KIRKLEES HEALTH & WELLBEING BOARD
MEETING DATE: 28th April 2016
TITLE OF PAPER: Primary Care Strategy for Greater Huddersfield CCG and for North Kirklees CCG
1. Purpose of paper To present the Primary Care Strategies for Greater Huddersfield and North Kirklees Clinical Commissioning Groups
2. Background These documents are of strategic importance to the Health and Wellbeing Board. The strategies were developed during 2015/16 and have been agreed by the Governing Bodies of the respective organisations. The strategies are now presented to the Health and Wellbeing Board for information.
3. Proposal The Board is asked to note and support the content of the Primary Care Strategies
4. Financial Implications To be identified through the implementation of the strategies
5. Sign off The Primary Care Strategies have been signed off by the Governing Bodies of the respective organisations
6. Next Steps Systems and structures are in place to support the implementation of the Primary Care Strategies in the two CCG areas
7. Recommendations The Health and Wellbeing Board is asked to note receipt of the Primary Care Strategies for Greater Huddersfield and North Kirklees CCGs
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Greater Huddersfield
Clinical Commissioning Group

Greater Huddersfield Primary Care Strategy

Foreword

Dr Steve Ollerton, Clinical Chair, Greater Huddersfield Clinical Commissioning Group

"Tough times never last, but tough people do" quoted Robert Schuller. He had nothing to do with primary care but I like the quote.

I think we can all agree that general practice is under pressure from a number of angles at the moment. We have dwindling resources (money), inequity in provision (for various reasons), recruitment and retention issues and a never ending surge of demand from an ageing population with multiple conditions. We have politicians telling us to work 7 days and providers buckling under pressure which ends up causing us more work. That brings me to another quote from Albert Einstein "insanity is doing the same thing over and over again and expecting different results".

If we want to continue to serve our patients and give them a high quality, timely service then we have to do things differently and we have to be tough. Our CCG is passionate about primary care, especially general practice. We are taking on full delegation from April 2016 and we need to make bold decisions to transform our primary care system. This strategy has been developed through extensive engagement with our patients, practices, federations and other stakeholders. They have told us the "what" and the "how" we should be changing. The "when" is the next 5 years.

General practice cannot undertake this transformation in isolation. We need to work with other primary care colleagues and allied providers e.g. local authority. Let's not forget the patients too - they will need to play their part in ensuring the future sustainability of general practice.

I hope we can all own this strategy and use it to inform our decision making over the coming years. The CCG will do all it can to see it come to fruition but we need our member practices to make it happen.

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1. Case for Change

1.1. Why do we need a primary care strategy?

The central facets of general practice have not changed greatly since the inception of the NHS; whereas other parts of the NHS have seen large-scale change, this has not happened in general practice in the same way. What is clear is that the 'ask' of primary care and specifically of general practice has changed. Primary care has had to take on more responsibility, complexity and roles, often acting as the default provider of all services not seen as within the remit of other services. This has been within the context of growing demand through changing demographics with patients living longer with multiple co-morbidities.

The NHS is facing a challenge as in no other time. The Five Year Forward View makes the case for change nationally, with £22billion of savings expected to be made by 2020. The vision is that new models of care will be developed to deliver this, within which primary care will be central.

The challenge that we face locally and nationally to deliver these new models of care are demand, access, workforce, technology, finance and estates, especially with the national aspiration to 7 day working.

The CCG recognises these challenges and the potential impact it has on the local health economy and community. In order to prepare for these changes we have been developing strategies for primary, secondary and community health services.

From the 1 April 2016 Greater Huddersfield Clinical Commissioning Group (GHCCG) received full delegation to commission general medical services. In real terms this means that the CCG will gain much more influence to shape commissioning locally to support the needs of our population. This will enable us to work with local practices and stakeholders to develop ways of working and the better use of resources so that they will best meet the needs of our patients. This could involve reinvesting the funding from Directed Enhanced Services (DES), locally agreed practice based services and even aspects of the Quality and Outcomes Framework (QOF) into more appropriate, targeted schemes. To achieve this we have and will continue to seek input and involvement from local practices and other stakeholders so that the service that we develop together will work for patients and practices alike.

This strategy will focus on general practice with a view to working with wider primary care and other stakeholders as key partners in development and implementation.

1.2. What does this mean on the ground?

Through sessions we've done over the last 12-18 months, member practices have already told us that doing nothing isn't an option. Doing nothing will mean that:

- The service will become more reactive to crisis management
- There will be an increase in variation
- There will be a decrease in patient safety and quality
- Increase in costs (utilisation of locums etc.)
- Increased pressure to the rest of the health care system – particularly secondary care
- Increase in loss of GPs and practice staff
- Practice closures.

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In Greater Huddersfield, the impact of this has already been seen with practices closing and merging, and positive steps have been made by practices in forming federations which enables collaborative working and strengthens the voice of primary care as providers of services. One example to date of successful collaboration amongst practices has been the development of the anti-coagulation service.

Authoritative sources such as the British Medical Association (BMA), the Kings Fund and Nuffield Trust have all reiterated that there needs to be a new model for primary care and that delivery of services on a bigger level ‘primary care at scale’ is the way to do this either through networks, federations or large super practices. Another fundamental is the delivery of care in partnership and integrated with other services. The Care Closer to Home (CC2H) model in Greater Huddersfield has strengthened the approach to delivering services to people in the community but fundamental to the success of this model is integration of primary care with community services. The workforce is finite, so to maximise resources, we will need work to collaboratively and breakdown traditional boundaries between general practice, secondary care, community services, social care, voluntary and community sector and community pharmacy to recognise a patient’s physical, social and mental health needs.

1.3. Enablers

Technology has rapidly developed and is a significant part of our everyday lives, this is expanding into the delivery of health and social care but often in small pockets and limited to certain services. Barriers of different systems and information governance have led to a lack of information sharing to support patient care which needs to be considered and addressed. Working in an integrated way and at scale cannot be fulfilled without easy, secure access to the appropriate patient information held within clinical systems.
We recognise that the workforce challenge is felt keenly across all services and particularly in general practice. A lack of GP trainees, an ageing workforce and the challenges of being a clinician and a business owner pose difficult challenges for the profession.

As a General Practitioner, it is one of, if not the only business model where the chief executive is also the shop floor worker. As the pressures rise in terms of funding (the business) and clinically (as a medical practitioner) the profession is becoming a less desirable one. It is time to identify new roles, allow GPs to deal with the level of complexity they are trained to manage and utilise other practitioners with the skills to assess, diagnose and treat patients with certain conditions where appropriate. GPs will become the clinical leaders or ‘primary care consultants’ of their organisations much as consultants lead multi-disciplinary teams (MDTs) in secondary care.

Estates is another important enabler to the delivery of a new model of primary care, we have some knowledge about the estate in primary care and this is currently being reviewed and updated. We know that much of the estate is not fit to deliver services now and is limiting the potential of delivering new and advanced services in a primary care setting and in some cases even putting a barrier in place to delivering core services.

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2. Stakeholder involvement in development

2.1. How we developed the strategy

As the strategy is centred around general practice and making it fit for a sustainable future, we established a programme structure to support the development of the strategy. This incorporated representatives of the CCG, both federations and the Local Medical Committee (LMC) at Programme Board and working group level. Based on the key areas of challenge and need for development, we established small groups to look at the following areas:

- Core offer
- Advanced offer
- Workforce and workforce development
- Estates
- IT systems and technology
- Engagement

These groups met regularly during the development of the strategy to shape the content and consider and incorporate themes from the feedback from our engagement activities.

2.2. How stakeholder engagement has shaped our strategy

Patients and public

Locally, we have proactively gathered patient and public views about primary care and the wider health and care system through a number of exercises (a full list can be found at Appendix 2). This information has been used to inform the development of this strategy. Some of the key messages that patients and public told us were:

- There needs to be better access to information and advice and better communication through a variety of channels
- Need for better working with other professionals including better knowledge of local voluntary sector and community groups
- Continuity of care is important when the patient has a long-term condition or ongoing need but for one-off needs, patients are happy to see any available clinician
- Better access to GP appointments
- Wider range of services and professionals within practices is desirable
- General practice should provide localised services.
- There is an appetite to expand the use of online booking, Skype and telephone consultations, email and text reminders
- We need to enable patients to care for themselves.

Practice membership

Engagement with, and gaining feedback from, the wider practice membership has been crucial to developing the right strategy for the future which is achievable, sustainable, evidenced and outcome based. Each group considered the feedback that had already been shared over the last 12-18 months through various exercises and meetings such as Practice Protected Time and the Business

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Meeting. This was reflected on in developing the proposals for each area.

Further specific engagement exercises were undertaken and feedback has been incorporated into this strategy (included at Appendix 2).

Wider stakeholders

In addition, we held a session with wider stakeholders to discuss the development of the strategy and where there are interdependencies with primary care within their transformation plans. This supported identifying which areas we need to work on collectively and is reflected within the strategy.

A summary of all the engagement information utilised and the events and sessions held can be found at Appendix 2.

3. Vision

Our vision for this strategy is to create:

'Thriving and progressive general practice with patients at its heart'.

Our mission is all about:

- Patients being able to make appropriate choices and responsible decisions about their health and wellbeing
- Patients being able to expect a high standard and consistent range of primary medical services from every GP practice
- Primary care as a cornerstone of an integrated system of 'out of hospital' care
- Primary care accessible to patients 7 days per week
- An 'enhanced' level of service accessible to all patients as part of our Care Closer to Home model
- Strong and innovative workforce design and use of modern technology
- Education and training opportunities that cultivate professional excellence and high motivation
- A culture which promotes openness, transparency and the ability to make mistakes in a supportive and learning environment
- General practice at the heart of the health and social care system working collectively with partners and the wider community
- Greater Huddersfield being *the* place that clinicians choose to work.

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4. Relationships

Strong relationships are fundamental to the success of this strategy. There is a shared intention to break down traditional silo working and foster effective partnerships. Relationship building is being encouraged and enabled across the health and social care system and local communities.

Through talking to our health and social care partners, we have identified examples of good integrated working, driven by the need to change and work differently to improve patient outcomes and system efficiency. Looking beyond the usual links between community services and secondary care, there is tremendous scope to work with the large numbers of voluntary/third sector organisations, community pharmacy (60 pharmacies in the Greater Huddersfield area), social care, and our 'out of hours' provider (Local Care Direct).

Opportunities to engage local schools and businesses in the promotion of health and wellbeing will champion healthy lifestyle awareness and ill health prevention, with potential to tailor for particular communities and community groups.

Whilst this strategy is focused on general practice, it is being progressed in the context of a much wider primary care service across Greater Huddersfield. Strong messages from our partners signal a shift towards an improved local system:

- We are keen to be involved early in the design phase when changing services
- There are huge opportunities to reduce inefficiency and duplication by working together and differently
- We need to work together to manage the workforce challenge, making sure patients are seen by the right person in the right place (with new opportunities to work with the VCS and community pharmacy)
- Improvement in communication channels will make a huge difference and allow us to work together.

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5. Outcomes and measuring success

Mattering most to the patients and service users we talked to:

I'm seen by the right person at the right time

More of my care happens nearer to home

Me and my carers know how to manage my health and wellbeing

Everyone involved in my care knows my story

During the design of Care Closer to Home, which places primary care at the heart of community services, we worked with groups of patients and service users to understand the outcomes most important to them to achieve.

These outcomes provide the framework for the primary care strategy and measuring success. Whilst the outcomes translate across services, there are some particular priorities for primary care. These are identified in Table 1.

Patients

Table 1

Outcome	Primary care priority	Measure
I'm seen at the right time by the right person	All patients are able to get same day access for urgent needs	% patients with an urgent need receiving same day access / consultation
More of my care happens nearer to home	Unplanned hospital admissions More planned services delivered in a primary care setting	Unplanned admissions (primary care dashboard) % patients accessing planned services in primary care setting
Me and my carers know how to manage my health and wellbeing	Care planning for patients with a long term condition (LTC) All patients understand how to keep themselves healthy	% patients with an emergency care plan to manage exacerbation of their LTC(s) Uptake of vaccinations and immunisations and screening
Everyone involved in my care knows my story	Improve communication and coordination between professionals and carers involved in a patient's care	For patients with a long term condition, Care Plans are reviewed by a MDT at least twice a year or more frequently as required

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Strategy outcomes

In addition to improving outcomes for patients, there are some key outcomes which will also help us to measure the success of our strategy. The key priorities are identified in Table 2 below.

Table 2

Area	Outcome	Measure
Workforce	A strong resilient workforce	Staff survey (satisfaction levels) Vacancy levels in practice
IT	Access to information through technology for clinicians and patients alike	% patients booking appointments online % patients with access to, and viewing, their electronic record
Estates	Multi-purpose community facilities delivering comprehensive services to patients	TBC

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6. Core offer

Definition	The core offer is the basic offer that every patient registered with a practice in Greater Huddersfield should expect from their practice. All practices will be required to provide the core offer and meet the minimum standards agreed.
Where are we now?	There is currently an inconsistency of access, provision and quality within general practice and limited description of the expectations of the core offer articulated by current contracts.
What are we trying to achieve?	Ensure people know what to expect from general practice and clarify expectations. Ensure there is good access and high quality of service. Define minimum standards of provision. Encourage and facilitate appropriate use of services by patients.
Vision	Access to and provision of high quality general practice services to every patient registered with a practice in Greater Huddersfield.

We know from talking to patients and professionals that there is still inequity of service provision for core GP services. In order to create sustainable general practice for the future, we need to create and implement some core standards and principles that patients are able to understand.

The GMS contract provides an outline of the core services all practices are expected to deliver but does not identify standards in detail which has led to differing interpretation of what is 'reasonable'. In defining the core offer, the CCG is not seeking to expand the core offer, rather provide a local agreed interpretation of those areas not defined in the GMS contract.

Some of the key principles and standards include:

- Promote self-management and patient education with patients
- Minimum scheduled appointment time for a routine GP appointment will be 10 minutes – this should support preventative and person-centred approaches
- Continuity of care where possible for both patients and clinicians
- All patients with an identified long-term condition (see appendix 3 for full list) will have a mutually agreed care plan in place where a patient agrees to take part in developing the care plan
- Personal development and an active appraisal system for staff will be provided by the practice
- Patient experience and feedback should be sought and acted upon
- All practices will have an effective patient reference group

A full list of the key standards and principles can be found at Appendix 3.

One of the most prevalent issues facing patients in primary care is the inequity of access to services. We know that the impact of this is to put pressure on other parts of the system, when patients cannot access a timely appointment within primary care, they are more likely to seek alternatives such as out of hours GP and attending local A&E services when their need would have been much better met by their local GP service.

In order to try to bring some consistency to access and provision of information, the following key requirements and standards have been identified as part of the core offer (a full list can be found at Appendix 3):

- Every practice should ensure clinical advice is available for all their registered patients from 8am - 6.30pm
- Access to same day requests, where appropriate, must be available and addressed for patients contacting the practice between 8.30am – 6pm on that day (this will be access to an appropriate clinician but will not necessarily mean a face-to-face appointment)
- Online access should be available and actively promoted for appointments and prescriptions
- All practices must offer telephone consultation / appointments
- All practices must have a regularly updated website with information sources for patients to access
- Unplanned routine appointments e.g. back pain / minor infection will be provided within 5 working days (this is with an appropriate clinician as determined by the practice)
- Planned routine appointments e.g. reviews are not subject to minimum timescales and should be made as appropriate for the individual patient
- All practices will enable, and promote to their patients, electronic access to their records (Patient Online).

Case Study: Self-management of coeliac disease

An increasing number of people are being diagnosed with coeliac disease and, for people who are diagnosed; knowing how to keep themselves healthy with the right food choices is an important issue. Greater Huddersfield CCG worked with the Coeliac Society and students from Huddersfield University to produce podcasts which support people who are newly diagnosed to make the choices that are best for their health. By filming in local supermarkets and restaurants, the choices available were easy to demonstrate in a format that was simple and reassuring. This is one example of using technology to support people to learn more about how to look after their health.

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Funding

Core services are those which are defined within the GMS contract and will therefore be delivered through the payment made through the core contract, based on the registered list.

6.1. Support mechanisms

Whilst the CCG is able to influence locally decisions about the commissioning of primary care through full delegation from April 2016, it will not have the power to change or enforce breaches of the national GMS contract.

However, it is fundamental that all practices meet the core requirements over the lifetime of the strategy to ensure that patients get the services they need. Some practices have demonstrated and told us that they are already fulfilling all of these requirements and meeting these standards, however, we know that this is not the case for all practices and as such, the CCG will support these practices to meet the standards through the provision of:

- Learning and best practice from other practices and projects such as Breaking the Cycle
- Toolkit and resources
- Hands on support from personnel within the CCG.

Local federations have told us they are committed to providing peer support to their members to drive quality of primary care within Greater Huddersfield.

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Case Study: Patient Online accelerator site

The patient’s perspective

Adam was one of the first patients to trial the use of patient online.

Adam registered as a patient at the University Practice over 20 years ago when he first attended Huddersfield University. Over the years, Adam has had regular contact with the practice. ‘Practice staff have taken good care of me and my family, from help when my partner and I had our child 11 years ago, to more regular care since I was diagnosed with type 2 diabetes three years ago.’

‘I find it much easier to book and even cancel appointments online. It’s so easy to log on via the app on my phone or on my computer and book an appointment when I need it. Ordering repeat prescriptions online also saves me a lot of time. If I realise I’m running low and the practice is closed on the Saturday, all I do is log on, request the relevant medication from the drop down list and then pick it up a few days later.’

Had these services changed the nature of his consultations with his GP? ‘Absolutely! I realise my GP’s time is precious therefore when I expect my blood test results to be in; I book an appointment for the week after. Once the result is in, I check it against past results and I check the notes of my last consultation to remind myself what was said. This results in me and my GP having a far more productive meeting as I am more prepared and I’m able to ask relevant questions.’

Would Adam recommend other patients to register for online record access? ‘I certainly would. I can see appointments and repeat prescription ordering being really useful for most patients and record access useful for those, like me, who need to have more regular contact with their GP. In fact, I’ve already signed up my partner and my 11 year old son!’

The GP’s perspective

The GP involved in the pilot, Dr Littlewood, was initially reluctant to share online test results and records with his patients but is now very much in favour.

‘At first I was quite nervous about the prospect of patients accessing information that they may not understand, or that they may find upsetting. This all changed when one of my diabetic patients signed up for access. Almost immediately, I could see a positive change. My patient started preparing ahead of his consultation by accessing his latest test results and comparing them to past results. This has meant the 10 minutes we get together is very productive. 10 months down the line, I am even seeing this patient’s diabetic controls are improving.’

7. Core plus offer

Definition	The core plus offer should be available to all patients on a registered list but this may be delivered through formal arrangements with other providers within the patient's own practice.
Where are we now?	There is currently an inconsistency of access, provision and quality of services beyond a basic 'core' offer. Not all of our current enhanced schemes work for practices or provide good outcomes for patients.
What are we trying to achieve?	Ensuring good access to additional services beyond the basic core offer. Ensuring that access to these services is available within a patient's own practice and therefore equitable.
Vision	Patients in Greater Huddersfield will have equitable access to a range of additional services at their practice. This may be delivered in collaboration with other providers.

Existing enhanced services are variable in the impact they make on local populations, practices have told us that some schemes do not benefit local patients or work for practices.

Through the opportunities afforded by holding full delegated authority for commissioning general medical services, the current local practice based services and DES schemes will be reviewed and a new 'core plus' offer identified which will support local priorities and benefit patients.

A list of potential core plus services can be found at Appendix 3.

Funding

Core plus services will come with an additional funding stream to enable delivery of these services.

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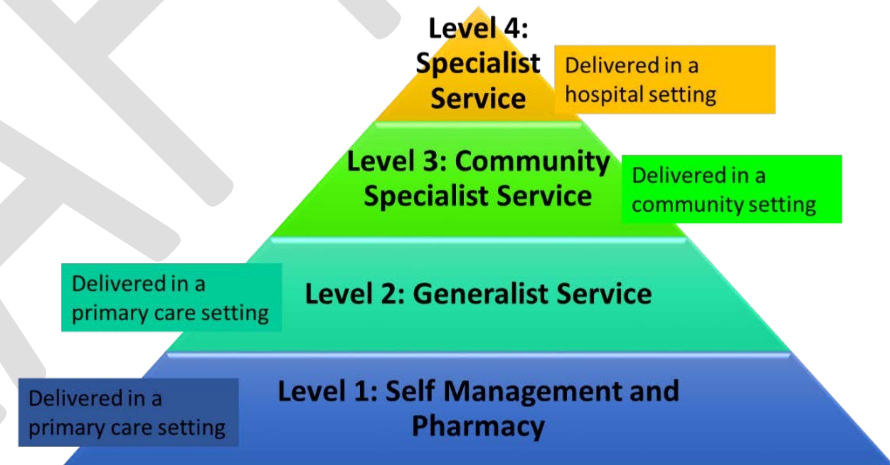
8. Advanced offer

Definition	The advanced offer is composed of services which will be available to all patients in Greater Huddersfield in a primary care setting. There is no expectation of practices to deliver these services, this is optional.
Where are we now?	There is an under-utilisation of skills in primary care and a large number of low-skilled low-tech interventions are taking place in secondary care which could otherwise be delivered in primary care. There are some existing examples of practices collaborating to deliver advanced services to patients in a primary care setting.
What are we trying to achieve?	Ensuring services are utilised appropriately and that patients can access appropriate services in primary care wherever possible.
Vision	Patients in Greater Huddersfield will have access to a wide-range of services closer to home in a primary care setting which are currently delivered in secondary care. This will be delivered through collaboration and partnerships between practices and other providers.

The movement of planned services out of a hospital setting and into a community setting is in line with the aspirations for Care Closer to Home and as part of the acute hospital reconfiguration programme. It is intended that by 2020 the majority of tier 1-3 planned services will be delivered in a primary care setting where this is clinically appropriate, with collective working between professionals across primary, community and secondary care. Only specialist services will continue to be delivered in a hospital setting. In addition, there is opportunity to move some of these specialist services out into community with a movement of specialist staff from secondary care.



There are a number of services already delivered collaboratively and in a primary care setting, including the anti-coagulation service and the winter scheme to offer additional urgent appointments at weekends and over bank holidays working in hubs across Greater Huddersfield. A potential list of services which could be delivered in

a primary care setting is included at Appendix 3. It is proposed that these are commissioned and rolled out in a phased way.

Funding

Advanced services will come with an allocated funding stream to deliver the service to patients in Greater Huddersfield, not to a registered list.

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9. Workforce

Where are we now?	There is a national and local workforce challenge. GPs are in short supply and a large proportion of the nursing and practice management and support function workforce are approaching retirement. There are excellent staff within primary care but demand is rising, presenting a challenge to morale and retention of the current workforce.
What are we trying to achieve?	We aim to create a sustainable, engaged workforce to deliver a new offer in primary care including supporting patients to manage their own conditions, working efficiently whilst retaining a personal service for patients.
Vision	Greater Huddersfield will be seen as a place of choice to work, providing excellent opportunities to train, develop skills and for career progression for all roles, clinical and non-clinical. General practice will be driven by sustainable and efficient multi-disciplinary teams, led by GPs; ensuring patients receive high quality services delivered at the right time, by the right professional.

Our focus for workforce and workforce development is:

- **Training the future workforce**

Engagement with practices identified that training and development opportunities are fundamental to the retention of existing staff and attracting new staff, making Huddersfield an attractive place to work. We will work with all ages of children and young people to offer work tasters and work experience within primary care and open the option of primary care as a career within a multitude of roles.

We know that attracting nursing staff in particular to primary care has been limited through the lack of pre-registration opportunities for new trainees before they undertake their training. We can quickly address this working with Huddersfield University and local practices to offer placements and to train nursing staff and Allied Health Professionals (AHPs) within practice as mentors to provide the required mentorship for this scheme. This will in turn provide professional development for those staff trained as mentors.

Fundamental to training the current and new workforce is to deliver lifelong learning and succession planning with opportunities to develop at all levels within primary care supported by proactive talent management. Through collaborative working, there is an opportunity for clinicians with different expertise to work across practices and develop enhanced skills in specific specialisms, creating professional development opportunities for staff, a wider-range of services for patients and efficiency for practices.

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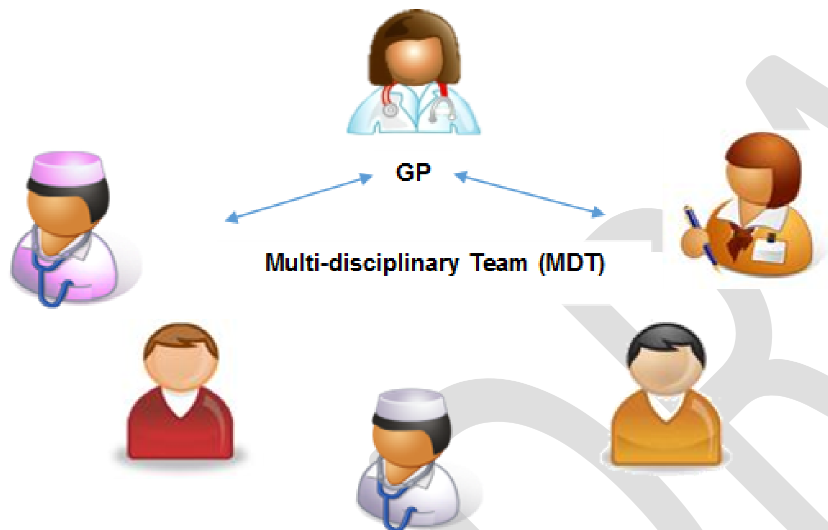
- **GP as the 'primary care consultant'**

A fundamental shift will be the role of the GP to one of a 'Primary Care Consultant' acting as a hospital consultant does, coordinating a team of professionals to deliver care to patients, offering clinical leadership and oversight to the team whilst seeing the most complex patients and retaining overall accountability for the care of patients as the accountable lead clinician.



In order to facilitate this, the workforce will expand to include new roles, some of which have already successfully been piloted in Greater Huddersfield (including pharmacists and OTs) creating capacity for GPs to undertake this role and deal with the more complex clinical interventions. Some of these roles are already embedded within other services delivered by partners such as Care Closer to Home, community pharmacy and voluntary and community sector and require closer working with these services to deliver services in a smarter way and achieve better outcomes for patients, ensuring they are seen by the right person at the right time. In other areas this may be specific recruitment of new roles as alternatives to existing roles, particularly where there are recruitment pressures.

Case Study: Occupational Therapists in primary care

Is there a role for Occupational Therapy in Primary Care?

Could OT reduce the number of contacts/frequent attenders to GPs?

Working with University of Huddersfield and two local GP practices, a 70 hour project has looked at these questions. A client group was identified that met the following criteria:

- Over 65
- More than 75 GP contacts per year
- Anxious, isolated, with health conditions impacting on role function and independence.

The pilot project found that:

- There was a clinical role for OT maximising the unique dual training in physical and mental health
- The service was not commissioned elsewhere or duplicating with other roles as these patients' needs were not severe enough to meet the criteria for secondary care or community services
- If OT intervention reduced these attendances by one-third over the year there would be savings to

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- **Upskilling everyone**

The focus for primary care is to deliver more wide-range and complex services and manage the increasing demand for traditional services in general practice. There is a recognition by practices locally that many services and interventions are delivered by inappropriately qualified levels of staff for example, patients assessed by a GP who could be better seen by a nurse, Allied Health Professional or pharmacist or patients seen by a qualified member of staff who could be seen by a Health Care Assistant with the right skills and training.

By utilising a competency framework and upskilling staff, it ensures that patients are seen by the most appropriate professional and therefore achieve the right outcomes, capacity is created at the higher levels of qualification and professional, delivering a lower cost-base and creating time for senior clinical staff to lead, mentor and supervise the team and supporting personal development.

This will be supported by ensuring training and development opportunities are available for all roles and levels of staff within primary care and through working with local educational institutions to support learning throughout everyone’s career.

It is important to recognise that this approach is inclusive of the wide-range of non-clinical roles within general practice. Practices, particularly our practice managers, have articulated a vision for the future management of general practice in which back-office and administrative functions are shared across practices to deliver economies of scale; requiring consistency of processes across these groups of practices. Operating at scale will also create opportunity for progression and demand for new roles within general practice including business and operations managers to manage integrated Human Resources, payroll and Organizational Development functions. This must be considered when identifying training and development needs.

- **Self-management and patient education**

Self-management is an over-arching ethos of this primary care strategy and fundamental to the core offer. Every professional should be considering how their involvement is enabling a patient to live as independent a life as possible. For the workforce, there will be a culture shift required to ensure that primary care professionals are embedding an ethos of self-management with patients and that this is reinforced at every level. This must be reinforced through training at all levels.

In addition, there will be a need to ensure patients understand that they do not always necessarily need to see a GP and understanding who is the best professional to meet their needs. The findings of the ‘Breaking the Cycle’ project (see Appendix 1) demonstrated that utilisation rates of roles other than the GP are significantly lower with patients still defaulting to the need to see a GP.

Underpinning this is a focus on reducing duplication with other professionals and making efficiencies within current roles and processes alongside a focus on patient education.

Funding

The funding for workforce and for training sits in a number of places; specifically with Health Education Yorkshire and Humber, the Deanery and within individual practice budgets. Practices have already indicated that there may be some opportunities to support

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recruitment and training through collaboration and joining of resources between practices. The CCG will support this process and provide a central role in supporting development of initiatives such as the mentorship scheme and ensuring CCG funded training offered via forums such as PPT is targeted to support the priorities within this strategy. The CCG will also look to provide support to schemes which support workforce redesign and development in primary care e.g. the recent OT in primary care pilot, and work with Health Education Yorkshire & Humber and local educational institutions to support the creation of a workforce fit for the future.

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10. Information management and technology

Where are we now?	In primary care, technology is not currently being maximised and there is often scepticism or low levels of utilisation of technology. It is often as seen as an additional burden rather than an enabler. Sharing of records is limited by multiple clinical systems and the current equipment and infrastructure is not always of the required standard to allow use of the available innovations.
What are we trying to achieve?	We want to utilise the systems and technology available to us to maximise efficiency in primary care. We will ensure the foundations are laid through provision of appropriate infrastructure and equipment, training, a shared repository for information and support to migrate all practices to SystmOne. We will utilise these foundations and technological innovation to support patient care and communication with patients and other professionals.
Vision	Primary care will maximise the use of information management and technology where this directly supports patient care and allows clinicians in primary care to work more efficiently and effectively.

Technology and systems are a huge part of the healthcare system and a focus for the NHS with the challenge for health and social care systems to become paperless by 2020.

There are some challenges to maximising the use of technology within general practice, however, where developments maximise benefits for patients, practices in Greater Huddersfield have embraced this; we are the national leader in facilitating access to Patient Online. There are five strands to our strategy relating to IT and technology:

- A shared care record underpinned by a single clinical system for general practice
- Infrastructure and equipment
- Training and support
- Patient facing technology
- Shared resources and repository

The diagram (diagram 1) below outlines our vision for IT and technology developments by 2020.

The pace at which technological developments occur must be taken into account and this is one area of the strategy which will require frequent review to ensure it takes account of the developments of the time e.g. cloud based technology, connectivity, security and encryption, and shared portals.

Access to clinical records across professionals is a national and local issue with many systems looking at different ways to tackle the problem. With further collaboration and integration, the need for visibility of patient information is crucial in order to be efficient and effective and manage clinical risk appropriately. Currently across

Greater Huddersfield we have 23 practices using SystmOne and 14 practices using EMIS as their clinical system, with a number of EMIS practices discussing migration; the next due to take place in July 2016. In addition a number of the key partner providers use SystmOne in the local area (including Locala, Kirkwood Hospice, and Local Care Direct as well as other partners using SystmOne viewer). We have reviewed options for system integration including portal solutions and believe that whilst this technology will develop in the long-term, it will not provide the level of visibility and functionality required to give us the most benefit in primary care.

Practices have the option to choose their clinical system under the core contract and this choice will remain. However, the majority of practices (75%) told us that having all General Practices on one clinical system would be beneficial to the whole health and social care system. Our partners have also reflected this as beneficial to integrated and collaborative working.

The benefits of doing this for the system and at a practice level have been outlined below (diagram 2). Whilst practices can continue to choose their clinical system, the CCG will support practices wishing to migrate to SystmOne to do so through project management, training and implementation support. There is funding available through our current budget to migrate practices from EMIS to SystmOne and we have learned valuable lessons from practices which have made the transition recently which can help make the process as smooth as possible with the right support offer.

In support of moving towards a shared care record, we will work to integrate with secondary care systems (EPR).

Funding

The CCG has a budget to support information management and technology for general practice which covers equipment, infrastructure, training and other resources. It is clear that some of the aspirations for this strategy will require further investment (e.g. mobile working) and we will continue to seek funding opportunities nationally to support our ambition (e.g. to submit bids for capital and national discussions on converting capital available for technology into revenue streams).

Practices have told us that training and support is fundamental to the best use of IT and clinical systems and there is a commitment to ensuring that this is implemented. To support the strategic intent, the CCG will only provide ongoing IT educational support for SystmOne. Training must be systematic and continuous to gain the maximum benefit.

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Diagram 1 – Vision for information management and technology

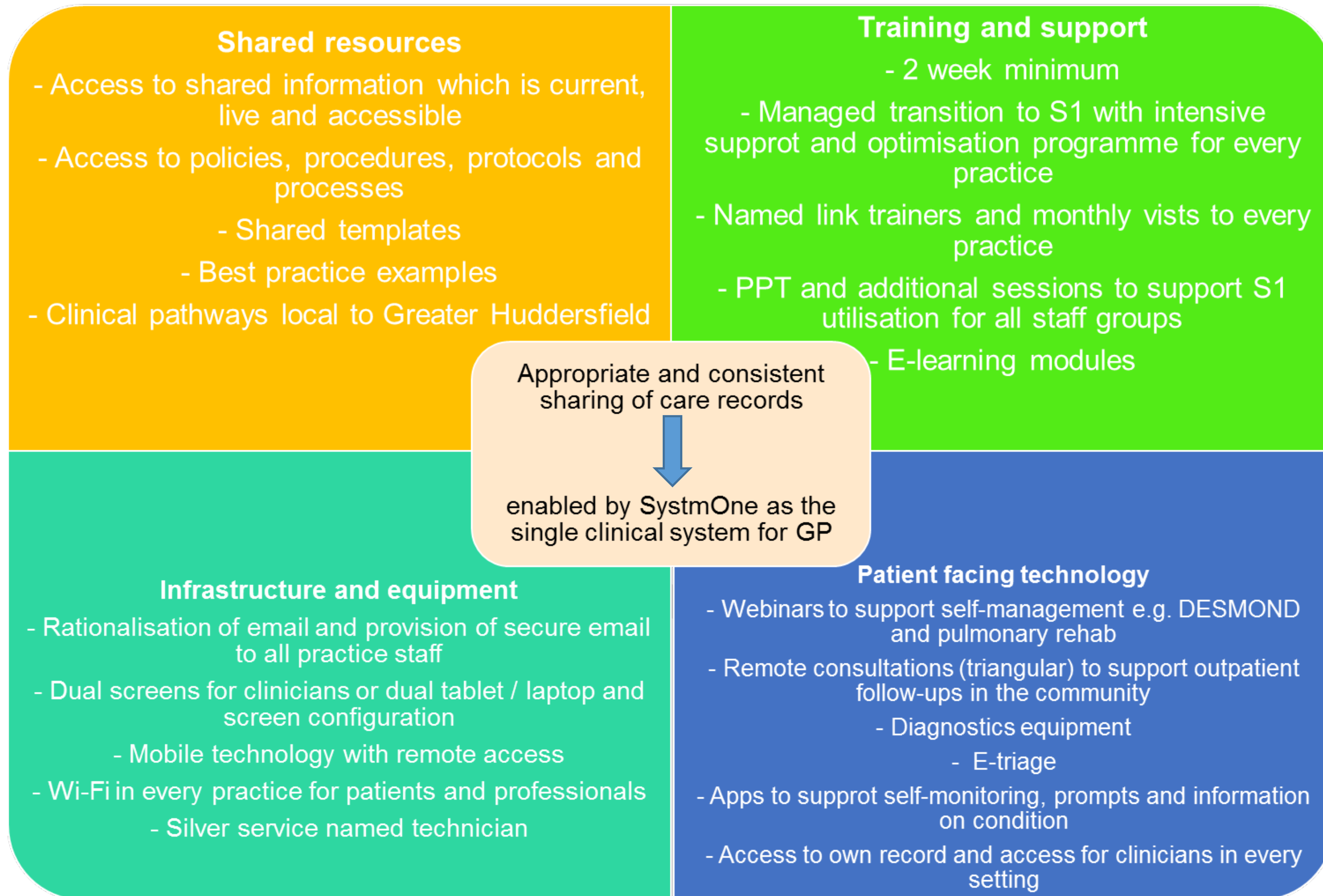

Diagram 2 - Benefits of all practices moving to SystmOne

Cashable benefits – CCG / system	**Cashable benefits – Practice**
• Recurrent cost savings through running one system e.g. 'spoke' servers for EMIS which can be reinvested into other areas e.g. training • Reduction in costs associated with supporting two systems	• Some 'extras' such as self check-in for EMIS are an additional cost for practices (this would not be a cost for S1) • Using same system as community provider has shown to increase QOF points and financial reward • Removal of costs for back-ups for EMIS
Non-cashable benefits – CCG / system • Increased visibility of clinical records across providers (efficiency and clinical safety) Locala, Kirkwood Hospice, LCD all using S1 – CHFT, SWYFT and Barnsley FT also using S1 clinical record viewer • Supports more integrated working across providers and practices • A single system will support the national requirement to be paperless by 2020 • A single system will enable consistent reporting ensuring better information about the activity and demand in primary care (and better data quality support) and make contract monitoring seamless	**Non-cashable benefits – Practice** • Time-releasing benefits* – using one system, the CCG could support practices by running reports centrally rather than required at practice level • Time-releasing – CCG could centrally support the development of templates and protocols for use by practices • Ability to view interventions of other providers e.g. community, hospice, specialist nurses, MSK and prison service • Ability to work better with other providers and practices collaboratively e.g. hub working to support provision ***NB – time-releasing benefits may be converted to cashable benefits**

11. Estates

Where are we now?	In a number of cases the current estate is not fit for purpose to deliver core essential services and will limit the ability to provide any additional services. There is inequity in the estate which patients access, with some receiving services in purpose-built state of the art facilities whilst others utilise premises of limited size and quality. Some of our estate is not sustainable for future use.
What are we trying to achieve?	We are aiming to ensure that primary care estate is sustainable and from that create a portfolio of estate within the community which meets the needs of patients and fulfils our ambition for general practice in the future.
Vision	We will deliver a primary care estate which is fit for the future, geographically coherent and efficiently-funded.

The CCG has recently completed a strategic estates plan and this has been reviewed to ensure that it responds to the requirements of the full primary care strategy.

In order to appropriately plan our estate, this requires a much longer-term view beyond the next 5 years and operating within the constraints of limited budgets and revenue funding streams to support capital investment.

Our ambition for primary care estate is the following:

- Sustainable, efficient primary care estate in the right place
- A 21st century estate, featuring a new health centre to serve central Huddersfield, funded in the most efficient way, serving the needs of communities with a blend of hospital care and care closer to home
- Prioritised estate development according to greatest need
- Access to a large range of shared, community facilities – enabling integrated activities (including third sector, social care and mental health) to take place as locally as possible
- A network of appropriately located, functionally-suitable GP and community based premises – ensuring that all areas of the community are equitably served – based on need
- A number of appropriately located, functionally suitable health centres/large community clinics (treatment centres) – providing appropriate settings for specialist community based services
- That the Primary Care estate is regarded as a community asset. All sorts of wellbeing related activities are coordinated on behalf of the community. A diverse range of services, medical and non-medical are delivered from these community delivery points.

We are not currently utilising estate to maximum efficiency. For example, we have small practices in close proximity using estate which is not fit for purpose to support provision of core services. There are opportunities such as new shared premises which will

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offer more efficient use of better estate for patients and the system and rationalisation of premises over time to improve the overall quality of the primary care estate.

To support the strategy in the movement of services from secondary care to primary care, and the need for greater collaboration with other practices and partners to deliver these services in a more integrated way, our estate will need to be big enough and well-enough equipped to deliver these services.

Our first priority is the completion and review of the six facet survey which will give an up-to-date view of the current primary care estate. There is then the potential to work with other local providers to review our collective estate and identify opportunities for collective working and rationalisation.

GP infrastructure funding

The CCG will need to access the GP infrastructure fund available from central government to support development of estate in line with this primary care strategy. The CCG will establish a structure which will ensure all bids and approvals are in line with the ambitions and principles outlined in this strategy and the information on the current primary care estate will inform the prioritisation process.

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12. Communication and Engagement

Fundamental to successful implementation of this strategy will be engagement with member practices, our partner organisations and patients and carers.

12.1. Practice membership

Member practices have been engaged throughout the development of the strategy and this strategy addresses specific themes that have been highlighted. A summary of the feedback gained throughout the development of the strategy has been made available to all practices on the CCG’s intranet. The practice membership is vital to the successful implementation of the strategy and a full communications and engagement plan will be developed to support this process.

Practices have told us that they access the intranet but this resource is not utilised to its full potential. We can improve this quickly by sharing more information through the intranet (linked to the IM&T objective to create a shared repository for practices) and highlighting new resources and information through our e-newsletter - “40fied”.

Moving into implementation of the strategy, there will be opportunities for practices to stay up to date with and to contribute through the following mechanisms:

- Involvement in work streams and task and finish groups (once these are established for implementation)
- Engagement as more detailed plans develop for each area and the opportunity to shape these
- Regular intranet and 40fied updates
- Designated sessions at Business Meeting and Practice Protected Time.

12.2. Wider stakeholders

Building on the initial engagement with partner organisations during the development of the strategy, our approach to implementation will be to review and agree programme governance for implementation and widen the membership of work stream groups and establish task and finish groups with representation from partners where there is opportunity for joint development and implementation.

We will also continue to work with partners on a regional level through the development of the Sustainability and Transformation Plan (STP), our Healthy Futures priorities and the Urgent and Emergency Care Vanguard programme. All of these regional initiatives will have implications and important roles for primary care; we will ensure that these are aligned with, and supportive of, this strategy for primary care in Greater Huddersfield.

12.3. Patients and carers

Patients and carers will continue to be involved and engaged through the Patient Reference Group Network and other patient and community groups and forums. We will share our strategy in the public domain and identify where patients and carers can support us with the development of detailed plans and priorities during implementation.

We will continue to have active involvement with patient groups to understand how overall access, use and experience of primary care services is impacted by the implementation of the strategy. Patient

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and carer feedback will be crucial to assessing whether the strategy has met the outcomes identified.

13. Commissioning and contracting

13.1. Impact of full delegation

The CCG received full delegated commissioning for general medical services from NHS England at 1 April 2016. This brings with it, responsibility for the following functions:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action, such as issuing branch/remedial notices, and removing a contract)
- Newly designed enhanced services (local practice based services and DES)
- Design of local incentive schemes as an alternative to QOF
- Ability to establish new GP practices in an area
- Approving practice mergers
- Making decisions on ‘discretionary’ payments (e.g. returner/retainer schemes)
- CCGs also have the option to pool commissioning and GMS/PMS funding for investment in primary care services

Full delegation requires the creation of a ‘primary care commissioning committee’ to oversee the exercise of delegated functions. This will be similar composition to the Joint Commissioning Committee in operation during 2015/16 with GP representatives from the Governing body, lay members, and open invitation to the LMC to attend these committee meetings.

13.2. Commissioning, contracting and procurement

The core offer will have no impact on current contractual arrangements as the existing contracts will still provide the framework for delivery of core services.

The core plus offer will redefine the current enhanced services and fund local priorities for these schemes which will have attached funding streams. These will largely be delivered to a registered list population so will unlikely require a procurement approach although each will be assessed on a case by case basis. This will be managed through the governance structure to support full delegated commissioning responsibility.

The advanced offer is predicated on delivery of services in a primary care setting to the whole population of Greater Huddersfield and not linked to the registered list. As such, each service will require review to determine the procurement approach required. The phasing of services will be determined through feasibility / market testing where required and timelines linked to decommissioning services where required.

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14. Market development

There are currently 37 practices in Greater Huddersfield of which 30 are currently represented by one of two GP Federations in the area. Fundamental to the implementation of the strategy and vision and aspirations for primary care within Greater Huddersfield is the ability of a strong primary care provider market to respond at a practice level and more widely as a group of practices or part of a federation. We want to create a market which encourages and enables practitioners and service providers to innovate and work collaboratively.

Our partners have told us clearly that in order to work together, better, smarter and in a more integrated way, economy of scale is crucial. These organisations (large and small) cannot work in 37 different ways with 37 different practices, there is a critical mass which will enable change and thus a mechanism to engage with general practice collectively is required.

A key theme of the engagement work with practices has been the identification of collaboration between practices as the vehicle for change and the mechanism to deliver the vision for primary care.

Any new models of care discussed locally will heavily involve wider primary care and primary care will need the leadership and a strong unified voice to be a partner in this process.

The CCG will provide support to develop the primary care provider market, including strengthening the voice of collaborative general practice through facilitation of federation development.

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Appendix 1 - Case for Change

National Policy and drivers

The NHS Mandate

The Mandate renews the focus on improving patient outcomes and reducing health inequalities.

The NHS Constitution

The NHS constitution sets out principles for what patients can expect from the NHS and what the NHS can expect from patients.

The NHS Outcomes Framework

The indicators in the NHS Outcomes Framework are grouped around five domains:
Domain 1 Preventing people from dying prematurely;
Domain 2 Enhancing quality of life for people with long-term conditions;
Domain 3 Helping people to recover from episodes of ill health or following injury;
Domain 4 Ensuring that people have a positive experience of care; and
Domain 5 Treating and caring for people in a safe environment; and protecting them from avoidable harm.

For each domain, there are a small number of over-arching indicators followed by a number of improvement areas.

Everyone Counts: Planning for Patients 2014/15 to 2018/19

The five offers as set out in NHS England's planning framework 'Everyone Counts:
Offer 1 NHS Services, Seven Days a Week;
Offer 2 More Transparency, More Choice;
Offer 3 Listening to Patients and Increasing their Participation;
Offer 4 Better Data, Informed Commissioning, Driving Improved Outcomes; and
Offer 5 Higher Standards, Safer Care.

GP Contract

The GP contract 2015-2016 for England has been negotiated and agreed between the BMA general practitioners committee (GPC) and NHS Employers on behalf of NHS England. Changes to the current GP contract will be implemented over the lifespan of this strategy. Any change or increased flexibility should be fully utilised to help bring about the strategic change that is needed.

Five Year Forward View

Outlines the vision for new models of care, introducing the concept of vertical and horizontal integration models including primary care – Primary and Acute Care Systems and Multi-specialty Community Providers.

New deal for general practice

The Secretary of State described commitments to general practice linked to the Five Year Forward View on: a) workforce, b) infrastructure, c), reducing bureaucracy, d) helping to support struggling practices. He also outlined plans to review the way quality of care is assessed in general practice. In return he is asking GPs to work towards:

- Offering appointments seven days a week

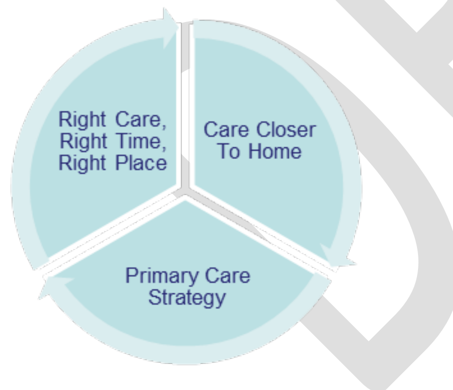
- Assuming social prescribing responsibilities
- Playing a more prominent role in public health
- Taking 'real clinical responsibility' for patients.

Local drivers

Transformation

Locally, Greater Huddersfield is undertaking three major transformation programmes, of which the primary care strategy forms one pillar with Care Closer to Home changing the way community services is delivered following the procurement of a lead provider and Right Care, Right Time, Right Place, currently at formal consultation stage on how hospital services will be reconfigured and provided in Greater Huddersfield.

It is recognised that all of these programmes are interdependent, if one of these fails to achieve its vision, goals and the required sustainability; all three will fail.



Care Closer to Home identified a vision for a community service wrapped around GP practice, supporting patients through locality teams. Close working between primary care and community services is essential to deliver outcomes for patients and support more care out of hospital settings.

Right Care, Right Time, Right Place focuses on reconfiguration of local hospital services of which several factors will impact upon primary care:

- Delivery of more planned services in a primary care / community setting
- Role of primary care in ensuring unnecessary attendances and admissions to hospital are avoided
- Role of primary care workforce in supporting the proposed Urgent Care Centres.

Workforce

The national workforce challenge within healthcare and primary care is well documented; in Greater Huddersfield the challenges are no different. We know that:

- 7% GPs in Greater Huddersfield are due to retire / leave general practice in the next 12 months (8-9 that we are aware of)
- 21% practice nursing workforce are at risk of retirement (55+) (see graph 1)
- 30% practice management / non-clinical staff are at risk of retirement (see graph 2)

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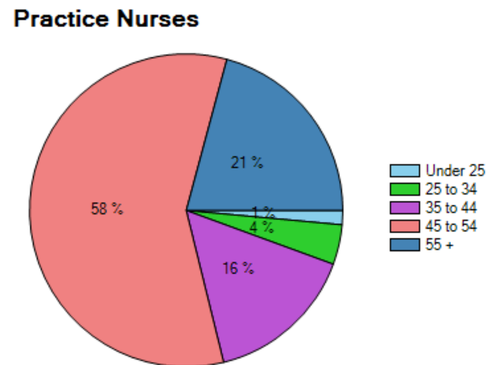
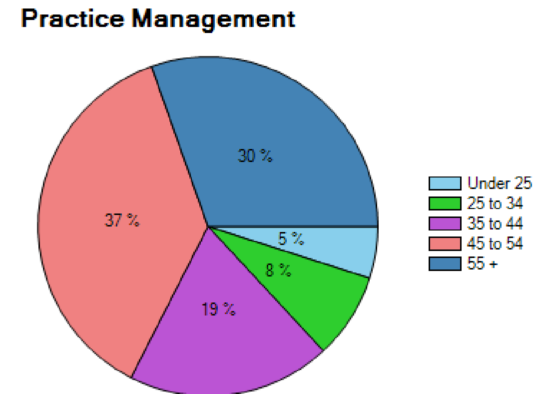
- Health Education Yorkshire and Humber is concerned about workforce supply – not just GPs but also nursing staff and wider roles.

Graph 1 - Age profile Practice Nurses in Greater Huddersfield, Health Education Yorkshire & Humber



Graph 2 - Age profile Practice Management in Greater Huddersfield, Health Education Yorkshire & Humber



Finances

Locally, 22 of the 37 practices in Greater Huddersfield are on a PMS contract, currently under review. This is posing some of these practices with a significant financial challenge, whilst other GMS practices are being impacted by the removal of funding through the Minimum Practice Income Guarantee (MPIG).

Demand, activity and process

There is limited data and information available on the demand and capacity within primary care. During ‘Breaking the Cycle’ undertaken over three separate 5 day periods during 2015, 32 practices took part in an exercise with partners to look at new ways of working. A full analysis is underway but some key information has been taken from this exercise:

- Over the 5 day period 26 practices received 20,903 telephone contacts
- Approx. 50% were appointment requests

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- Across 23 practices there were 3,456 requests for urgent appointments
- There is under-utilisation of appointments of some categories of health professional including practice nurses and health care assistants (see Table 3 below)
- Access to specialist opinions need to be rapid and reliable or the system backs up
- Cross-organisational appointment scheduling would be useful
- Real time information matters
- Soon but not urgent approach could help patients and YAS dispatchers
- A very small number of patients receiving a home visit go on to hospital showing the positive impact of clinicians in keeping people at home
- Utilisation of online booking is extremely low (1.1%) and resulting in a huge amount of time booking appointments by administrative staff
- Practices are willing to innovate and try new ways of working
- There is still inefficiency in process which is impacting on outcomes for patients which can be improved.

	Available	Booked	DNA	Utilisations	DNA%
GP/s	4681	3959	152	85%	4%
Advanced Nurse Practitioner	1220	1011	28	83%	3%
Practice Nurse	1781	988	103	55%	10%
Health Care Assistant	1061	368	48	35%	13%
Phlebotomist	281	63	9	22%	14%
Telephone Appointments	71	62	0	87%	
Midwife	40	20	3	50%	15%
FY1	20	20	2	100%	10%
Midwife:	18	16	0	89%	0%
Antenatal	16	13	0	81%	0%
Minor Surgery:	12	12	0	100%	0%
Counsellors:	12	11	0	92%	0%
Registrar	11	10	1	91%	10%
Health Visitor	11	7	0	64%	0%
Other - Shared Care	4	7	2	175%	29%
Other - Child/Minor Ailment	104	0	2	0%	
ENT Outreach Clinic:	7	0	0	0%	
Urology Outreach Clinic:	10	0	0	0%	
Other - Midwife	1	0	1	0%	
Other - OSDC	1	0	2	0%	
Grand Total	9362	6567	353		

Table 3 - Appointment utilisation rates by role

Appendix 2 - Engagement

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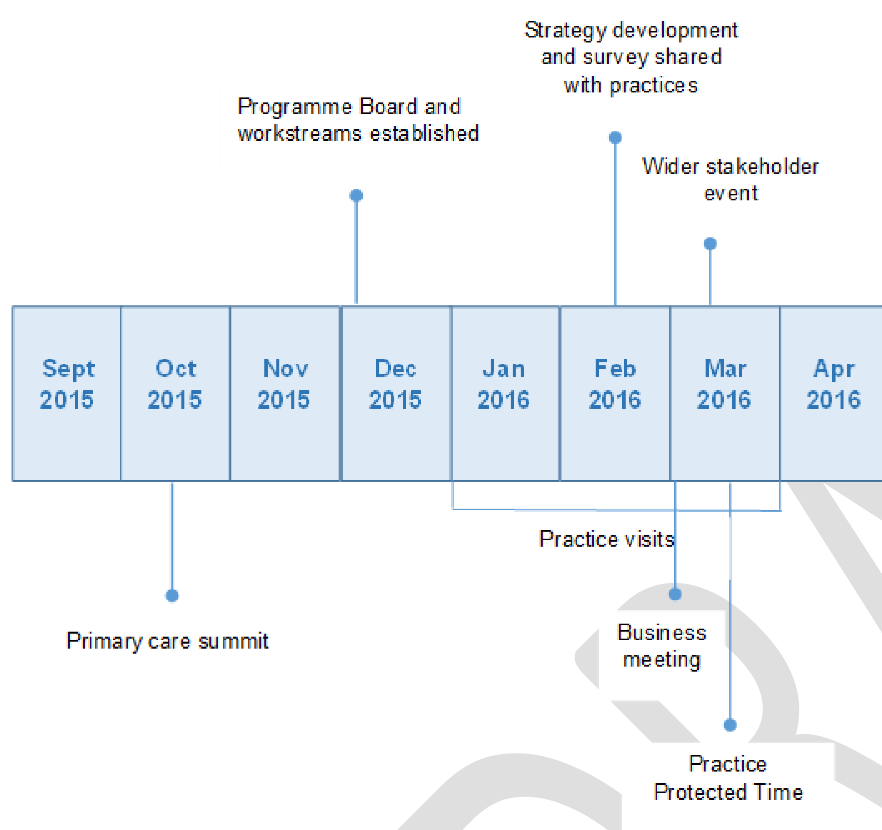

Engagement with practices

Information utilised from practices:

- Practice Protected Time (PPT) (March 2015)
- GHCCG and Primary Care Commissioning, Developing our primary care strategy (July 2015)
- Member Practice Business Meeting (July 2015)
- Practice Managers' Reference Group, Future Management of General Practice (October 2015)
- Primary Care summit (October 2015)
- GP Registrars' session (November 2015)
- Survey to practices (February 2016)
- Member Practice Business Meeting (March 2016)
- Practice Protected Time (PPT) (March 2016)

Engagement with wider stakeholders

Session held on primary care strategy development on 3 March 2016 attended by:

- Calderdale and Huddersfield NHS Foundation Trust
- Locala Community Partnerships
- South-West Yorkshire Partnership NHS Foundation Trust
- Local Care Direct
- Third Sector Leaders
- Community Pharmacy West Yorkshire
- Kirklees Council

Engagement with patients and public

Patient and public engagement information utilised:

- CC2H stakeholder events (2014)
- Right Care, Right Time, Right Place stakeholder events (2015)
- Patient Reference Group Network (December 2015 and February 2015)

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- Primary care engagement with Community Voices (community assets) (December 2015) which included the following groups:
  - The Denby Dale Centre
  - Kirklees Visual Impairment Network
  - Moldgreen United Reformed Church
  - The Basement Recovery Project
  - LS2Y
  - Mencap in Kirklees
  - Support to Recovery (s2r)
  - Volunteers Together
  - Honeyzz
  - PRJM Ltd.
  - Women's Centre
  - One Good Turn Charity MBE
  - Yorkshire Children's Centre
  - Royal Voluntary Service
  - Indian Workers Assn
  - Huddersfield Pakistani Community Alliance
  - Q 4 E
  - Huddersfield Mission

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Appendix 3 – Core, core plus and advanced offer

Core offer (list based)

The key principles and standards for the core offer will be:

- Promote self-management with patients

- All practices will achieve CQC 'Good' standards in all domains, be legally registered and deliver core standards
- Minimum scheduled appointment time for a routine GP appointment will be 10 minutes – this should support preventative and person-centred approaches
- There will no minimum appointment time for practice nursing staff, recognising these will require great flexibility based on the individual patient's needs
- All patients identified and coded as having a long-term condition will be managed to meet the standards prescribed by QOF
- All patients with an identified long-term condition (COPD, diabetes, epilepsy, asthma (requiring regular inhalers / steroids), palliative patients) will have a mutually agreed care plan in place where a patient agrees to take part in developing the care plan
- Treatment should take into account individual needs and preferences, with patients having the opportunity to make informed decisions about their care, with a health professional. If the individual does not have the capacity to consent, guidance within the code of practice supporting the Mental Capacity Act should be followed
- Personal development and an active appraisal system for staff
- Patient experience and feedback should be sought and acted upon
- All practices will have an effective patient reference group

Access

The key requirements of the core offer which will address the current issues with inequity of access for patients are:

- All practices should be open from 8am – 6.30pm Monday – Friday
- Access to same day requests, where appropriate, must be available and addressed for patients contacting the practice between 8.30am – 6pm on that day (this will be access to an appropriate clinician but will not necessarily mean a face-to-face appointment)
- Patients living in care homes or nursing homes are included within the delivery of the core offer. The Carr Hill funding formula does account for this but we recognise that additional support and investment is required
- Online access should be available for appointments and prescriptions
- All practices must offer telephone consultation / appointments
- All practices must have a regularly updated website with information sources for patients to access
- NHS Choices should be kept up to date
- Unplanned routine appointments e.g. back pain / minor infection will be provided within 5 working days (this is with an appropriate clinician as determined by the practice)

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- Planned routine appointments e.g. reviews are not subject to minimum timescales and should be made as appropriate for the individual patient
- All practices must use the Electronic Prescription Service (EPS) to make available to all eligible patients (noting the opt out on this for dispensing practices, of which there is one in the Greater Huddersfield area)
- All practices will enable their patients to have electronic access to their records (Patient Online)

The services listed have been identified through the development of the strategy and feedback from practices. Core plus and advanced services will be defined and agreed during implementation of the primary care strategy.

Examples of core plus services (list based)

The services listed are those commissioned by the CCG and does not include those services commissioned by the Local Authority / Public Health e.g. sexual health and drug and alcohol services.

Supporting training and placements for practice staff
Enhanced care home provision
Enhanced access models
Joint injections
Ring pessary fitting
Providing diagnostics in primary care above core offer
Complex leg ulcers and wounds
Ears, Nose and Throat (ENT) GPwSI clinics/ outpatients
Enhanced diabetes provision
Endometrial biopsy
Peripheral vascular disease checks e.g. ABPI measurements and Doppler assessments of legs for ulcers and PVD
Minor surgery and some intermediate level surgery
Bladder scanning
ECG and spirometry
Minor injury service

Examples of advanced services (not list based)

Dermatology outpatients
Audiology / hearing aids
Ophthalmology
Paediatric outpatients
Urology outpatients
Vasectomy
Mental health services
Step-up / step-down provision (consideration as to whether this could be extended to include patients in their own homes with a wrap-around intermediate tier service provision)
Cardiology GPwSI service

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Respiratory outpatients
Rheumatology outpatients
Physiotherapy
Podiatry
Some advanced diagnostic services
Anticoagulation above core offer
Dementia tier 2 service
Full allergy patch testing
DVT diagnosis and management service

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Appendix 4 – Delivery plan

Action No	Action	Commences	Complete
CO1	Assessing baseline of delivery of core services	Apr-16	Jun-16
CO2	Develop support offer to practices to ensure every practice can deliver the core offer	Jul-16	Oct-16
CO3	Promotion of patient online access - online booking, Patient Online, EPS via T&F group	Apr-16	Jun-16
CP1	Review current local practice based services	Apr-16	Jul-16
CP2	Commence review of current DES and QOF	Aug-16	Nov-16
CP3	Implement new core plus schemes and revisions to locally based practice schemes / DES / QOF	Apr-17	Apr-17
CP4	Commence review and assessment and refinement for core plus schemes	Jan-18	Mar-18
AO1	Identify priority phase I services to move to or expand provision within primary care setting and subsequent phasing	Jul-16	Sep-16
AO2	Identify procurement implications for each service and revise timescales	Sep-16	Sep-16
AO3	Plan phase I implementation	Sep-16	Mar-17
AO4	Implement phase I advanced services	Apr-17	Sep-17
AO5	Evaluate phase I services and identify changes to implementation plan and approach for advanced services	Sep-17	Dec-17
W1	Implement HEE competency framework	Sep-16	Mar-17
W2	Develop work experience offer for primary care in Greater Huddersfield	May-16	Sep-16
W3	Develop mentorship programme to train practice nursing staff to enable placements in primary care	Apr-16	Sep-16
W4	Develop self-management support resources and training	Apr-16	Sep-16
W5	Develop training opportunities with local university and colleges	Oct-16	Mar-17
IT1	Commence planning to roll-out Wi-Fi to every practice in Greater Huddersfield	Apr-16	Jun-16
IT2	Initiate task and finish group to support transfer of practices to S1	May-16	May-16
IT3	Commence planning and set-up for shared portal	Oct-16	Mar-16
IT4	Develop educational support / training offer for S1	Jul-16	Dec-16
IT5	Review opportunities for bids to support equipment and infrastructure investment	Apr-16	Ongoing

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E1	Complete six facet survey to understand the current estate in primary care	Apr-16	May-16
E2	Undertake baseline exercise to understand the current ownership model in primary care	Apr-16	May-16
E3	Identify options for development in central Huddersfield to create access to a quality primary care facility for patients and rationalise existing estate not fit for purpose	Mar-16	Jun-16
E4	Create a task and finish group to review all available estate across primary care, community services and secondary care to identify options for rationalisation and facilitation of integrated working	Sep-16	Mar-17
CE1	Develop plan to engage with member practices on completed strategy and plans for engagement	Apr-16	May-16
CE2	Work with VCS partners to access updated directory of services for community organisations and make available to general practice	May-16	Jun-16
CE3	Establish project to improve intranet resources for practices including: information available, intranet icon on the desktop of every practice computer, working with IT work stream to establish a shared repository	Apr-16	May-16

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Glossary

AHP – Allied Health Professional

APMS contract – Alternative Personal Medical Services Contract

CC2H – Care Closer to Home

CCG – Clinical Commissioning Group

DES – Directed Enhanced Service

GMS contract – General Medical Services Contract

GP – General Practitioner

GPwSI – General Practitioner with Special Interest

HCA – Health Care Assistant

LES – Local Enhanced Service

MPIG – Minimum Practice Income Guarantee

OT – Occupational Therapist

PMS contract – Personal Medical Services Contract

PPT – Practice Protected Time

QOF – Quality and Outcomes Framework

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DRAFT

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NHS
North Kirklees
Clinical Commissioning Group

A vision for the transformation of healthcare in North Kirklees

Primary Care Strategy 2016-2021

“The secret of **change** is to focus all your energy not on fighting the old, but on **building the new**”

Socrates

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This strategy sets broad parameters for the system as a whole, recognising that there are many contributors shaping the future of primary care in North Kirklees

Foreword

As the Primary Care Support and Development Team for North Kirklees Clinical Commissioning Group, we are pleased to present the Primary Care Strategy for 2016-2021.

North Kirklees Clinical Commissioning Group recognises and accepts its responsibilities for assisting and supporting member practices and NHS England with a view to securing continuous improvement in the quality of general practice and primary care as a whole.

General Practice has been identified as one of the strategic work programmes for North Kirklees Clinical Commissioning Group's in 2015-16 and beyond, supporting along with a number of other programmes, the delivery of the strategic outcomes and overall vision for North Kirklees.

The Primary Care Transformation Programme very much builds on the arrangements and work already underway to commission improvements in primary care, within the context of General Practice in particular, and the main challenges posed by its pivotal role in delivering and supporting healthcare system reform through the NHS Five Year Forward View, both now and in the future.

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This document will guide and inform the response and future work plans of the Primary Care Transformation Programme plan and should be read in conjunction with:

- Joint Strategic Needs Assessment
- Joint Health and Wellbeing Strategy 2014-2020
- NKCCG Five Year Sustainability and Transformation Plan
- NKCCG One Year Operational Plan
- NKCCG Quality Strategy
- Care Closer to Home Strategy
- Urgent Care Strategy
- Planned Care Strategy
- Estates and Infrastructure Strategy
- Workforce Sustainability Strategy

Our vision

Our vision for healthcare in North Kirklees is one of seamless, high quality, accessible care delivered to all patients.

The challenge for Primary Care in the coming years will be to work in collaboration with the Care Closer to Home and Urgent Care agendas, laying the foundations for total service transformation in line with the objectives of the NHS Five Year Forward View.

By breaking down the old boundaries we aim to deliver patient centred care, regardless of provider. We will explore new and innovative ways of delivering place based care through integrated budgets, designing services to meet the needs of specific geographic populations.

The overall objectives required to deliver the overarching vision for transformation of health in North Kirklees have been identified as:

- **Easily accessible primary care services for all patients**
- **Consistent, high quality, effective, safe, resilient care delivered to all patients**
- **Motivated, engaged and integrated workforce with the right skills, behaviours and training, available in the right numbers**
- **Premises and infrastructure which increases capacity for clinical services out of hospital and improve 7 day access to effective care**
- **Effective contracting models which are fairly and properly funded to deliver integration and positive health outcomes**

We recognise the need to be linked with the community, acute, mental health, social care and public health strategies, so that patient pathways are seamless and the health economy works well together.

"Our Primary Care Strategy is focused around the **care of patients**—the people doctors and nurses enter general practice to serve"

Improving health outcomes and significantly reducing inequalities remain a key focus. Access, clinical effectiveness and patient experience are key components of our direction of travel.

All General Practices will need to have a relentless focus on improving the quality of care to patients, supported by proactive use of data, information and patient feedback. Quality improvement needs to balance and combine external scrutiny and regulation with locally-driven, peer led approaches with the needs of the patient at the forefront.

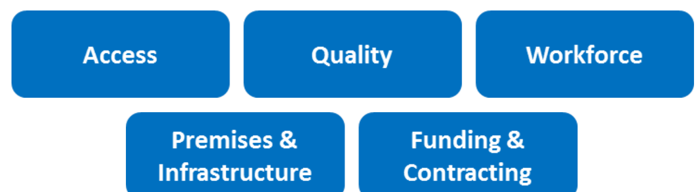
The key to achieving this balance is transparency. Reporting on quality indicators and service improvements to patients, between peers, to other care partners and to commissioners and regulators can help create a culture of continuous quality improvement.

General practice services should be outcome focussed, delivering health improvement and preventive care. By working collaboratively, sharing data on comparative performance, general practices are more motivated to drive each other to improve performance.

North Kirklees CCG member practices need to plan together and deliver together to achieve a better health service and be responsive to the challenge of providing a more efficient service. The CCG will support them to achieve this aim.

The overall objectives listed here stem from the key areas for improvement identified as part of the case for change through engagement with our member practices, stakeholders, patients and the wider public.

Having looked at the array of data available these overall objectives have been distilled into five key themes:



North Kirklees Primary Care Strategy 2015-2020
Themes for Action

KEY THEMES	OVERALL OBJECTIVES
1. Access to care	Easily accessible primary care services for all patients
2. Quality of care	Consistent, high quality, effective, safe, resilient care delivered to all patients
3. Workforce sustainability	Motivated, engaged and integrated workforce with the right skills, behaviours and training, available in the right numbers
4. Premises and Infrastructure	Premises and infrastructure which increase capacity for clinical services out of hospital and improve 7 day access to effective care.
5. Funding and Contracting	Effective contracting models which are fairly and properly funded to deliver integration and positive health outcomes.

More details about the objectives and specific projects that will support the achievement of the overall objectives can be found in 'Themes for Action' on pages 14-19.

NHS
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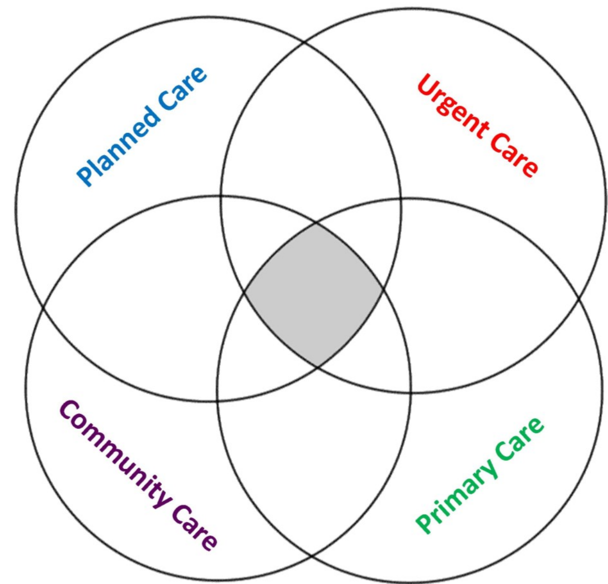
National context

The structure of the National Health Service and its approach to delivering healthcare is changing. This strategy is produced at a time of continued change, following the creation of Clinical Commissioning Groups (CCGs) which put general practice clinicians at the heart of commissioning healthcare services.



The NHS Five Year Forward View released in October 2014 outlines objectives around focussing on preventative care, empowering patients and puts forwards a number of new innovative models of care which encourage integration and a patient centred approach to delivery of care across a geographic population.

Prior to this the White Paper, Our Health, Our Care, Our Say: a new direction for community services started the process of reconfiguring community based services towards a more integrated model of working and has expanded to include a vision to transfer some hospital based care from the acute sector out into communities. This now forms part of our Care Closer to Home Transformation Programme.

More recently Sir Bruce Keogh published his report 'Safer, Faster, Better' into the transformation of urgent and emergency care calling for an integrated approach between providers and outlined the key role that primary care had to play as first point of contact.

Over the next five years, primary care providers are faced with significant change, new challenges to improve the quality of services provided, develop a highly skilled and sustainable workforce and deliver truly integrated care.

The timing of this strategy is therefore also important to support primary care and enable it to deliver the vision of the NHS Five Year Forward View, meet the governments aims around 7 day access to services and provide assurance that North Kirklees CCG is commissioning excellence in overall healthcare.

"General practice has been at the **heart of the delivery** of primary healthcare in England for decades"

Local context

Here in North Kirklees and across the wider region of West Yorkshire there are significant programmes of transformation underway. The challenge going forward is to tie these together so that change becomes embedded.

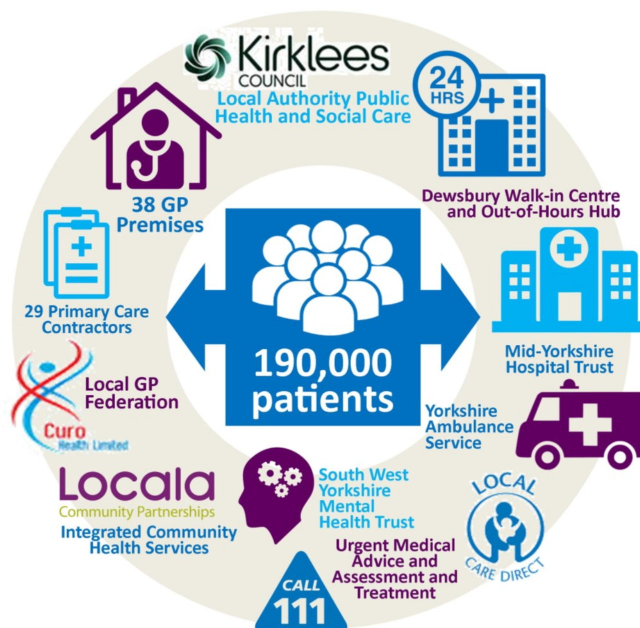
The North Kirklees CCG has a central role, working with stakeholder partners, Kirklees Council and NHS England, to ensure that our commissioning responsibilities are met in full. To certify that the care which we commission and provide is of the highest possible standard and quality, we will undertake constant review and scrutiny in order to achieve best practice, making sure we maintain a sustainable, safe and high quality local health service.

General Practice clinicians, our practice teams and our patients play an important role in influencing our strategy and we need to understand how a primary care strategy will affect commissioning decisions for local authority, acute, mental health and community services.

Urgent Care Transformation
The overall commissioning strategy for the CCG describes the significant changes being proposed across the Mid Yorkshire health economy through the 'Meeting the Challenge Programme' by consolidating services into specialist sites across the region aimed at improving productivity and sustainability of all health services. In addition to this the acute sector must also respond to the recommendations made in Sir Bruce Keogh's review of Urgent and Emergency Care and NHS England's call for new models of care.

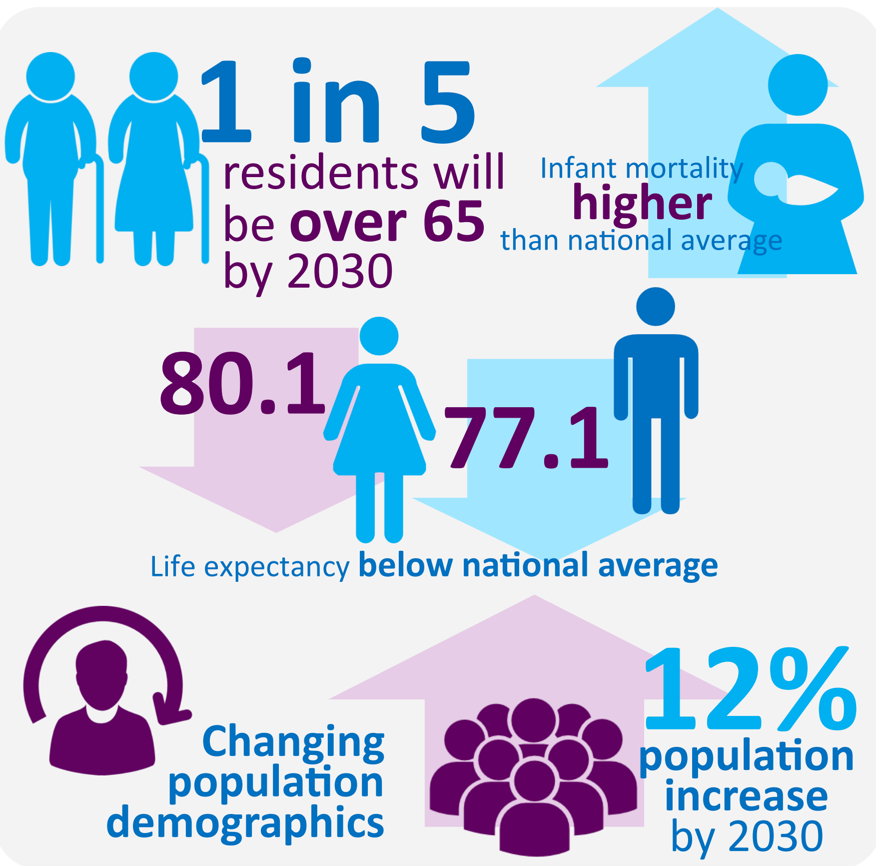
Care Closer to Home and Planned Care Transformation
There is a strategic shift of activity planned from hospitals to the community, preventing the need for hospital admission wherever possible. With enhanced integration of services for vulnerable patients, the aim is to ensure that people do not spend any longer in hospital than they need to.

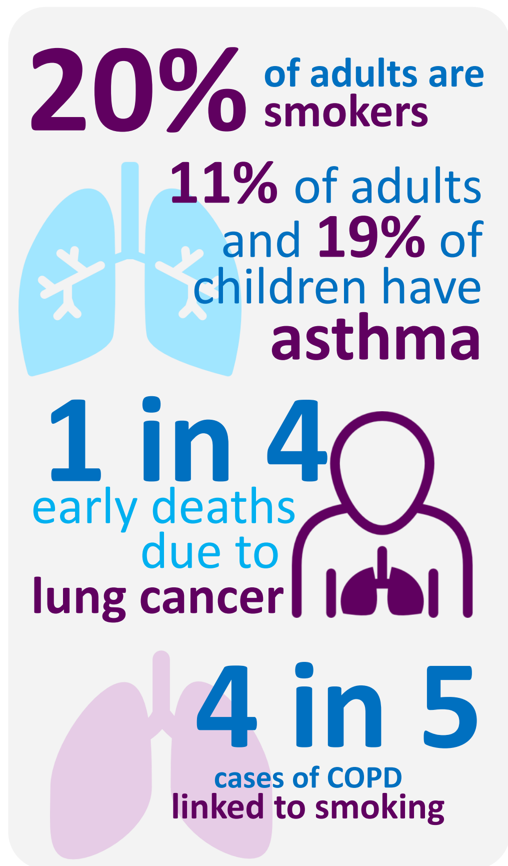
General Practice Transformation
North Kirklees CCG believes that general practice provides the foundation for all other healthcare services and that strong and sustainable general practice is crucial to securing health care services in the future. General practice has evolved significantly from its origins. Many practices have been at the forefront of innovation and quality improvement within primary care and the CCG will take the learning from these successes to implement further service improvements into general practice.

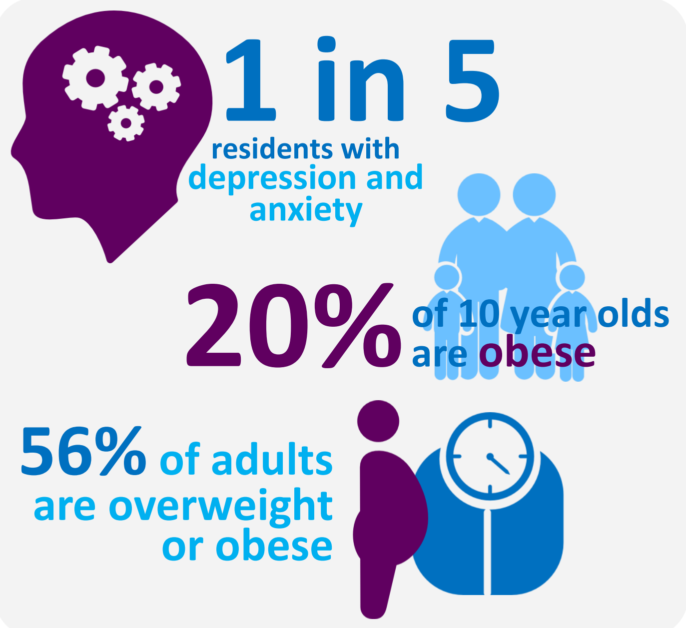


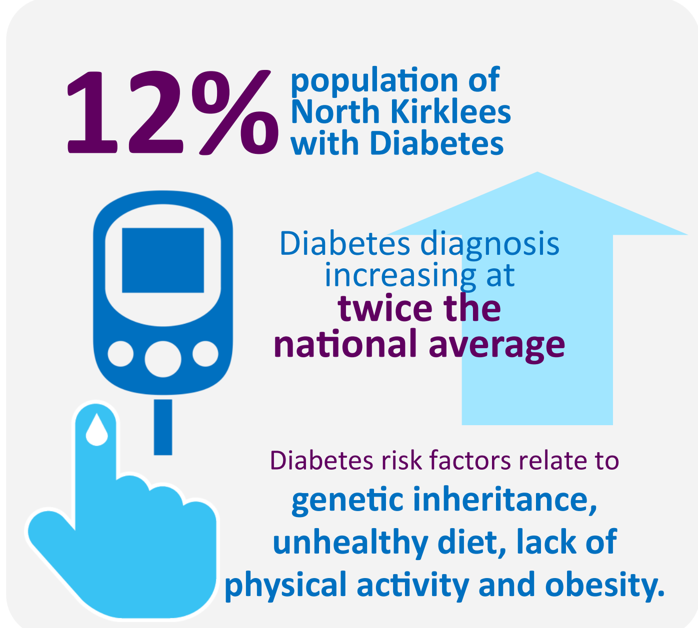
Health challenges in North Kirklees

North Kirklees has a population of 190,244 across Dewsbury, Batley, Birstall, Heckmondwike, Cleckheaton, Liversedge, Mirfield and Ravensthorpe. There are many communities with high levels of deprivation within the locality, with factors such as poor education achievement, unemployment, low income, and inadequate housing which increase the challenges of achieving positive outcomes for patients.









New models of care

Nationally, there is a growing consensus of the need to enable Primary Care to work at greater scale. New models of care should provide more proactive, holistic and responsive services for patients and some of these have been described in the NHS Five Year Forward View.

Multi-specialty Community Providers (MCPs)
While independent GP practices will remain where patients and GPs want that, the RCGP points out that general practice is entering its next phase of evolution. MCPs would provide a wider scope of services, making it possible for extended group practices to form through either Federations, Networks or single organisations and joining with community services to provide integrated care.

Primary and Acute Care Systems (PACs)
New contracting forms will allow a new variant of integrated care by allowing single organisations to provide list based GP and hospital services together, together with mental health and the community. This could be led by an Acute Trust or where there is a mature Multi-specialty Community Provider.

"Breaking down the old organisational boundaries, professional behaviours and political beliefs to **focus on what is right for patients**"

One possible result of the development of these new models could be an Accountable Care Organisation through integrated budgets across health and social care services which tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients.

In North Kirklees the view is to allow these models to evolve organically through increasing opportunities for collaborative working and the CCG will work with member practices to ensure that any new models are consistent with our ambitions for high quality, strengthened primary care. We will build on the clinical leadership that exists in our member practices to ensure clinicians are fully involved in decision making and new models of care across three service levels which are described below:

Level 1 – Individual General Practices
Level 2 – Cluster Networks
Level 3 – GP Federation

Level 1 – Individual General Practices

In the NHS, the main source of primary health care is general practice, providing the first point of contact in the health care system. Primary health care is based on caring for people rather than specific diseases. Therefore, the aim is to provide an easily accessible route to care, tailored to the patient's health care needs. This may mean, continuity of care for frail older people; nurse-led seamless care for patients with multiple long term conditions and urgent access for patients when they need it.

To support this approach, the CCG will look to commission additional services from general practice that will support the role of the accountable GP and improve services for older people and provide additional access to service for patients with urgent medical needs. The CCG will work with practices to support new ways of working that respond to patient needs and benefit the practice in terms of time and skills. This may include different ways of providing urgent appointments, home visits and support to nursing homes in partnership with community services.

Level 2 - Cluster Networks

Practice list sizes vary in North Kirklees, however, it is recognised that the current demands placed on individual practices is unsustainable and practices will need to work differently in the future to manage demand in new ways.

The CCG will support practices to work together through the cluster networks. This may be 'practice to practice' to encourage practices to provide more services on a locality basis or as part of integrated primary and community health and social care teams. The network will decide what services it wants to provide and how it will operate to deliver patient and practice benefits.

This may include how practices support housebound patients, inter-practice referrals or shared resources to improve outcomes for patients.
Patients have told us they want to see a flexible approach to health care and have greater access to the wider general practice team.

Level 3 - GP Federation

General practice is largely based around independent contractors serving relatively small populations. It is envisaged that collaborative, general practice led services will go beyond the current scope of GP contracts, providing accessible and responsive out of-hospital care led in conjunction with other practices and provider organisations. Concepts, such as Family Health Networks, Neighbourhood Development Groups etc, describe a model of care whereby most forms of non-acute, non-specialist care are provided at scale by general practice, in the community setting, with GPs playing a coordinating role on behalf of their populations.

Pressures facing General Practice as providers, mean that practices are increasingly working together to share economies of scale. In North Kirklees, all 29 practices have formed a provider federation (Curo Health Limited) which will allow practices to work in a more collaborative way, sharing back room economies of scale and providing a vehicle to offer a wider range of services. The CCG will work with the federation to develop new models of care that provide a greater range of services in the primary care setting, while maintaining quality, efficiency and equitable access for all patients.

Case for change

The NHS Five Year Forward View sets out the case for change in healthcare. North Kirklees CCG aims to enable general practice to play an even stronger role at the heart of more integrated out-of-hospital services that deliver better outcomes, more personalised care, excellent patient experience and the most efficient possible use of NHS resources.

Our vision for transformation in primary care is built upon a compelling case for change with a clear set of reasons for improvement. In developing the primary care strategy, five key themes have been used to underpin our planning activities in the short to medium term and these build on the work already undertaken and the improvements achieved.

Demand and Variation

Feedback shows there is still room for improvement when offering a service which is accessible to patients. The increasing level of demand both from an aging population and raised patient expectations means that primary care needs to find new ways of both managing activity, whilst at the same time delivering services in ways that meet patient needs. It is well known that there are limited numbers of GPs available within primary care and so assessing skill mix to make the best use of the skills and expertise available should be a focus. Because there are many different contractors providing services variation is inevitable however primary care providers need to come together to make processes, and pathways more efficient and consistent across the whole of the service.

Workforce challenges

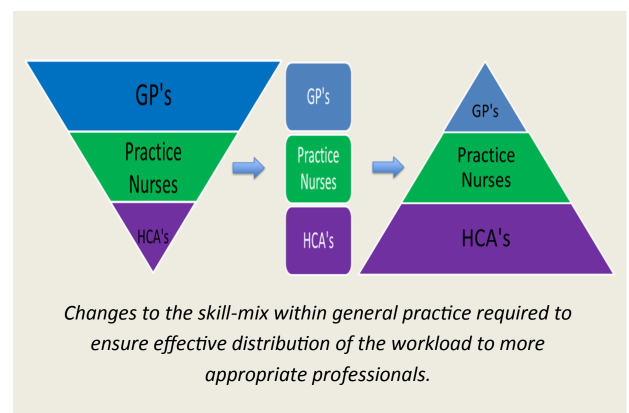
Challenges around sustaining a competent and motivated workforce are well documented through evidence from Health Education England's Workforce Audit Tool, and providers feedback around the pressures of recruiting and retaining staff. Added to this, North Kirklees has a significant number of GPs, Nurses and Practice Managers approaching retirement age and struggles as an under-doctored area compared to other CCGs. Staff development and succession planning are areas which need a joined up approach with other local partners to avoid the cycle of staff moving around the healthcare system.

Premises and Infrastructure

Whilst North Kirklees is fortunate to have a number of recently built PFI estates there are still some smaller practices in old converted residential buildings which are not fit for purpose. Ensuring that building are well used and fully occupied by the right services is an issue locally. Whilst primary care has 97% unified clinical systems, optimising the use of these systems to support wider access to care, increasing the use of digital systems such as Patient Online and e-consultation to improve clinical to patient and clinician to clinician communication still requires further work.

Contracting and Funding

Primary care contracting is complex and not always focussed on outcomes for patients. Providers and commissioners report that implementing, and monitoring contracts across so many providers offers challenges. With the shift of care into the community, effective and properly funded contracts are vital. Integrated approaches which are focused on the needs of the patient and improvements to the quality of care are needed to ensure that different groups of providers work better together.



Changes to the skill-mix within general practice required to ensure effective distribution of the workload to more appropriate professionals.

Engagement

As part of the development of the Primary Care Strategy the CCG held a number of engagement events with patients, the public, member practices and other local stakeholders.

Our engagement team worked to undertake patient surveys. Existing data was collated and analysed as part of the engagement process. This included patient feedback from Patient Advice and Liaison Service (PALs) complaints, Freedom of Information requests, GP Patient Survey data and Patient Experience data. The CCG engaged with member practices through a number of different routes including feedback from a Membership Forum, a number of Governing Body development sessions, via the GP Federation and through a specially arranged Primary Care Summit. The comments gathered from this engagement activity included:

General access to services

Patient wanted more flexibility around opening hours and access to appointments outside of core hours, this was particularly important to working patients. Extended access to both same day and pre-bookable appointments was indicated. Patient surveys reflected a desire for increased access on Saturdays for routine care but the majority felt that most weekend appointments should just be for urgent medical needs. GPs felt that improving access to core primary care services would have positive impacts for patients.

Networking practices to improve access

For urgent appointments, patients were happy to see another clinician other than their own named GP and were willing to travel to other practices if necessary. For routine appointments patients were less likely to travel for an appointment and felt that where the patient was elderly, vulnerable or had a long term or complex condition, continuity of care and the reassurance of their own practice was important. This was also reflected in the comments from clinicians relating to more collaborative working.

Use of effective signposting and triage models

The use of a triage system whereby a healthcare professional could assess their needs and signpost them to the most appropriate service was seen as acceptable by patients. It was made clear though, patients preferred that triage be done by a healthcare professional and not a receptionist. Patients were happy to speak to their GP or a health professional via telephone but improvements would need to be made to any call back systems. The use of clinical triage was supported by clinicians and had been successfully used by some practices.

Better use of online services

An overwhelming number of patients reported that their practice had an appointment system where they had to ring at 8:00am to get an appointment which did not work and was frustrating. Patients wanted to be able to ring up or go online at any time to book appointments in advance.

Patients already using online services were keen for these to expand to include appointments with other health professionals. There was a general lack of awareness though of online services with both patients and primary care staff about what these could do and that these services are available via a phone app. Some patients and clinicians were not yet comfortable with the use of email or video consultations as they felt it may take longer than a phone consultation however they did suggest video consultation could be useful for patients requiring pre-booked reviews. These views were supported by GPs through a desire to make better use of technology generally.

Provision, quality and information about services

Patients were keen to see a wider range of services provided via their GP Practice such as physiotherapy, counselling, social care and hospital based services. They would be happy to access these services at another practice although concern was expressed again over the accessibility for vulnerable patients.

Patient education

A key message that came across from both the public and staff was the need for patient education both on the services available and how and when to access them. It was commented that information about different healthcare professionals and their roles would support patients to understand which clinicians to choose or why they had been signposted to particular clinicians.

Themes for action overview

The CCG Governing Board members are key to supporting the delivery of this strategy, by using their clinical expertise, skills in leadership and the co-operation of the member practices and health and social care partners to effect change.

The delivery of the strategy will help address the challenges and opportunities presenting in shaping the local NHS in North Kirklees. The strategy will succeed with the clinical ownership by North Kirklees GPs and working in conjunction with Kirklees Council and other health partners.

The strategy proposes several key objectives that are focussed on what North Kirklees CCG and its member practices need to plan and deliver together.

The need to have a proactive approach to planning and delivering health and social care services is vital, now more than ever. Our aim will be that we not only focus on developing preventative care pathways which ensure patient's are given the right care, at the right time, by the right person but also to think more medium and long term rather than only focussing on short term solutions.

We will encourage input, feedback and views from a wide range of stakeholders across the North Kirklees health economy and patient representatives, as part of our commitment to maintain continuous engagement with our member practices and health and social care partners.

We will publish an equality impact assessment on any proposed changes and the comments and views on specific issues will help to shape the final proposals for general practice transformation throughout the coming years.

"Primary Care is at a critical juncture. Whilst seen by the Government and NHS England as **the 'foundation' for the future delivery of healthcare** there are a number of significant challenges that must be overcome."

THEME 1—Access to care

Easily accessible primary care services for all patients in North Kirklees.

CORE ACCESS
Easy access to same day and pre-booked appointments within core hours Monday-Friday 8:00am-6:30pm at all GP Practices

OVERNIGHT ACCESS
Easy access to urgent medical advice and/or treatment 8:00pm to 8:00am 7 days a week

EXTENDED ACCESS
Easy access to same day and pre-booked appointments during extended hours from an efficient delivery model

DIGITAL ACCESS
Increased uptake of digital access to services via Patient Online, email and video consultation and tools to support self care.

Patients should be able to easily access routine general practice services from all providers during core hours, Monday-Friday 8:00am-6:30pm. Achieving this outcome is seen as a key enabler to deliver other parts of service transformation such as the Keogh recommendations around urgent care. By ensuring there is sufficient same day capacity within primary care this will allow patients to go to their GP as a first point of contact. We will also be looking at the quality of access available to patients not only the quantity.

The CCG wants to ensure that there is appropriate extended access to primary care services beyond core hours. This will support the Government's agenda on 7 day access to GP services. The CCGs view is that, whilst taking in to consideration patient's views on convenience, extended access to both urgent and routine care should be delivered from a model which is both efficient and accessible such as a hub and spoke model. A collaborative approach to service deliver also offers added resilience to smaller practices who struggle to offer extended services and will be implemented through collaborative working with the Care Closer to Home programme.

Rapid response to urgent medical needs and professional clinical advice should be available to all patients within North Kirklees 24 hours a day, 7 days a week. The challenge moving forward is to integrate and simplify services in a way which enables patients to understand where and how to access care when they need it.

In order to support wider access to primary care, adoption of digital ways of working will be promoted. This includes digital access to appointment booking, prescription ordering and medical records, digital consultations via email and video as well as encouraging patients to manage their health and wellbeing through easy access to advice and self care tools.

Demand is currently restricted in some cases by poor access, so management of the inevitable increase through increasing capacity is absolutely key if it is to remain sustainable.

Prevention, self care, meaningful chronic disease management and a comprehensive system of educating and empowering patients would all be part of this. Monitoring changes in demand and capacity will provide evidence to support any changes to service provision.

Samira's Story

Samira is a 30 year old mother of 3 who is normally fit and well. On Friday morning as she was getting ready for work she developed an itchy rash near her right eye and is extremely worried that it might spread. She contacts her GP practice on Friday afternoon after finishing work as an early years teacher at the infant and primary school just around the corner.

Her GP practice offers her a telephone consultation with a GP on the same day, and Samira agrees. At 3:40pm she is contacted by a GP and is given advice on how to manage the rash.

She is still extremely worried and would prefer to see someone in person in spite of the advice given. Samira is offered a face to face appointment with and Advanced Nurse Practitioner at 7:30pm that day but with a neighbouring practice.

Although not her own practice, Samira accepts the appointment as the clinician will be able to see her medical records happy to attend and just wants to be seen and re-assured.

THEME 2—Quality of care

Consistent, high quality, effective, safe care delivered to all patients.

CONSISTENT CARE
Reduce or eliminate variation in the quality of core services across all practices.

EFFECTIVE CARE
Improved performance in patient reported outcome measures such as GP Patient Survey, satisfaction surveys and Friends & Family Test.

HIGH QUALITY CARE
Above threshold/national average performance in key quality areas such as QoF, CCG Outcome domains.

SAFE & RESILIENT CARE
Reduction in number of Patient Safety Incidents and increased use of Event Reporting Systems.

Our vision is that general practice providers will consistently provide high quality, accessible, safe and resilient care, as evidenced through appropriate assurance systems. This may include regular capacity and demand audits, Primary Care Assurance Tool, Primary Care Quality Matrix to demonstrate year on year improvements.

Overall quality of services will be assessed in conjunction with the CCG's Quality Strategy. The production of transparent, publicly available benchmarking data will allow patients and the wider public to see and provide feedback on the performance of local services.

All providers will be expected to participate in incident reporting to improve patient safety outcomes and be engaged in peer review to support a culture of continuous improvement. Practices should include advice, engagement and support from a wider clinical peer group across the health and social care system delivered through improved digital working such as web-conferencing, virtual meetings and e-consultation.

Working in collaboration with Care Quality Commission and NHS England, the CCG will ensure that all providers meet with contractual and regulatory requirements. An open approach will be adopted which encourages shared learning with examples of best practices from providers.

The CCG will encourage co-operative working between providers, community healthcare services and public health teams to deliver proactive, preventative, holistic and integrated services. This will mean that patients will be assured that their care and treatment in general practice is delivered to the same high standards regardless of which practice they are registered with and they can easily compare their service to others in North Kirklees.

Doris' Story

Doris is 85 and suffers from hypertension, diabetes and arthritis. Her general health has been declining since her husband died three years ago. She hasn't been able to get to her doctors surgery for a blood test in a while as she does not have transport. Her GP surgery recently started to work with other neighbouring practices to offer routine care on Saturdays. Doris gets her son to take her to see a diabetes nurse who is shared between all the practices.

The nurse sees that Doris is struggling to manage her diabetes and often finds all the medication she is taking confusing. The diabetes nurse sits down with Doris and works out a treatment plan for her diabetes with some realistic goals around improving her mobility. To support her to achieve these the nurse refers her to the 'Better in Kirklees' social prescribing hub who arrange for her to join a local AgeUK exercise club and even arrange for a befriending service to drive her to the club.

The diabetes nurse also arranges for a care co-ordinator to visit Doris at home. The care co-ordinator talks with Doris about the different long term conditions she has, the medication she is taking and how to take it properly.

At her next appointment her diabetes is much improved, she feels more confident and happy as she is getting out more to the club. She has even made some new friends from the club who go for lunch together each week and her hypertension is also better after the care coordinator showed her the right way to take her tablets and why it was important.

THEME 3—Workforce sustainability

Motivated, engaged and integrated workforce with the right skills, behaviours and training, available in the right numbers.

INTEGRATED WORKFORCE
Integrated teams with GPs at the core, using a range of skilled professionals to deliver appropriate clinical care.

EXTENDED WORKFORCE
Use of non-clinical professionals, community and voluntary and patient groups to support recovery, self care and independence.

Primary Care workforce is changing. We need a plan to ensure that we have a workforce to deliver this strategy. General practice workforce requires modernisation, still based around the GP practice holding responsibility for the care of its registered patients but with a stronger population focus and an expanded workforce. It will be important to support these changes through training, education and opportunities for professional and personal development.

A separate strategy will be developed which will focus on the four R's of sustainability; *recruitment* of new staff, *retention* of existing staff through expanded, enhanced roles and clear career development, *returning* staff to the workforce and *replacing* some roles with different ones to allow a more effective workforce.

We see the need for a modern, integrated general practice team which has the GP at the core but blends different skilled health and social care professionals together to ensure that patients are treated by the most appropriate person to meet their needs. This holistic approach will also look to utilise the skills of voluntary and community sector staff.

The CCG will address the need to embed general practice succession planning with a high proportion of practice staff approaching retirement. Staff development should be a high priority for all general practices.

"Only **29%** of GP Trainees want to become contractors or GP partners. Flexibility and work-life balance is a key consideration"

MOTIVATED & ENGAGED WORKFORCE
Staff who feel valued, involved and empowered to improve themselves, their colleagues and the services they work in.

COMPETENT WORKFORCE
All staff have clear career progression and remain competent and resilient through opportunities for professional and personal development.

SUSTAINABLE WORKFORCE
Roles which are sustainable through internal staff development and robust proactive succession planning.

CHALLENGED WORKFORCE
Staff are encouraged to innovate and improve through a culture of continuous learning, research and teaching opportunities.

Dr Smith's Story

Dr Smith has been a GP for 15 years. He has been struggling under the pressure of ever increasing demand from patients. Through collaboration, he and his four neighbouring practices have joined together to form an operational network. Patients from all five practices can access extended hours care up to 8pm on weekdays through a hub practice with access to shared medical records.

The practices have also agreed to share staff providing much needed nursing input around diabetes which his own nurse was not trained in. In exchanged for 1 day of ANP time from a neighbouring practice. Dr Smith is now able to offer a Dermatology clinic for all patients in the network, a skill which he had little time to use previously. The network also employs a full time Clinical Pharmacist who amongst many other things, responds to acute medicine requests, reviews patients on complex medication regimens, completes medication reviews with patients and processes prescription medicine requests in outpatient and discharge letters.

THEME 4—Premises and infrastructure

Premises and infrastructure which increase capacity for clinical services out of hospital and improve 7 day access to effective care.

To deliver the ambitions of primary care it is essential to have estates and infrastructure which are fit for purpose to deliver effective general practice services. Infrastructure including technology should support staff to deliver care in an efficient way. Premises, infrastructure and technology should support digital working, clinician to clinician interfaces and clinician to patient interfaces. To support this the CCG will look for unified clinical systems and integrated communications platforms.

The key to this will be to work with other partners for example the local authority, practice landlords and NHS Property Services to maximise premises within communities. The aim should be to deliver flexible multi-use premise that are adaptable to service needs and look for innovative and collaborative projects for health and social care provision.

The CCG will work in collaboration with local public sector partners on a proactive Estates and Infrastructure Strategy. To strengthen workforce development, premises and infrastructure should support a culture of teaching, learning and development for both staff and patients. An educational focus within estates will be key to this.

Infrastructure and technology should support patients to be involved in managing their own health and wellbeing and decisions about their care through information, advice and engagement.

Terry's Story

Terry is 48 and works as a mobile breakdown mechanic for a small company in town. Terry is working longer hours than ever and having to cover a greater area. He feels like he is only home to sleep and then back out to work, free weekends are becoming less frequent. He is concerned that the extra stress is affecting his blood pressure. He does not have time to make an appointment with his GP surgery due to his unpredictable job.

His surgery uses a health pod in the reception area. Terry is able to pop in when he is free on his way home and take his own blood pressure. The pod is linked to his medical record. Terry's blood pressure is a little high so he calls the surgery the next day to speak to the GP over the telephone. His GP can see Terry's BP reading from the previous day and is able to offer him some advice without the need to come in to the surgery.

ADAPTABLE INFRASTRUCTURE
Purpose-built, flexible, multi use, premises which are adaptable to changes in services, capacity or demand.

DIGITAL INFRASTRUCTURE
Effective and efficient digital working which supports clinician to clinician and patient to clinician interfaces.

EDUCATIONAL INFRASTRUCTURE
Premises which support a culture of teaching and learning both for healthcare professionals and patients.

WELL UTILISED INFRASTRUCTURE
Integrated, multi occupancy premises which include a range of providers and services but with sufficient room for future growth/expansion.

PLANNED INFRASTRUCTURE
Pro-active estates and infrastructure plans , well managed which link whole health and social care systems.

HEALING INFRASTRUCTURE
Premises and infrastructure which support staff and patients wellbeing, relieve stress and support recovery.

EMPOWERING INFRASTRUCTURE
Premises and infrastructure which supports patients to manage their health and wellbeing and be involved in decisions about their care.

"**Four** out of **10 GP practices** felt their current premises were not suitable to deliver services to patients"

BMA GP Survey 2015

THEME 5—Funding and contracting

Effective contracting models which are fairly and properly funded to deliver integration and positive health outcomes.

In starting to explore how we can influence real transformational change in general practice across North Kirklees we need to consider some key principles, the main one being that "no work is moved without proper resource being moved with it" – i.e. workforce or finances. Member practices have already identified several key principles and areas which will form priorities in terms of service change throughout 2015-16 and beyond. These are:

- Supporting true equitable funding for core service provision across all general practice providers.
- Contract models which facilitate integration of services or close collaborative working.
- Proactive management of workload shift from secondary care to primary care, properly resourced and planned
- Effective contract management of all providers to ensure performance and activity levels remain affordable ensuring that poor performance does not negatively impact on other parts of the healthcare system
- Streamlining and simplifying enhanced service contracting and management based on improved health outcomes.

The introduction of co-commissioning is seen as a key enabler allowing the CCG an opportunity to take more strategic control over general practice budgets, thereby retaining any efficiency savings within primary care for future investment.

The purpose of this is not only to support further improvements to quality in general practice but also to provide additional investment where possible ensure the long term sustainability of general practice services in North Kirklees.

"**90% of patient contacts** in the NHS happen in primary care for only 8% of the total budget"

The aim should be the integration of all budgets both local authority, health and social care through either a multidisciplinary community provider (MCP) or primary and acute care system (PACS). One possible future could see the formation of an Accountable Care Organisation allowing for placed-based budgets, which truly deliver cradle to grave services for the entire population.

PLANNED CONTRACTING
Proactive management of activity shifts out of secondary care to ensure movement is properly planned and resourced.

PROACTIVE CONTRACTING
Use of co-commissioning to take strategic control of primary care budgets enabling new/enhanced service development.

OUTCOMES-BASED CONTRACTING
Simplified and streamlined contract and funding models which are easy to understand for providers and commissioners and are based on outcomes.

EFFECTIVE CONTRACTING
Effective contract management through prioritisation and sustainability to ensure performance and activity levels remain affordable.

INTEGRATED CONTRACTING
Contract models which facilitate close collaborative working and integration of services through place-based commissioning.

FAIR CONTRACTING
True equitable funding for core service provision to reduce variation between providers.

Abigail, Practice Manager's Story

Abigail struggles with her role as Practice Manager, to reconcile all the different service payments the practice is due for the work it does beyond the core contract. Historically her practice was not as well equipped at negotiating as some others in the CCG and so finds wide variation between what she and her neighbouring practice receive for the same work. With an integrated primary care contract all additional services provided to registered patients are linked together as a single payment which is the same for every practice delivering the services making it much each for Abigail to and the CCG to process., leaving time to spend on improving the services in the future.

Enablers to support transformation

Co-commissioning of primary medical services

On 1st May 2014, Simon Stevens announced new opportunities for CCGs to co-commission primary care services in partnership with the NHS England. The NHS Five Year Forward View describes primary care co-commissioning as a key enabler in developing seamless, integrated out of hospital care based around the diverse needs of local populations. It will also drive the development of new models of care such as multi-specialty community providers and primary and acute care systems.

There are three models that the CCG could take forward:

Level 1 - Greater involvement in primary care commissioning
Level 2 - Joint commissioning
Level 3 - Delegated commissioning

Co-commissioning would allow us to create a joined up, integrated out of hospital service for our local population with primary care leading and shaping the desired model. Helping to drive the development of an MCP model described by Simon Stevens 'Five Year Forward View', and building around groups of GPs combined with nurses and other community health services, mental health and social care.

The focus would be on a holistic, integrated approach to the individual and would be built around populations aligned with community and social care services. Co-commissioning is seen as an opportunity to collaboratively develop solutions around workforce, including exploring new models of working across health, for example Physician Assistants. Examples include supporting GP access arrangements and exploring seven day working by collaborative working.

Co-commissioning would allow the CCG strategic control of the primary care budget to protect and invest resources in response to healthcare challenges and advances in technology through a sustainable and resilient model. For example, digital working, such as video consultations, telemedicine and other solutions which would support general practice to work more effectively.

In January 2015, the CCG Member practices voted in support of the CCG to commission Level 1 - greater involvement in primary care commissioning for 2015/16. In October 2015 member practices again voted to remain at Level 1 - greater involvement in primary care commissioning.

"Transforming primary care needs to **maximise the use of enablers** available to shape a healthier future for patients and lead the out of hospital agenda."

Clinical Leadership
The CCG Governing Board members are key to the delivery of this strategy, by using their clinical skills, skills in leadership and the co-operation of the GP membership and health and social care partners to effect change. Every GP, Practice Nurse and the extended primary care team are essential to effecting positive outcomes for patients.

In addition, the CCG will work with individual Clinicians and the Membership board to strengthen clinical leadership within the CCG:

- Clinically led Peer review to promote individual learning through best practice
- Improved relationships with secondary care clinicians through Clinical Networks and pathway redesign

Patient Education
Throughout all the transformation programmes underway, patient education is seen as the core. Education empowers patients and puts them in the heart of services. It is about designing and delivering health and social care services in a way, which is inclusive and enables residents to take control of their health care needs. An empowered activated patient:

- Understands their health condition and its effect on their body.
- Feels able to participate in decision-making with their healthcare professionals
- Feels able to make informed choices about treatment.
- Understands the need to make necessary changes to their lifestyle for managing their condition.
- Is able to challenge and ask questions of the healthcare professionals providing their care.
- Takes responsibility for their health and actively seeks care only when necessary
- Actively seeks out, evaluates and makes use of information.

Empowered patients will better understand how to navigate between the many sectors in the healthcare system. When unsure about where to go or what to do next, the empowered patient will feel confident to ask for the information they need.

Monitoring and evaluating

Having the right governance and implementation structures in place to support achieving the objectives that will deliver our vision for general practice in North Kirklees is vital.

Recently the CCG underwent an external review of its governance processes and a number of recommendations have been made.

To ensure that general practice is transformed in a way which ensures integration with the other key service transformation programmes around Care Closer to Home and Urgent Care an overarching governance structure has been proposed. This would integrate the existing Primary Care Strategy Group with the CCGs Clinical Strategy Group to offer a more holistic view of transformation. It was also felt that a working group aligned to each of the five key themes would be required to deliver real impact in these areas ensuring that the objectives outlined previously were being addressed.

By feeding back into the overarching governance structure the challenges faced in each of the five working groups can be looked at in conjunction with other projects running in the co-dependent transformation programmes. This is because many of the issued faced are similar across the three programmes.

The new structure highlights the view that in order to affect change, transformation must be delivered from the bottom up. The involvement of general practice contractors through the four cluster networks and the GP Federation will engage member practices so that they are able to take ownership of areas of work, get involved with trialling new ways of working themselves and support the development of grass roots innovation.

In addition to aligning a key theme to a cluster we are proposing that Clinical Leaders working in the Planned Care Transformation Programme identified in our commissioning intentions, are also able to work with an identified cluster of practices. Service development and pathway redesign can then be reviewed by local clinicians and have the benefit of wider input with member practices.

Clusters should take the lead in developing and supporting commissioning plans from the ground up, work on specific national and local performance areas where appropriate and collaborate with practices to provide a test bed for future service improvements.

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