NHS
Blackburn with Darwen
Clinical Commissioning Group

PRIMARY CARE CO-COMMISSIONING COMMITTEE (PCCC)

Date of Meeting	**6th May 2015**	**Agenda Item No.**	**6.**
Title of Report	**Primary Care Strategy**		
PCCC Responsible Officer	**Dr Malcolm Ridgway**	**Lead Clinician**	**Dr Malcolm Ridgway**
		Lead Manager	**Mr Peter Sellars**
Summary/Purpose of Report	**Provides Strategic Direction for Primary Care (General Practice) in Blackburn with Darwen**		
PCCC Action	**To Ratify the Strategy**		

Please indicate the Committee(s)/Group(s) where the paper has been discussed/developed		
Executive Group **Operations Group** **Commissioning Business Group** **Governing Body**		
Please note the following section must be completed in full		
Patient and Public Engagement Completed	**Not applicable**	**(if yes, complete outcome)** **N/A at this time**
Equality Analysis Completed	**Not applicable**	**(if yes, complete outcome)** Completed
Financial Implication(s)	**To be determined as projects developed**	
Risk(s) Identified	**To be determined as projects developed**	

CCG Strategic Objectives supported by this paper		
1.	**To extend the life of our citizens and their quality of life adding life to years as well as years to life.**	**Y**
2.	**To ensure there will be no gaps, no duplication – with integrated services and partnership working; including better relationships with voluntary, community and faith sector organisations.**	**Y**
3.	**To engage and encourage patients and the public to participate in everything we do and the importance of self-care and family wellbeing.**	**Y**
4.	**To improve services and tackle inequality, evidence best practice to inform decisions and root out poor practice.**	**Y**
5.	**To offer effective service interventions which will provide a better experience for patients with privacy and dignity.**	**Y**
CCG High Impact Changes supported by this paper		
1.	**Delivering high quality Primary Care at scale and improving access.**	**Y**
2.	**Self-Care and Early Intervention.**	
3.	**Enhanced and Integrated Primary Care and Better Care Fund.**	
4.	**Access to Re-ablement and Intermediate Care.**	
5.	**Improved hospital discharge and reduced length of stay.**	
6.	**Community based ambulatory care for specific conditions.**	
7.	**Access to high quality Urgent and Emergency Care.**	
8.	**Scheduled Care.**	
9.	**Quality.**	**Y**

CLINICAL COMMISSIONING GROUP (CCG)

PRIMARY CARE CO-COMMISSIONING COMMITTEE (PCCC)

6TH MAY 2015

PRIMARY CARE STRATEGY

1. Introduction

1.1 Blackburn with Darwen Clinical Commissioning Group (CCG) is committed to improving the health and quality of care for the local population and patients as explicitly stated in its mission statement:-

"To deliver effective, efficient, high quality, safe, integrated care. This will improve the health and wellbeing of the population of Blackburn with Darwen and help people live better for longer, reducing health inequalities and improving outcomes in the borough".

1.2 To achieve this aim it is imperative that Primary Care (General Practice) as the foundation of care needs to fundamentally change from its current model of fragmented services, to an integrated high quality services model, having collective responsibility for the health of the population. General Practice will be the lynch pin of care based on the registered population, coordinating and providing that care. For these changes to be innovative and sustainable it needs to be General Practice provider driven and clinically led.

1.3 Primary Care is commonly described as community based health services that are usually the first and often the only point of contact that patients make with the health service. It covers formal professional services provided by General Practitioners (GPs), Community and Practice Nurses, Community Therapists (such as Physiotherapists and Occupational Therapists), Community Pharmacists, Optometrists, Dentists and Midwives. Care is also provided in a primary care community setting informally by family, carers and, formally by social services commissioned providers

1.4 This document in the main concentrates on General Practice as it is part of the wider local Integrated Community Care Vision. Also the 2012 NHS reforms place GPs at the centre of clinical commissioning, which in turn has increased demands on GP time and especially practice partners. Practices also are reporting that the pace and intensity of workload has increased whilst investment has declined in real terms (appendix 1)

1.5 In Blackburn with Darwen, the current business model for many practices is based around relatively small organisations, working independently. The greatest potential for Primary Care could be reached by General Practice working together collectively. The shift of care to out-of-hospital settings is a significant opportunity for General Practice, unfortunately the ability to maximise these changes is compromised by a fragmented and variable GP provider landscape.

1.6 Complementary with General Practice strategic development, Community and Social Care services will need to be delivered by integrated teams of professionals whose incentives and purpose will be aligned to prevent illness, promote healthy living,

diagnose illness early, refer or treat, and educate the public in self-care and early recognition of illness.

1.7 This integration has now commenced and is in the process of being extended. The multi-disciplinary/ multi-professional (Integrated Teams) will be coterminous with the 4 recently established localities North, East, West Blackburn and Darwen), and will provide care for the registered population of the practices rather than be geographically based. In tandem an Intensive support at home programme and a directory of services/navigation hub is currently being designed to further support care based in the community. National work has also commenced in regards to community pharmacy (*Improving Health and Patient Care through Community Pharmacy -A Call to Action*) this will be informed further for inclusion in this strategy development process through Local Professional Networks. As services are developed along with new primary care provider organisations the CCG would be planning and commissioning services on a locality basis.

2. Service Vision

2.1 Blackburn with Darwen CCG's vision for Primary Care is to function in an integrated health and social care model having close interface and operating systems between all providers in the community including all independent contractor groups and the voluntary sector to provide a high quality and seamless service for the population.

2.2 Delivery of these services will be as close to home as possible through a modern fit for purpose hub and spoke estates solution, including appropriate community bed provision. Primary Care will be accessible on a 24/7 basis through core, extended and out of hours services utilising the best in digital communication to improve access and flow for patients and will provide community based services that are currently delivered in a hospital setting. (Ref BwDCCG Care Strategy 2012)

3. Why Change?

3.1 Primary Care and in particular General Practice is accepted as the foundation of NHS provision providing people with first point of access, advice, diagnosis and treatment together with on-going support.

3.2 General Practice nationally and locally is under pressure from an increasing range of supply, demand and other health service factors as identified by NHS England's Call to Action, these being:-

- An ageing population, growing co-morbidities and increasing patient expectations, resulting in large increase in consultations, especially for older patients along with the number of people with multiple long term conditions set to increase.
- Increasing pressure on NHS financial resources, which will intensify further from 2015/16
- Growing dissatisfaction with access to services. Most recent GP Patient Survey shows further reductions in satisfaction with access, both for in-hours and out-of-hours services.
- Persistent inequalities in access & quality of primary care.

- Increasing workforce pressures, including recruitment and retention problems both locally and nationally and in recognising a GP shortage.

3.3 Along with these factors General Practice is being asked at the same time to do more to relieve pressure in urgent /emergency care, out of hours care, supporting integrated care, playing a central role in commissioning and look to providing 7 day accessible care.

3.4 These pressures in tandem with relatively flat investment, revalidation and workforce issues potentially render the model in its current form unsustainable.

3.5 In understanding the current pressures and aspirations both from the Government and the Public to improve Primary Care, it would be necessary through good planning to introduce innovative solutions and actions to improve access through a variety of means. These could include extending hours, using digital technology, and by local agreements in which patients could access other sites / practices for consultation visits, or referral into locally developed services, this in tandem with improving quality and consistency including shifting care out of a hospital setting.

3.6 Given the current and future directions and pressures, Primary Care (General Practice) locally is now at a staging post in which it can be proactive, taking ownership and control in determining its future potentially drawing in facilitation and support not only from the CCG via various Local Improvement Schemes (LIS), investment through Everyone Counts planning guidance but also from NHS England – (*Improving General Practice – A Call to Action*)

3.7 In developing Primary Care / General Practice in meeting the demands being made it is expected that Primary Care would respond and exhibit the core attributes described below.

4. Comprehensive

4.1 The organisation is accountable for meeting the majority of patients' physical and mental health care needs, including wellness, prevention, and acute and long-term conditions care. Where the right skills or services are not available within the primary care organisation, staff play a central role in coordinating community care teams involving professionals from other community services and specialists in secondary care, and signposting people to relevant local welfare, wellbeing and other social support services.

5. Person-centred

5.1 This is relationship-based care, premised on trust, and concerned about the whole person. Patients and their carers' are recognised as core participants in decision making about care and treatment. When registered with a primary care organisation, a patient benefits from continuity of care with a professional, when that is important to the patient and beneficial for their treatment. Person centred care takes seriously the ways in which broader life experiences (such as wealth, housing and family circumstances) carry consequences for an individual's health and care.

6. Population oriented

6.1 The organisation is responsible for providing services not only to those who attend their premises, but also for a specified population. Depending on the model in question, this might include all individuals registered with the organisation; all those who are resident in a specific geographic area; and/or individuals who belong to a specific population group (e.g. the frail elderly or homeless).

7. Coordinated

7.1 Care is coordinated across all elements of health care system, with particular attention paid to overseeing and being accountable for transitions between providers, and building and sustaining open and clear coordination between the patient and their various care teams.

8. Accessible

8.1 Patients experience appropriate waiting times for initial consultation and advice, diagnosis and care; they have 24/7 access to medical and nursing advice and care, and organisations are responsive to patient preferences around access.

9. Safe and high quality

9.1 Care is evidence-based wherever possible and clinical decisions are informed by peer support and review. Clinical data sets are shared within the organisation to inform quality assurance and improvement. The organisation is financially sustainable, such that safety and quality standards will not be compromised by resource pressures.
Adapted from the Patient Centered Medical Home model, as described by the US AHRQ (AHRQ, 2013) cited in Securing the Future of General Practice (Kings Fund & Nuffield Trust 2013)

9.2 In recognition of the above GP's and practices will need to take ownership of this major change along with considering financial viability and being able to achieve excellent outcomes for patients, setting the future 'GP practice' on a firm and sustainable base.

9.3 Blackburn with Darwen CCG has committed to delivering services through the 4 locality model with the intention of working with practices on a larger scale to maximise economic and quality benefits for patients rather than on an individual and isolated basis.

9.4 The challenge to Primary Care and General Practice providers in particular is their response to delivering this strategic vision of the future of Primary Care.

9.5 General Practice will need to consider alternative organisational operating forms, in particular moving away from single handed practice models. This would allow and develop a provider response model through joint working arrangements. These could include Super-partnerships, federations / networks, Community Health or Integrated Care Organisations or similar working with the 4 localities with the ambition to develop improved and a wider range of services for patients.

9.6 In order to provide more care in the community, skills will need to be developed across the workforce (upskilling upstream) with integral sub-specialisation and an extended primary care team. General Practice will need to support the concept of multi-disciplinary working embracing skills development through training programmes, skill mix and development of new roles for professionals to create sustainable, high quality and well-motivated teams. This could entail increasing Advanced Nurse Practitioners (ANPs) developing Practice Nurses (PN's) and Health Care Assistants (HCA's) allowing GP's to become Expert Generalists being able to focus on more complex work. This would then enable the shift in care from the

hospital through re-commissioned transformed services that would ensure quality improvement and reduced variation in care delivery.

9.7 Taking this workforce planning approach would assist the creation of an area that would retain current and attract new General Practitioners along with other professional; this initiative is closely linked to delivering and operating from fit for purpose buildings and a supportive educational environment. The public must also play its part in this transformation, becoming more informed and self-reliant in terms of self-care. Primary and secondary care will need to play a pivotal role in educating the population in innovative ways such as attending schools and colleges and promoting self-care at every patient contact.

10. What would success and patient benefits look like:-

- Improved patient satisfaction.
- Patients fully informed and involved in decisions about their care and in planning future services.
- Improved patient access and flow
- Improved health and wellbeing outcomes for the population.
- Provision of high quality acute Primary Care both in and out of hours (24/7)
- Improved quality with reduced variation through standardisation and consistency of evidence based care. Decision support services will play an increasing role in improved quality and standardisation (e.g. software, consultant advice, education)
- Extended Primary Care provision, this would include closer collaboration or partnering arrangements with Pharmacy, Dental, Optometry, Community services, Mental Health, and the 3rd sector.
- Appropriate shift of care and resources from secondary to primary care and delivery of the 'Care Closer to Home' agenda.
- Reduced Emergency Department and Urgent Care Centre attendances and reduced hospital admissions and readmissions utilising integrated primary health care teams and appropriate locally based premises.
- Improved productivity
- Improved staff recruitment, retention, education and skill development (career pathway opportunities).
- Collective responsibility for the population health across a network of practices, providing earlier diagnosis and systematic care planning and reducing health inequalities.

10.1 A future patients' story

Mrs Haworth, an elderly recently bereaved lady with diabetes, heart failure and mild dementia, has contacted her GP via her carer using the bypass telephone. She is confused and generally weak and "off her legs". She is seen by her usual GP who then contacts the Blackburn with Darwen Hub to organise care in her own home. The GP is advised that the Intensive Home Support team will visit her within the hour to undertake investigations, instigate relevant treatments and also to organise

increased social care and reablement support to manage her in her own home. After a period of a few days she is feeling better so her care is passed onto her own locality integrated health care team for ongoing management and support. This is coordinated by the lead nurse with supervision and liaison with her own GP. The MDT subsequently discusses Mrs Haworth at a review meeting when further support and review is felt necessary, with her medications reviewed and rationalised by the team pharmacist, her medical conditions optimised by her GP in liaison with the community Geriatrician and other relevant consultant colleagues and ongoing support from social care, nursing for a few weeks longer. Ultimately she makes a full recovery and feels better than before since she is on the appropriate medication with minimal side effects, she is doing more for herself following reablement and occupational therapy and because she and her carer understand how to manage her illnesses (via the Expert programme) she requires minimal medical and nursing support. She attends the practice for her systematic annual review to prevent further problems developing and when required. Recently she has been bought an iPad and has now started consulting with her doctor via FaceTime, which she thinks is marvelous."

11. How will this be achieved?

11.1 This strategic direction paper sets out a programme for change through Developing the Provider (General Practice) This programme initiates a framework for conversations to be had within General Practice and 'wider local Primary Care' to develop the overall strategic vision and implementation along with credible timescales. The CCG will help and support the facilitation of 'new GP Champions / leaders, creating time for the design and implementation of new models. It will also enable the discussions and collaboration across all contractor groups to support organisational change and remodeling of provider organisations, recognising that this will be Provider Driven and clinically led and independent from the commissioner role.

11.2 The CCG will embed these changes through Co Commissioning Primary Care (General Practice) having full delegated arrangements from NHS England but working closely with Public Health Colleagues from April 2015, actively seeking opportunities to commission care on a locality basis. This would include providing the direction from moving away from single handed practices.

11.3 Underpinning commissioning services the CCG will facilitate conversations, engaging and involving the public in these strategic changes to deliver the aspirations of the local population and be actively involved in evaluation of the services. Blackburn with Darwen CCG has a well-established and successful Patient Participation Group (PPG) network centred on our member practices within the four localities and we have significant plans to develop this through our Patients in Participation initiative. This will offer a range of opportunities for patients, carers and the public to give views on what is best in primary care services and what might need improvement. This will be driven through the Primary Care Commissioning Committee (Lay Person led) drawing on the wider range of public involvement activities.

11.4 Engaging patient's views will operate using GP surgery patient participation groups at its core and will develop further listening events across the area where local people will be invited to share their experiences of primary care services, and there will be additional opportunities to contribute via the website and social media. There will also be specific engagement activity with hard to reach groups, including the travelling community, BME communities and those with physical or mental health conditions.

11.5 The CCG will work closely with NHS England and gain support with other organisations e.g. NHS Improving Quality, academia, the deaneries and a range of leadership development organisations such as the Leadership Forum (General Practice Work stream)

12. Estate and Infrastructure

12.1 Recognising that major service change and delivery will require appropriate high quality estate and supportive infrastructure including Information Technology and data sharing, the CCG will review current arrangements with local partners and NHS Property services to inform the future estate landscape.

12.2 The review process and any estate development will naturally be driven by the service delivery model, the expectation being through a hub and spoke model within each of the 4 localities. Initially the review will consider all community estate assets including all Primary Care Centres and surgeries and link with the Community Asset review being undertaken by Blackburn with Darwen Borough Council.

12.3 The review will focus on current provision across all organisations and to identify the future requirements in determining the required space and location. This approach will facilitate linkage of estate strategies across partner organisations to ensure that investment and disinvestment in the estate is tied to future service delivery. This approach also allows identification of opportunities for future sharing of property along with potential of estate rationalisation, and achieving the benefit of freeing up resources for reinvestment.

12.4 Integrated electronic care records will enable improved, safer care across the system and better communication between services. Social media and other forms of electronic communication will play an increasing role in educating and caring for people in convenient and accessible formats. Tele health / Telemedicine will facilitate consultations and monitoring of patients, with tele care increasingly supporting peoples' independence.

13. Finance and Resources

13.1 From the Five Year Forward View – 'the foundation of the NHS will remain list – based primary care. Over the next five years the NHS will invest more in primary care, whilst stabilising core funding for general practice nationally over the next two years. CCGs have the option of more control over the wider NHS budget, enabling a shift in investment from acute to primary and community services'.

13.2 The NHSE Local Area Team are currently responsible for administrating the payments for the national and local negotiated contracts. With the advent of Primary Care Co-Commissioning from 2015/16, the CCG is working with NHS England to strengthen GP commissioning and the underpinning payment system. Core contract activities will be remunerated in line with national agreements.

13.3 Under Primary Care Co-Commissioning, the primary care budgets for GP services will be delegated to the CCG by NHS England. The CCG will be required to manage these budgets within NHSE Business rules ie making a 1% surplus. A review of PMS premiums and Minimum Practice Income Guarantee (MPIG) has been carried over by NHS England and over seven years, the release of the PMS premium will aid the financial impact of investments in primary care.

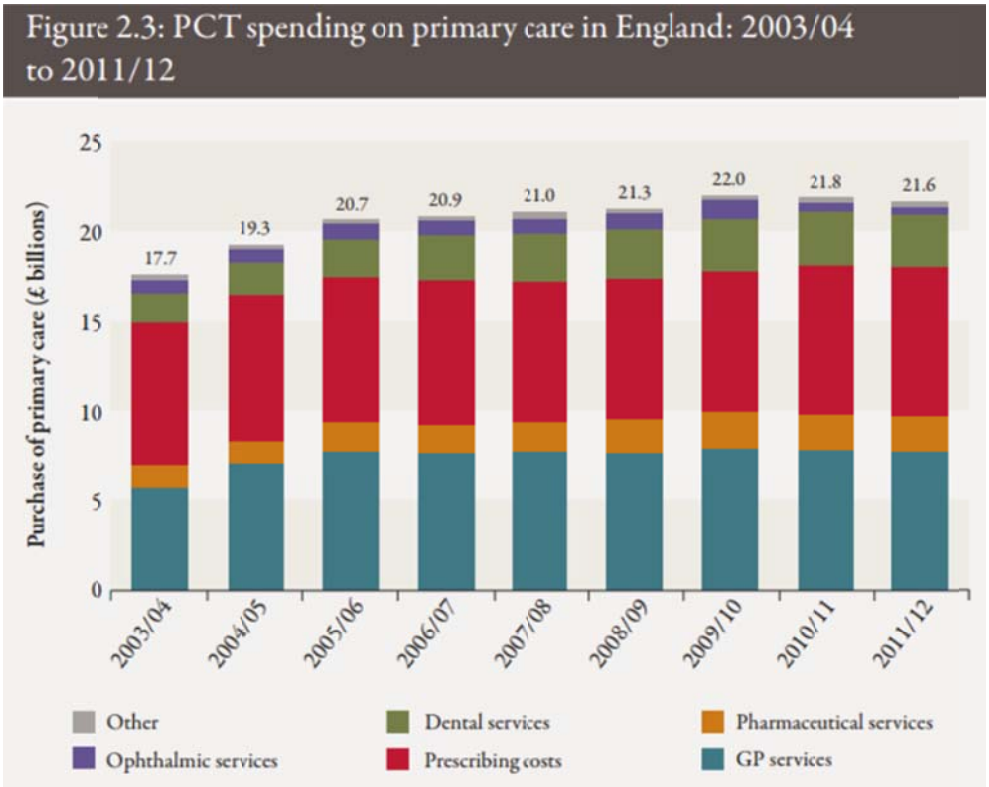
13.4 The CCG will support investment in primary care from the national funding schemes such as the Challenge Fund and the New Deal for Primary Care (to improve premises and infrastructure) supporting new ways of working and improved access to services.

14. Conclusion

14.1 There is an opportunity now for General Practice in Blackburn with Darwen to redefine primary and community care delivery for the benefit of patients and the local population. The approach suggested within in this paper is to support provider development and ownership, enabling clinical provider led transformation and innovation. This will ensure the future of General Practice and Primary Care is on a firm and sustainable footing to deliver high quality service to the local population maintaining the health, wellbeing and independence of people within a community setting

Peter Sellars
April 2015

Appendix 1



Year	Spend per head	Change
10/11	£ 143.39	
11/12	£ 143.33	-0.04%
12/13	£ 143.61	0.19%

Data source/s:
http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/130305_anatomy-health-spending_0.pdf

FIMS and ONS population estimates; 2011/12 PCT Allocation Book. Average costs per person per year by age group, including Acute, Maternity