales, Easington and Sedgefield Clinical Commissioning Group would like to take this opportunity to thank everyone who has contributed to the development of this Primary Care Strategy. This would include:-

- DDES CCG Council of Members and 40 DDES GP Practices
- Patient Reference Groups
- Health Networks
- Area Actions Partnerships
- Durham County Council Public Health
- Health and Well Being Board
- Tees, Esk and Wear Valley NHS Foundation Trust
- North Tees and Hartlepool NHS Foundation Trust
- County Durham and Darlington NHS Foundation Trust

Appendix B – Engagement Documentation

Primary Care Strategy: 2016 – 2018 Refresh

What should Primary Care should look like in the future?

Primary Care Strategy

Following the formation of Durham Dales, Easington and Sedgefield CCG in April 2012 work was undertaken to develop a Primary Care Strategy and Implementation Plan. The 2013 – 2015 Primary Care strategy set out a vision to develop Primary Care in readiness for the ambitions in the Call to Action supporting a total transformation of the NHS to meet the burgeoning demands of patients and the reality that this was unsustainable with a £20 million gap by 2020

In October 2015 the FYFV was published which set out how the values of the NHS have not changed, however the world has. In order to meet these new challenges we are required to take a longer view and, therefore, it is an appropriate time to refresh the Primary Care strategy to ensure that it supports this vision.

We would like your views.

The presentation that you have heard outlines the vision and objectives that the CCG has for Primary Care in 2016 – 2018. However, we would like to hear from you on the following points:-

- Are the Vision and Objectives still current?
- Do you agree with the aspirations in relation to Primary Care?

How can I respond?

If you would like to forward us your views then please complete the attached proforma and return it via email or post to:

NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group

Sharon Gooch
Personal Assistant

Joseph Chandy, Director of Primary Care, Partnerships and Engagement
Gail Linstead, Head of Primary Care, Development and Engagement

Sedgefield Community Hospital
Salters Lane,
Sedgefield,
TS21 3EE
Direct Line: 0191 371 3235
E: sharon.gooch@nhs.net

Primary Care Strategy: 2016 – 2018 Refresh

Engagement Proforma

1. Do you think the vision and objectives need to change? If so what suggestion/ideas do you have?

2. Do you agree with the way forward? Please include any additional suggestions or alternative ideas you may like us to include.