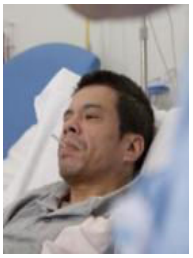
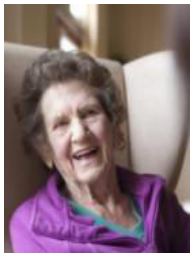
High Quality, Sustainable Primary Care
A Strategic Framework for East Anglia





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Foreword

This strategic framework is predicated on the belief that good General Practice and wider Primary Health Care is the bedrock of a high quality and cost effective health care system. Improving the nature of services provided outside hospital and supporting the public in self-care are key ingredients for a sustainable NHS.

This strategic framework aims to ensure that the NHS England East Anglia Area Team, with local Clinical Commissioning Groups and other key partners, can be confident that people living and working in East Anglia have access to thriving, high quality and sustainable general practice and wider primary care services which work as part of an integrated health and social care system. It also aims to give confidence to professionals working within primary care that there is a framework that will support them in their ambitions to provide high quality care in their local communities.

The structure of the document is as follows:

Section1: East Anglia Strategic Framework for Primary Care

Section 2: Strategic Plans for Primary Care by CCG Area

- Cambridge and Peterborough
- Ipswich and East Suffolk
- West Suffolk
- Great Yarmouth & Waveney
- West Norfolk
- North Norfolk
- Norwich
- South Norfolk

It is recognised that this framework is an iterative document that will be updated as each CCG progresses with the engagement and consultation with their public and stakeholders in the refinement of their vision and 5 year development plans.

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SECTION 1 - EAST ANGLIA STRATEGIC FRAMEWORK FOR PRIMARY CARE

1 Introduction

In response to *A Call To Action* the NHS England East Anglia Local Area Team has been working with local Clinical Commissioning Groups and the Local Professional Networks to consider what we need to do, both at a national and local level, to be confident of ensuring our local population has access to high quality, sustainable and thriving primary care services.

Underpinning this work has been our collective commitment to the NHS England vision and purpose “high quality care for all, now and for future generations” and to the goals set out within Everyone Counts: Planning for patients 2014/15 to 2018/19.

A key principle of the Area Team approach has been to ensure alignment with our local Clinical Commissioning Groups and Local Health and Wellbeing Boards’ strategic planning processes.

East Anglia Area Team is made up of 8 Clinical Commissioning Groups:

- Cambridge and Peterborough
- Ipswich and East Suffolk
- West Suffolk
- Great Yarmouth & Waveney
- North Norfolk
- West Norfolk
- South Norfolk
- Norwich

There are 4 Health and Well-being Boards:

- Norfolk
- Suffolk
- Peterborough
- Cambridgeshire

We are confident that this will ensure that the key themes and issues set out within this strategic framework will support the wider health and social care planning work that is being taken forward led by the CCGs.

2 What Primary Care is and our vision for the future

Primary care services are the entry point for people for the prevention and treatment of illness and include General Practice, Dentists, Community Pharmacists, and Community Nursing.

The NHS Primary care services, in England, have a number of internationally recognised strengths:

- General Medical Practice registered lists are a key tool in the coordination and continuity of care. Around 99% of the population are registered with a general practice in the UK;

- Primary care services are well placed to utilise their knowledge of patients in a local community gained from repeated consultations over time to improve physical, emotional and social wellbeing;

- Primary Care services play a central role in the management of patients with chronic disease and identifies those at risk of worsening chronic ill health; and

- General medical practice displays a highly systematic use of information technology to support management of long term conditions, track changes in health status and support population health interventions such as screening and immunisations.

There is however, nationally and locally, a recognition that primary care services face increasingly unsustainable pressures. In responding to these pressures, this strategy sets out a framework to take forward an ambitious programme of development to build on current strengths and ensure that primary care services are at the heart of integrated, community based health and social care services, working to actively promote health and wellbeing.

In setting out our strategic vision for primary care it is important to recognise that East Anglia is a large and complex area, largely rural in nature. The feedback we have had through our local discussions with local professionals, clinical leaders and the public has confirmed the central role of Primary Care in improving health outcomes and meeting local need. Overall, existing primary care services across East Anglia are good and improving, providing a strong base for future development.

Our vision over the next five years will build upon this strong foundation to ensure that:

- Care is increasingly integrated and provided in a joined up way to meet the needs of the whole person;

- People will be increasingly able to play a full part in the management of their health and wellbeing

- Care is clinically effective and safe, delivered in the most appropriate way

- Primary care plays a full part in helping the wider healthcare system make the best use of limited resources

- We create an environment which ensures that we are able maintain and develop a motivated, skilled and dedicated primary care workforce

- There is a clear and shared understanding among the public and professionals of individuals rights, responsibilities and expectations

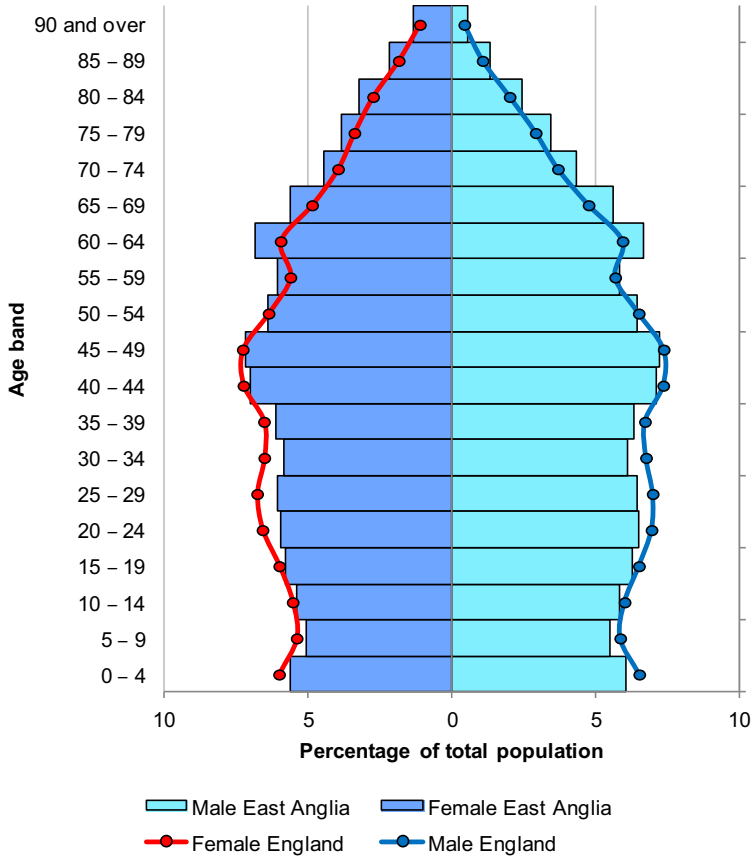
- We can be confident that there is equity across East Anglia – equity of “offer”, equity of “access” and equity of “outcome”

3 East Anglia Context

3.1 Population

The NHS England East Anglia Area Team covers an area which has a registered population of 2,457,100. There is a lower proportion of 0-39 year olds and a higher proportion of residents aged over 60 year old the England average.

The population as a percentage of the total in age bands for East Anglia compared to England (Census 2011)

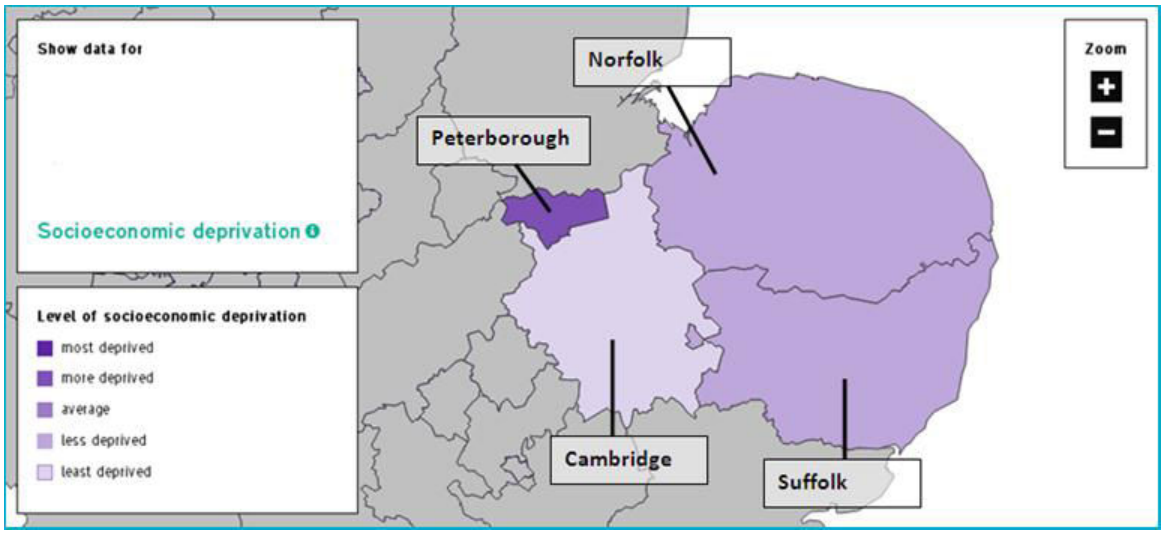


East Anglia	Census 2011
Total Registered	2,457,100
Total Resident	2.396.328
Male Resident	1,184,032
Female Resident	1,212,296
0-4 Resident	139.941
65+ resident	459,694
85+ resident	64,406

3.2 Deprivation

330 out of the 1445 Lower Layer Super Output Areas (LSOAs) in East Anglia are in the 20% Most Deprived LSOAs in the country.

Map 1 – Deprivation spread across East Anglia (Analytics Service: Midlands & East, Sept 2013)



3.3 Life Expectancy

While East Anglia experiences better health than England as a whole, there are very significant health needs and health inequalities. Across the Local Authorities within East Anglia Area Team, life expectancy at birth for men is better than the England average of 78.58 years in all authorities other than Peterborough where it is significantly worse.

For women born in East Anglia life expectancy at birth is better than the England average of 82.57 years, except in Peterborough where it is significantly worse.

Table 2 – Life expectancy across East Anglia Local Authority Areas (Analytics Service: Midlands & East, Sept 2013)

Local Authority	Life expectancy at birth		Gap in life expectancy between most & least deprived	
	Male	Female	Male	Female
Cambridgeshire	80.1	83.9	7.2	5.3
Norfolk	79.5	83.3	5.8	1.9
Peterborough	77.5	81.9	9.4	5.6
Suffolk	79.9	83.6	5.7	4.4

The slope index of inequality measures the gap in life expectancy between the most and least deprived communities within a Local Authority area. Across the four local authority areas in East Anglia:

- The gap in life expectancy for women varies between 1.9 to 5.6 years. The gap is statistically better than the England average of 5.9 years in Suffolk and Norfolk but statistically similar in the other two areas.
- The gap in life expectancy for men varies between 5.7 to 9.4 years. Cambridgeshire and Peterborough are statistically similar to the average across England of 8.9 years and Norfolk and Suffolk are statistically better.

Further detail of the health needs of our population can be found in the Joint Strategic Needs Assessments that have been developed by each of the Health and Wellbeing Boards covering each Local Authority. A Joint Strategic Needs Assessment (JSNA) is the means by which CCGs and local authorities describe the future health, care and wellbeing needs of the local populations and to identify the strategic direction of service delivery to meet those needs.
Cambridgeshire JSNA
Peterborough JSNA
Suffolk JSNA
Norfolk JSNA

3.4 In-Migration

The potential population growth through in ward migration is significant.

Planned residential growth across the 8 CCGs within East Anglia is shown in the table on the following table – the geographical distribution of this growth should be reflected in each individual CCG chapter in Section 2 of this report.

Table 1 Summary of Housing and Population Growth across East Anglia (LPP East Anglia Housing Growth Report Nov 2013)

Clinical Commissioning Group[1]	Plan Period	Local Authority	Number of Houses	Population Arising
Cambridgeshire &Peterborough CCG	2011-2031	Cambridge City Council	4,270	9,821
	2006-2026	East Cambridgeshire District Council	3,169	7,606
	2011-31	Fenland District Council	11,004	25,309
	2006-2026	Huntingdonshire District Council	5,500	13,200
	2010-2031	Peterborough City Council	24,795	61,988
	2011-2031	South Cambridgeshire District Council	18,842	45,221
Cambridgeshire & Peterborough CCG Total			**67,580**	**163,145**
North Norfolk CCG	2001-2021	North Norfolk District Council	9,488	20,873
	2008-2026	Broadland District Council (part of Greater Norwich Development Partnership)	12,900	29,670
North Norfolk CCG Total			**22,388**	**50,543**
West Norfolk CCG	2001-2026	King's Lynn and West Norfolk Borough Council	15,510	35,673
West Norfolk CCG Total			**15,510**	**35,673**
Norwich CCG	2008-2026	Norwich City Council (Part of Greater Norwich Development Partnership)	3,000	6,300
Norwich CCG Total			**3,000**	**6,300**
South Norfolk CCG	2001-2026	Breckland District Council	19,777	45,487
	2008-2026	South Norfolk District Council (Part of Greater Norwich	9,900	22,770
South Norfolk CCG Total			**29,677**	**68,257**
HealthEast CCG (Great Yarmouth and Waveney)	2014-2029	Great Yarmouth Borough Council	5,700	13,110
	2007-2025	Waveney District Council	2,875	6,325
HealthEast CCG (Great Yarmouth and Waveney) Total			**8,575**	**19,435**
West Suffolk CCG	2012-2031	Forest Heath District Council	7,338	16,877
	2010-2026	St Edmundsbury Borough Council1[2]	9,782	23,477
West Suffolk CCG Total (not including growth within Mid Suffolk District or Babergh District)[3,4]			**17,120**	**40,354**
Ipswich and East Suffolk CCG	2010-2026	Ipswich Borough Council	8,460	19,458
	2012-2027	Mid Suffolk District Council[3]	3,845	9,228
	2010-2027	Suffolk Coastal District Council	6,950	16,911
Ipswich and East Suffolk CCG Total (not including growth within the St Edmundsborough or Babergh District)[2,4]			**19,255**	**45,597**
Part combined CCG coverage	2011-2031	Babergh District Council[4]	3,955	9,097
Total for All Local Authorities and CCGs			**187,060**	**438,401**

[1] This represents LPP understanding of the LA Areas covered by each CCG however CCG and LA boundaries may not directly correlate

[2] Part of St Edmundsbury Borough Council area is covered by East and East Suffolk CCG

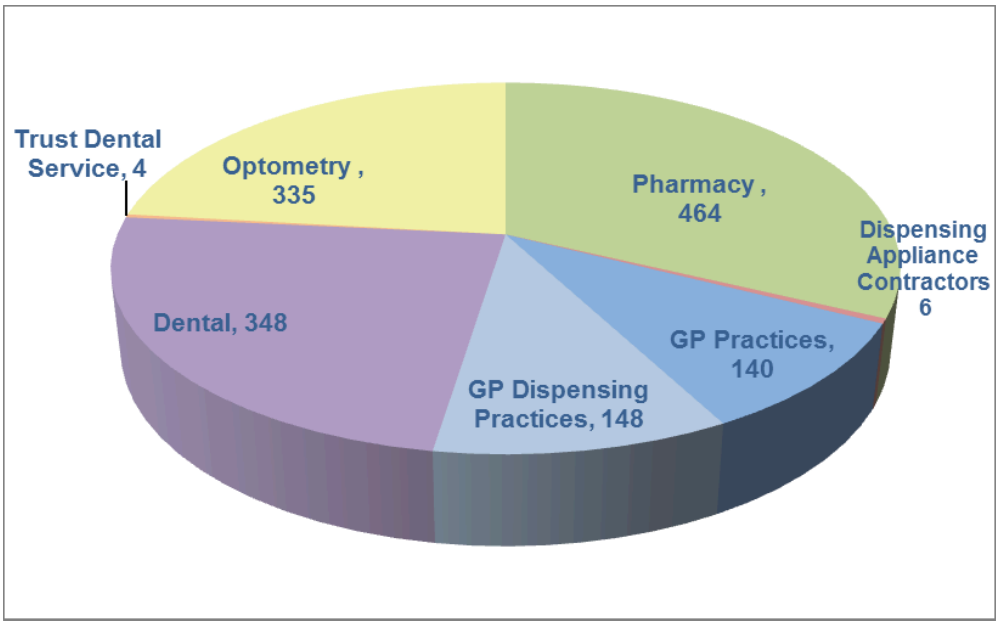
[3] Part of Mid Suffolk District area is covered by West Suffolk CCG

[4] The Babergh District Council area is covered by both West Suffolk CCG and Ipswich and East Suffolk CCG

4 Primary Care Provider Profile

Across East Anglia primary care services are provided through 1,543 independent contractors.

Graph 1 – Independent Contractors across Primary Care Disciplines (Serco data - April 2014)



4.1 General Medical Practice

4.1.1 Provider Profile and Sustainability

In East Anglia there are a total of 288 GP practices including 3 walk in centres with an annual contract value of £309.5 million. They are independent contractors with the following spread across the contractual models:

Table 2 GP Providers by Contractual model (Serco Data - June 2014)

Contracts	Number
GMS	122
PMS	150
APMS	16
Total	**288**

(Note: in 2014/15 it is expected that a further 5 GP practices (3 GMS and 2 PMS) which are aligned to Cambridgeshire and Peterborough CCG, but are located in the boundaries of another Area Team will transfer to become the responsibility of the East Anglia Area Team)

The number of GP providers is altering rapidly due to an increasing number of mergers. In addition a large number of the APMS contracts are approaching their

end date (following option for extension) and the Area Team will be embarking on procurements for these during 2014/15.

The proposed PMS review and alterations in the GMS/PMS contract changes for 2014/15 have a significant financial impact on a large number of practices across East Anglia. The Area Team are committed to working to support practices during the transition to ensure that practices remain viable and patient care is not compromised.

Table 2 Potential practice losses from PMS reviews (Area Team Finance Data June 2014)

Financial Impact	***Number of Practices***
Loss >£200K annually	42
Loss £100-199K annually	67
Loss £0-99K annually	38
Gainers	2
Total	149

Table 3 Practice losses and gains from redistribution of MPIG (Area Team Finance Data June 2014)

Financial Impact	***Number of Practices***
Loss of £50-£185k	15
Loss £0-50K	27
Gain of £0-£50k	46
Gain of £50-£165k	34
Total number of Practices	**122**

4.1.2 Scale

There is currently considerable variation in the scale of general practice provision across East Anglia with the range from less than 1,500 to almost 28,000 registered patients.

Graph 2 – Actual List Size across East Anglia Practices (Serco data April 2014)

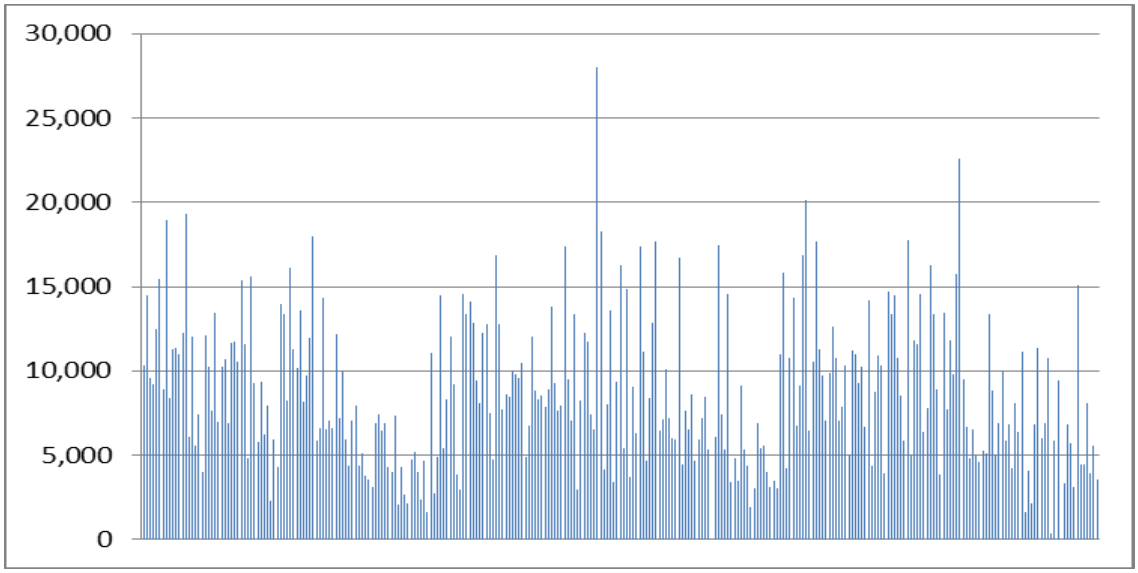


Table 5 Size of practices across East Anglia (Serco data April 2014)

Actual Registered List Size	Number of Practices
<1500	1
1500-2999	12
3000-4999	49
5000-7999	79
8000-9999	46
10000-12999	50
13000-16000	30
16000-19999	16
>20000	3

There are a large number of potential practice mergers across East Anglia as practices seek to ensure their long-term viability and to enable them to extend the services they can provide.

4.1.3 Access to Primary Medical Care

Overall satisfaction with primary medical care services across England remains high, but there are growing challenges in relation to reported patient experience of access to general medical practice care with nearly a quarter of all of patients not rating the

overall experience of making an appointment as good. In England the most recent survey found that 22 percent of people do not find it easy to get through to the surgery by telephone with significant variation reported across the country.

The position in East Anglia would suggest that the position is no different as reflected in the table 6 below.

Table 6 Patient Experience of Access

Indicator	C&P	GY&W	I&ES	Norwich	North Norfolk	South Norfolk	West Norfolk	West Suffolk	England Average
Good overall experience of GP surgery	88.16	90.80	89.71	88.26	90.53	85.44	89.07	91.13	86.74
Good overall experience of out-of-hours GP services	70.36	70.64	62.27	69.00	62.07	62.70	71.10	62.92	70.21
% of patients who find it is difficult to get through to someone at GP surgery on the phone	18.94	12.69	15.39	18.44	14.08	21.18	15.16	12.74	21.53
% of patients who were able to get an appointment to see or speak to someone	88.16	90.16	89.21	88.60	90.60	87.90	90.20	88.70	86.36
Good overall experience of making an appointment	79.58	83.32	81.10	77.53	80.96	74.41	80.96	81.49	76.34
% of patients who were able to see preferred GP on most occasions	63.70	72.54	63.70	58.35	60.51	63.39	66.26	65.64	62.78

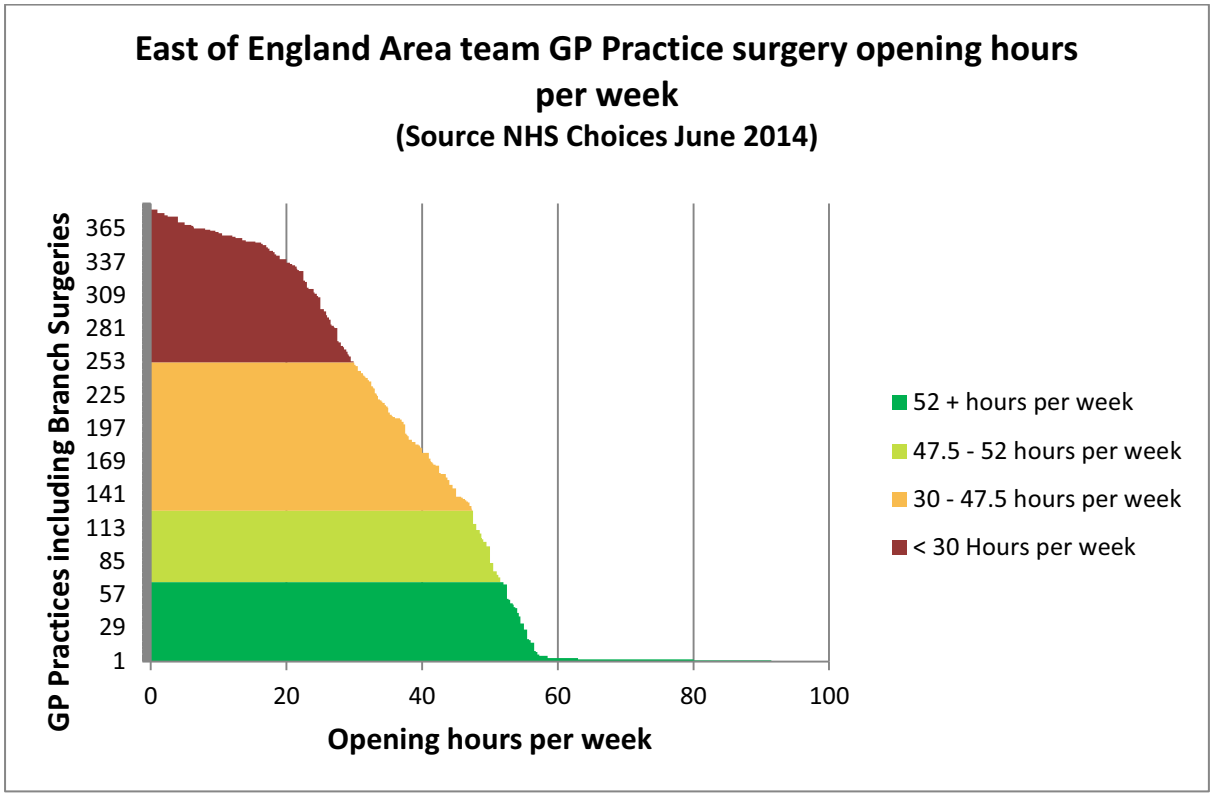
4.1.4 Ease of Access to GP Practices

In addition to patient surveyed perception of opening hours and ease of making an appointment, local analysis has been undertaken highlighting the significant differences in the degree to which a GP consultation is available at times that are convenient to all.

General practices are contracted to provide primary care services between the hours of 8.00 a.m. to 6.30 p.m. Monday to Friday. There is, however, local variation in opening times and specific opening hours are not a condition of national GMS contracts held by GPs although meeting the reasonable needs of patients is required. For example:

- in Cambridgeshire a significant number of practices provide cover from 8.30 a.m. to 6.0 p.m., with a local agreement that the out of hours service covers from 6.0 p.m. to 8.30 a.m.
- many practices close for lunch and/or for an afternoon each week

Graph 3 Distribution of Opening Hours across practices (including Branches)



The information available from NHS Choices suggest s that while 43% of practices (excluding Branch Surgeries) across East Anglia provide more than 52 hours per week in which to book appointments, 21% of practices offer fewer than 37.5 hours and 4% less than 30 hours per week. There is great variation across the CCG areas as outlined in the table below:

Table 7 Distribution of Practice Opening Hours across CCGs (NHS Choices data June 2014)

		Opening Hours per week (Source NHS Choices June 2014)							
CCG	Number of Member Practices	≥ 52		<52 and ≥47.5		<47.5 and ≥40		<40	
		Number	%	Number	%	Number	%	Number	%
Cambridge and Peterborough	103	25	24.3	35	34.0	34	33.0	9	8.7
Ipswich and East Suffolk	41	34	82.9	4	9.8	1	2.4	2	4.9
West Suffolk	25	20	80.0	4	16.0	1	4.0	0	0.0
HealthEast (Great Yarmouth and Waveney)	26	20	76.9	5	19.2	1	3.8	1	3.8
North Norfolk	20	5	25.0	9	45.0	5	25.0	1	5.0
West Norfolk	23	6	26.1	13	56.5	4	17.4	0	0.0
South Norfolk	26	5	19.2	16	61.5	4	15.4	1	3.8
Norwich	22	9	40.9	3	13.6	10	45.5	0	0.0

The distribution of opening hours illustrates times when our population is less likely to be able to secure a routine GP appointment, depending on the practice they are registered with. As general practice is supported to make a greater contribution to the health and care system, the availability of services at times that are convenient to all, together with the cost effective use of premises and workforce in primary care is a key consideration.

4.1.5 Dispensing Practices

In The UK it is generally expected that prescriptions written by a clinician will then be dispensed in a pharmacy. However in rural areas the Pharmaceutical Regulations allow for qualifying GP practices to dispense directly to their patients.

Of the 288 GP practices in East Anglia 148 are dispensing practices, which reflects the rural nature of the area. These practices have over half a million patients on their dispensing lists.

As part of the changes to the arrangements for dispensing doctors agreed as part of the GMS changes in 2006/07, a Dispensary Services Quality Scheme (DSQS) came into effect in September 2006. The Scheme rewards Practices for providing high quality services to their dispensing patients. Practices can choose to participate in the scheme and receive a payment for each dispensing patient; provided they meet the quality the standards. In East Anglia 139 practices signed up to the 2013/4 DSQS and provided evidence of meeting the quality standards. The evidence was supported by a number of quality assurance visits undertaken by the Primary Care Team to practices across the area.

In recognition of the work undertaken by practices to achieve the quality standards of the DSQS the Area Team paid £1.3 million in DSQS payments to practices.

4.1.6 Walk In Centres

East Anglia has 3 walk in centres:

Greyfriars Health Centre, Great Yarmouth
Service delivered in the centre of Great Yarmouth and has registered list of around 4200. Also provides 'walk in' services between 8am and 8pm over 7 days a week
Timber Hill, Norwich
This service is open 7 am – 9 pm, 7 days a week for walk in patients and GP registered list. GP list is approximately 8000 and rising.
St Neots Equitable Access Centre
Service delivered within the centre of St Neots with a registered patient list of approximately 4,000 patients. Also provides a walk in service over 7 days a week 8.00 am – 8.00pm Monday to Friday and 9.00am – 4.00pm Saturday & Sunday. The Practice is permitted Closure on Easter Sunday and Christmas Day.

4.1.7 Quality and Effectiveness

The Quality Assurance Management Framework for Primary Medical Services, supported by the Primary Care Web Tool, introduces high level indicators sorted by outcome standards which are a set of measurable indicators for general practice.

The General Practice Outcome Standards (GPOS) and the General Practice High Level Indicators (GPHLI) present a minimum level of service and outcomes that patients can expect from general practice grouped across the NHS Outcomes Framework domains.

The Primary Care Web Tool is intended to facilitate discussion between the Area Team, CCGs and individual practices to understand the reasons for any variation to support continuous improvement. There is recognition that the information on the Web Tool has a significant time lag and the Area Team will add more up to date information (such as uptake of DES and QOF performance) to aid these discussions

Across East Anglia there are 9 outliers against the GPHLI and the GPOS within the Primary Care Web Tool. The Area Team is developing a GP dashboard and quality improvement framework in collaboration with CCGs to continually monitor and improve the quality of general practice.

4.1.8 Premises

There are a large number of practices seeking to extend or replace their current buildings. There is a legacy of poor infrastructure in many areas resulting in a high number of premises developments in the “pipeline” and the Area Team has instigated a robust programme management processes to support practices to ensure patients are seen in safe and modern environment, maximizing the limited resources available. The area team engages with Local Authority planning departments to seek developer contributions for health care infrastructure to inform decisions on future premises developments.

4.1.9 Workforce

NHS Health of England East of England has undertaken analysis of the GP workforce census 2013 and this has identified that in East Anglia there is the following:

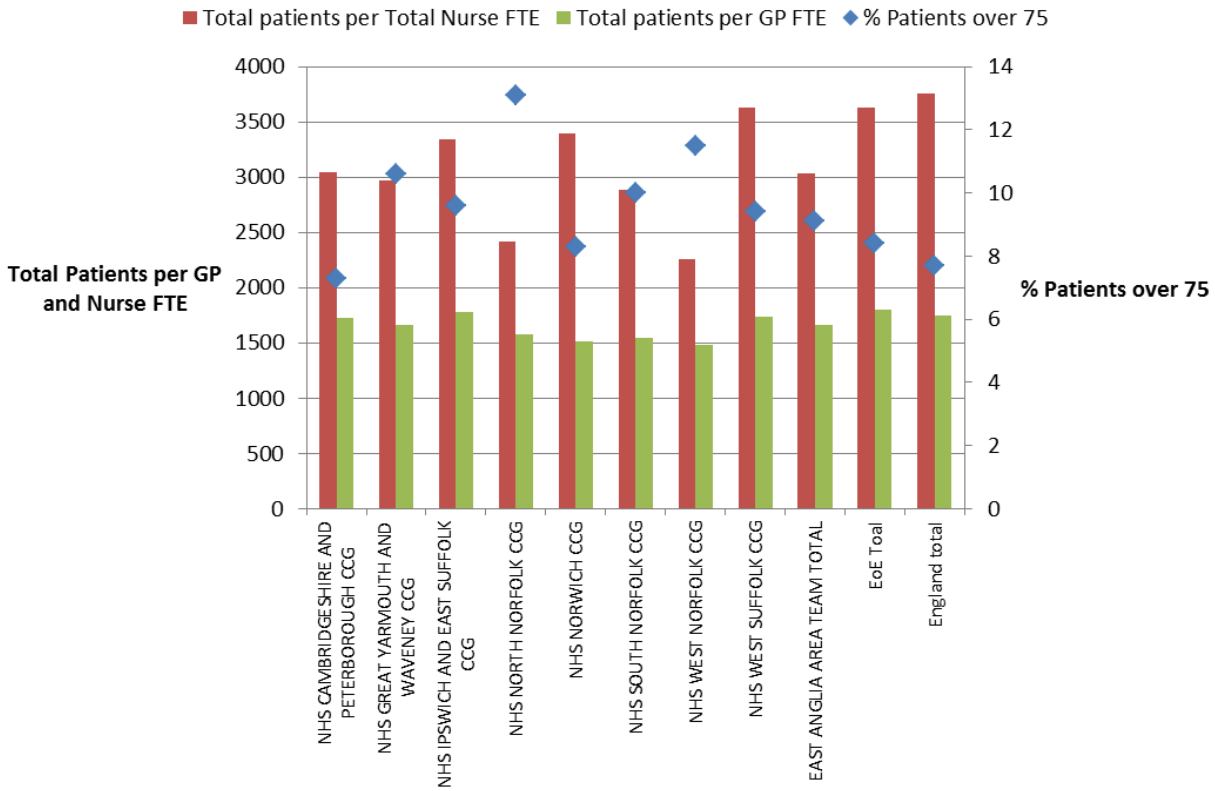
- The high ratio of GPs to GP registrar
- The proportion of non-UK GPs is lower than East of England average but in line with England average
- There are a high proportion of patients over 75 years old
- Although East Anglia is shown to have low number of patients per GP Full Time Equivalent (FTE) and per nurse FTE when viewed in the context for patients over 75 there are real pressures across CCGs
- It should be noted that many of these staff are approaching retirement age and may be hard to replace

- Nurses in East Anglia work more hours than East of England and England average levels
- High percentage of nurses who are Advanced or Extended Nurses
- Ratio of GPs to total nurses is below East of England and England average levels

Recruitment and retention is a significant issue across East Anglia, with particular pressures on general practitioners and practice nursing.

There is evidence of an increasing number of contractors who are taking extended periods of time away from the practice due to sickness and other issues which reflects the increasing pressures impacting on the services provided. The area team is committed to working with practices and CCGs to help address these issues and reduce the pressures upon general practices.

Graph 4 Number of Patients per Full Time Equivalent GP/Nurse by CCG (Workforce Census 2013)



4.2 Primary Care Dental Services

4.2.1 Overview of Provider Base

Primary dental services comprise essential mandatory services plus any agreed non-mandatory services. Since April 2006 there have been two main contractual frameworks to support the commissioning of dental services.

General Dental Services Contracts (GDS) are nationally negotiated contracts that are not time limited. They are classed as either general or mixed contracts; the latter including orthodontic services. Personal Dental Services Contracts (PDS) are negotiated locally but are underpinned by national regulations. They are time limited and generally apply to non-mandatory services such as orthodontic only practices, but can include services such as minor oral surgery, domiciliary services as well as general activity. PDS plus contracts are a variation of the PDS contracts and include quality metrics that reward the delivery of good oral health and improved access. There are a small number of Trust Dental Service Contracts (TDS) which are similar to PDS in being negotiated locally and time limited. They are utilised for 'Community Dental Services' who predominately provide general dental services, screening, epidemiology and treatment under general anaesthetic for vulnerable patients who are referred into the service.

Table 8 Dental Services Contracts by type in East Anglia (Serco data 2014)

Dental Service Contract	Type	Total Number
General Dental Service (GDS)	General	229
General Dental Service (GDS)	General/orthodontic	37
Personal Dental Service (PDS	General	41
Personal Dental Service (PDS	General/orthodontic	3
Personal Dental Service (PDS	Orthodontic	28
Personal Dental Service Plus (PDS+)	General	4
GDS Pilot	General	6
Total		**348**
TDS	General – community dental service	4
Total		**352**

The 348 Dental Contracts Value is £93.2 million per annum.

NHS England is the sole commissioner for all dental services (Primary, Secondary and Community services) and this provides the opportunity to redesign and implement end to end patient pathways for oral health cutting across historical and organisational boundaries improving the patient experience.

4.2.2 Access and Quality

The December 2013 GP Practice Survey Results (July to September 2013 data), show that 94% of patients, were successful in getting an NHS dental appointment in East Anglia in the previous two years. This is 1% above the England rate of 93%.

Overall experience of dental services for those who tried to get a NHS dental appointment in the last two years was 85% good or very good, 9% neither good nor

poor, 6% fairly or very poor. This is 1% above the England rate for good or very good and 1% below the England rate for fairly or very poor.

From the most recent Vital Signs data (March 2014) reports that 93.7% of patients reported satisfaction with the dentistry received against a national position of 93.8%. Satisfaction with the time to wait for an appointment was 91.0% against 90.9% nationally.

The Oral Health Needs Assessment and Orthodontic Needs Assessment, when completed, will guide the area team on future planning and procurement decisions for dental services.

4.2.3 Workforce

Historically there have been issues in recruiting general dental practitioners, in particular in the Norfolk and Great Yarmouth & Waveney area. However following the government initiative to train more dentists over the last past five years there are no reported difficulties in recruiting and retaining dentists within East Anglia.

Table 9 Dentists per head of population by PCT area: year ending 31 March 2013
(Source: Health & social Care Information Centre. Dental stats England 12-13)

	Year ending 31 March 2013				
	Total number of dentists	Population per dentist	Dentists per 100,000 population	Dentists difference 2012 to 2013	Percentage difference 2012 to 2013
Cambridgeshire PCT	324	1,921	52	-7	-2.1%
Great Yarmouth & Waveney PCT	124	1,716	58	-5	-3.9%
Norfolk PCT	375	2,032	49	25	7.1%
Peterborough PCT	102	1,808	55	14	15.9%
Suffolk PCT	325	1,892	53	10	3.2%
East of England	2,834	2,069	48	78	2.8%
England	23,201	2,289	44	281	1.2%

5 General Ophthalmic Services – Eye Health Services

5.1.1 Provider Profile

Table 10 Ophthalmic Contracts in East Anglia (Serco data April 2014)

Ophthalmic Service Provider	Type	Total Number
Mandatory Services Contracts	Independent Contractor (Sole/Partnerships)	73
Mandatory Services Contracts	Body Corporate	140
Additional Services Contracts	Independent Contractor (Sole/Partnerships)	46
Additional Services Contracts	Body Corporate	76
Total Contracts		335

The primary characteristic of the provider profile for general ophthalmic services is a mature retail market with an even split between larger chain and independent outlets. NHS commissioned spend is based on nationally negotiated services and prices. The annual spend on ophthalmic services is in the region of £22.4 million within East Anglia Area Team.

5.2 Community Pharmacy

5.2.1 Overview of Provider Base

The contractual framework for community pharmacy has three distinct elements:

Essential Services which must be provided by all contractors, this includes the dispensing of medicines and appliances, repeat dispensing, public health and support for self-care.

Advanced Services are nationally specified services that can be provided by all contractors if they have met the accreditation requirements and are providing all essential services. There are two advanced services particular to pharmacies – Medicine Use Reviews and the New Medicines Services. Pharmacies and Dispensing Appliance Contractors can also provide advanced services to support patients with their appliances – Appliance Usage Review and Stoma Customisation.

Enhanced Services - are services commissioned in an area or part of an area from community pharmacies and negotiated locally by the Area Team. In 2013/4 the East Anglia AT commissioned a flu vaccination service across the whole area and a service to provide potassium iodate from local pharmacies to residents near to the Sizewell Power Station in case on nuclear emergencies.

In addition to the above, which are commissioned by NHS England, ***locally commissioned services*** can be commissioned by CCGs or Local Authorities. They can include services such as smoking cessation, provision of emergency hormonal contraception and minor ailment services.

5.2.2 Access

Generally hours of availability of community pharmacies extend into the evening and weekend. In addition across the area there are 59 pharmacies that open for 100 hours per week

5.2.3 Dispensing Appliance Contractors (DACs)

Over 450,000 patients in England are currently using stoma or incontinence appliances as a result of conditions such as cancer, multiple sclerosis, and bowel disease or other serious illness or accidents. For many they are long-term conditions indicating that these patients are the most intensive users of specialist healthcare and social care services.

DACs are suppliers of appliances that have developed over the years in response to the growing needs of their patients and provided advice, care and support. DACs generally operate regionally or nationally offering delivery and related services for the supply of appliances. Their contracts are managed by the Area Team of the area where their contract is held; and their terms of service are outlined in the pharmaceutical regulations.

In East Anglia there are six DAC contracts that are managed by the primary care team

5.2.4 Workforce

Unlike the pressures seen within general practice, due to the creation of extra Schools of Pharmacy in the recent past there are plenty of qualified community pharmacists. There is opportunity to utilise this skilled and underutilised resource in addressing the workforce pressures within general practice and wider primary care service provision.

5.3 Summary

In summary,

- East Anglia is an extensive geographical area, which includes large rural areas and significant areas of deprivation.
- Significant population growth is anticipated across the whole area team which will impact on primary care commissioning and service provision
- GMS/PMS contract changes will adversely impact financially on comparatively high number of GP contractors in East Anglia

- Recruitment and retention is a significant issue across East Anglia, with particular pressures on general practitioners and practice nursing.
- There are more than enough community pharmacists who could possibly help reduce workforce pressures
- There is evidence of an increasing number of contractors who are taking extended periods of time away from the practice due to sickness and other issues which reflects the increasing pressures impacting on the services provided
- There are a significant number of time limited dental and medical contracts across East Anglia which may require procurements to be undertaken in the next 18 months
- There is a legacy of poor infrastructure in many areas resulting in a high number of premises developments in the “pipeline”

6 The Case for Change

6.1 Demographic Change

The population in England as a whole is growing and people are living longer. Both the proportion and absolute numbers of older people are expected to grow markedly in the coming decades. The greatest growth is expected in the number of people aged 85 or older – the most intensive users of health and social care.

While there are distinct differences in population profiles across East Anglia as illustrated below, the national trends are reflected locally.

Table 11 Expected Population Growth across CCG area

Population

NHS England

				By 2025			
CCG	Registered patients	Registered patients 65+	% Registered patients 65+	Registered patients	% increase in registered patients	Registered patients 65+	% Registered patients 65+
CAMBRIDGESHIRE AND PETERBOROUGH CCG	866,938	136,179	16	975,305	12.5	186,179	19
NORWICH CCG	208,024	34,627	17	226,330	8.8	45,266	20
IPSWICH AND EAST SUFFOLK CCG	388,915	77,782	20	426,640	9.7	63,372	28
WEST SUFFOLK CCG	236,834	48,973	21	263,359	11.2	63,206	24
SOUTH NORFOLK CCG	224,776	48,409	22	250,625	11.5	62,656	25
GREAT YARMOUTH AND WAVENEY CCG	231,401	52,799	23	248,293	7.3	68,200	27
WEST NORFOLK CCG	165,399	40,291	24	183,262	10.8	47,648	26
NORTH NORFOLK CCG	167,804	45,740	27	182,403	8.7	54,721	30

The health care needs of the population are also changing. In England 53 percent of people report that they have a long-standing health condition and the number of people living with more than one long-term condition is set to rise from 1.9 million in 2008 to 2.9 million in 2018.

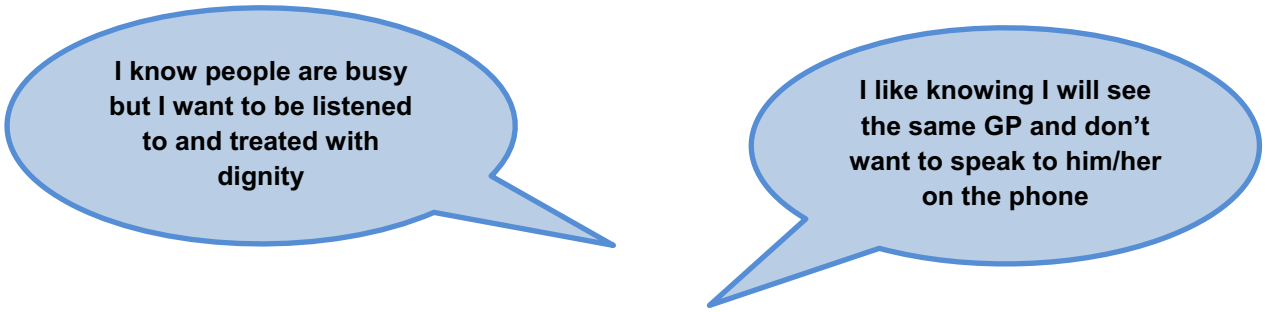
6.2 Changing Patient Expectations and improving access

The expectations of patients are changing and local discussions have highlighted what is seen by many working in primary care to be an increasing divergence between what patients are expecting/demanding and what would be clinical appropriate care i.e. need.

Although General Practice and other primary care services are generally highly valued within East Anglia the main concerns patients have expressed are:

- Please make it simpler for me, my family or carer to access and receive primary care services

- Please allow me to book in advance and not have to keep ringing day after day for an appointment
- I would like to see the same GP or nurse to ensure continuity of care
- I do not understand why referrals take so long and wish this was explained to me
- I feel that the GP is often rushed and that other staff do not treat me with respect
- I do not have access to a computer and feel disadvantaged as I can't book my appointment or order my prescription online
- I do not want to have a telephone consultation but want to see my Doctor face to face
- Please explain the difference between being registered with my Doctor and how I get Dental care
- Please make it clearer on dental charges and when people are exempt



There is a local acceptance among professionals working within primary care that this perception of poor access must be addressed through a combination of improving access AND helping patients to be effective and appropriate users of primary care services.

6.3 Increasing pressures on the wider NHS system and financial resources

Access to, and capacity within, primary care has also been linked to pressures being experienced across the rest of the NHS. Between 2003/04 and 2011/12 the number of emergency admissions for acute conditions that might not usually require hospital admissions is reported to have increased by 34 percent. There has also been a reported increase in the number of emergency hospital admissions and A&E attendances for conditions that could be treated in the community.

Financial constraints and wider health and social care system challenges also impact on how a primary care service is delivered.

Primary care will be expected to help meet the challenge of the projected 2021/22 funding gap of £28 billion, providing more personalised, accessible community-

based services for patients, particularly for older people with multiple long term conditions.

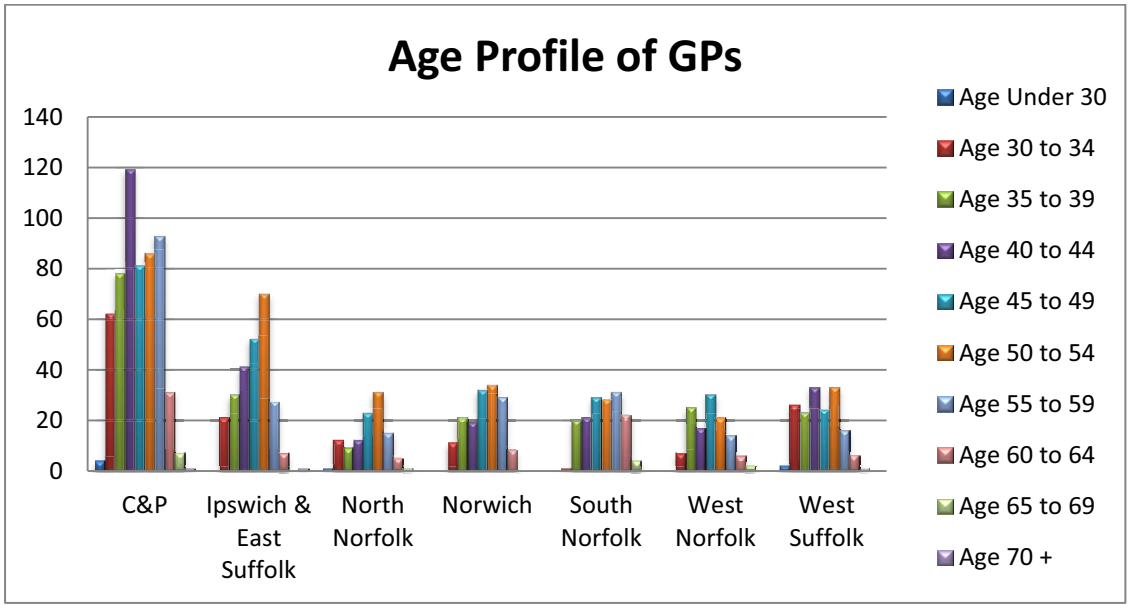
6.4 Increasing workforce pressures

The primary care workforce is also changing and there is increasing concern with regard to workforce pressures, including recruitment and retention problems particularly impacting on general practitioners and practice nurses.

The general practice workforce has not grown as quickly as other medical specialties - between 2002 and 2012 there was an average two percent increase in GPs compared to an average four percent increase in hospital consultants.
There is also a changing gender mix in general medical practice. In 2012, 57 percent of GPs were men and 43 percent were women with more women GPs under the age of 40 than men, and more men in the higher age bands, from 50 onwards. This has significant implications for workforce planning as female GPs are more likely to leave the profession earlier in their careers than their male counterparts. The peak age band for female GPs leaving the workforce is 30 – 34 years and the peak age band for males leaving is 55 - 59 years.

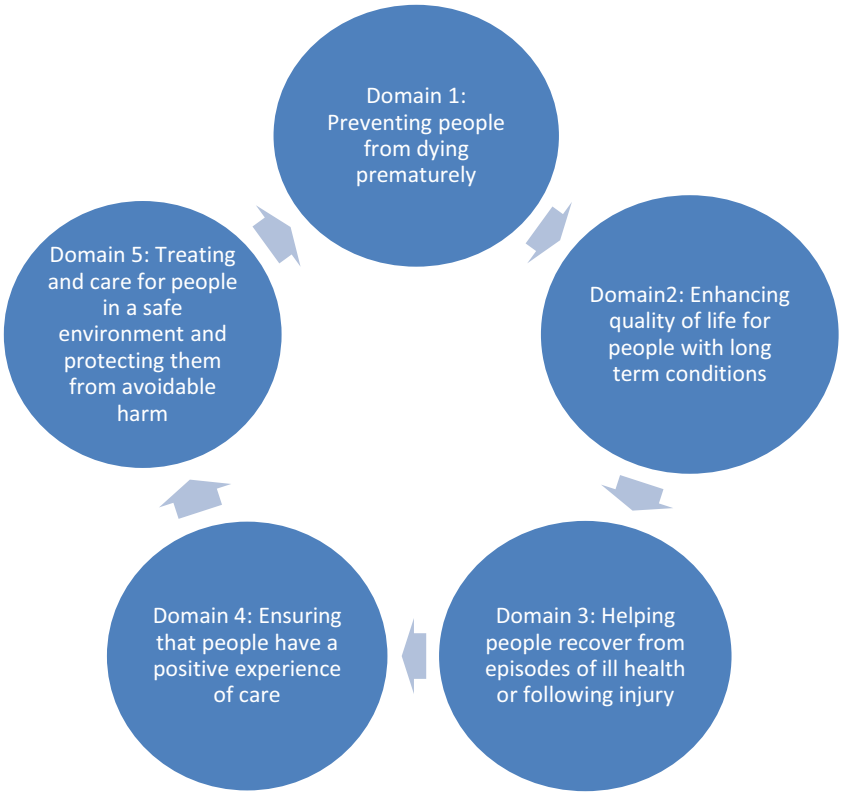
The discussions that have taken place across East Anglia would suggest that workforce pressures represent the most significant issue impacting on primary care sustainability at present.

Graph 5 Age Profile of GPs across CCGs in East Anglia (Workforce Census 2013)



7 A Shared Ambition - Locally Led, Nationally Enabled

Our local discussions have confirmed that there is a shared ambition to create thriving, high quality and sustainable primary care that works to improve health outcomes and support a reduction in health inequalities. This is directly linked to the ambition to ensure that primary care is able to maximise its' contribution to improving outcomes against indicators in the five domains of the NHS Outcomes Framework:



To do this, we recognise that we need to create an environment that enables general practice and primary care more generally, to play a much stronger role, as part of a more integrated system of out-of-hospital care to:

- Provide proactive co-ordination of care (or anticipatory care), particularly for people with long term conditions and more complex health and care problems.
- Offer holistic care: addressing people's physical health needs, mental health needs and social care needs in the round.
- Ensure fast, responsive access to care, preventing avoidable emergency admissions to hospital and A&E attendances.
- Promote health and wellbeing, reducing inequalities and preventing ill-health and illness progression at individual and community level.

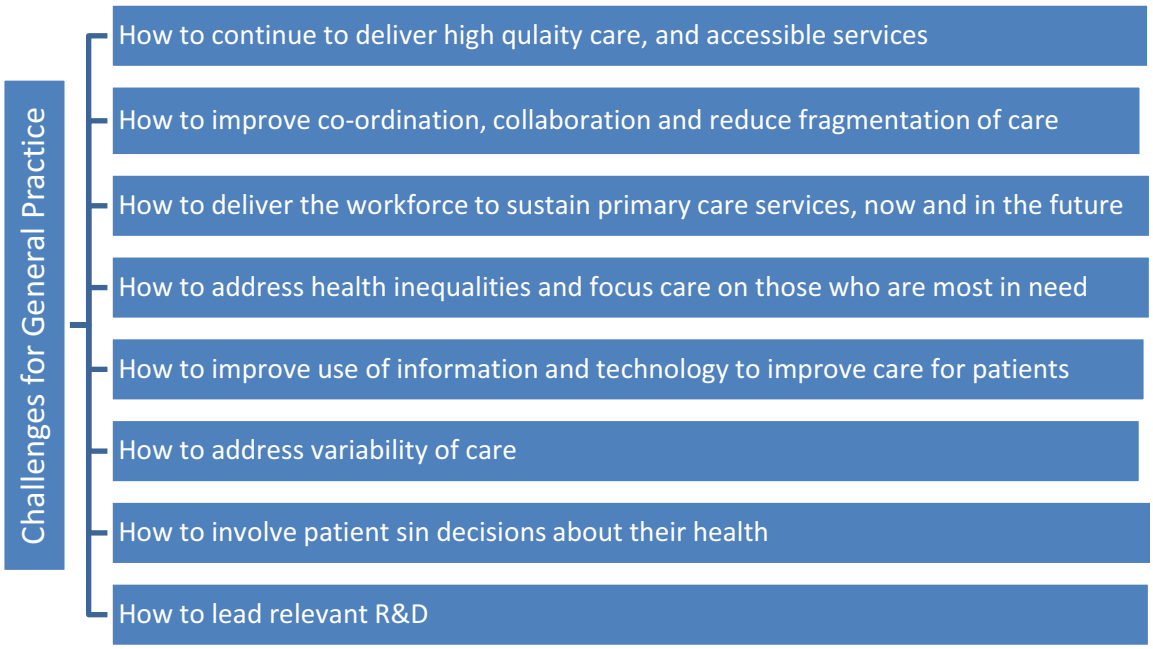
- Personalise care by involving and supporting patients and carers more fully in managing their own health and care.
- Ensure consistently high quality and value of care: effectiveness, safety and patient experience.

It is recognised that the development of primary care must be led locally, with strong collaboration between the NHS England East Anglia Area Team and the 8 Clinical Commissioning Groups and associated Health and Wellbeing Boards with which it works. Local strategies, based on the needs of local communities and the priorities that Health and Wellbeing Boards have identified will be key to informing this work.

NHS England nationally has a role in working to ensure that the national contractual frameworks can support the delivery of local approaches to enable primary care to be the best that it can be.

8 Transforming Primary Care – A Framework for East Anglia

There is a growing acceptance that general practice will be most likely be able to address these challenges and seize new opportunities if it operates at greater scale and in greater collaboration with other providers. At the same time there is also acceptance that general practice should preserve its traditional strengths of providing personal continuity of care and its strong links with local communities.[1]

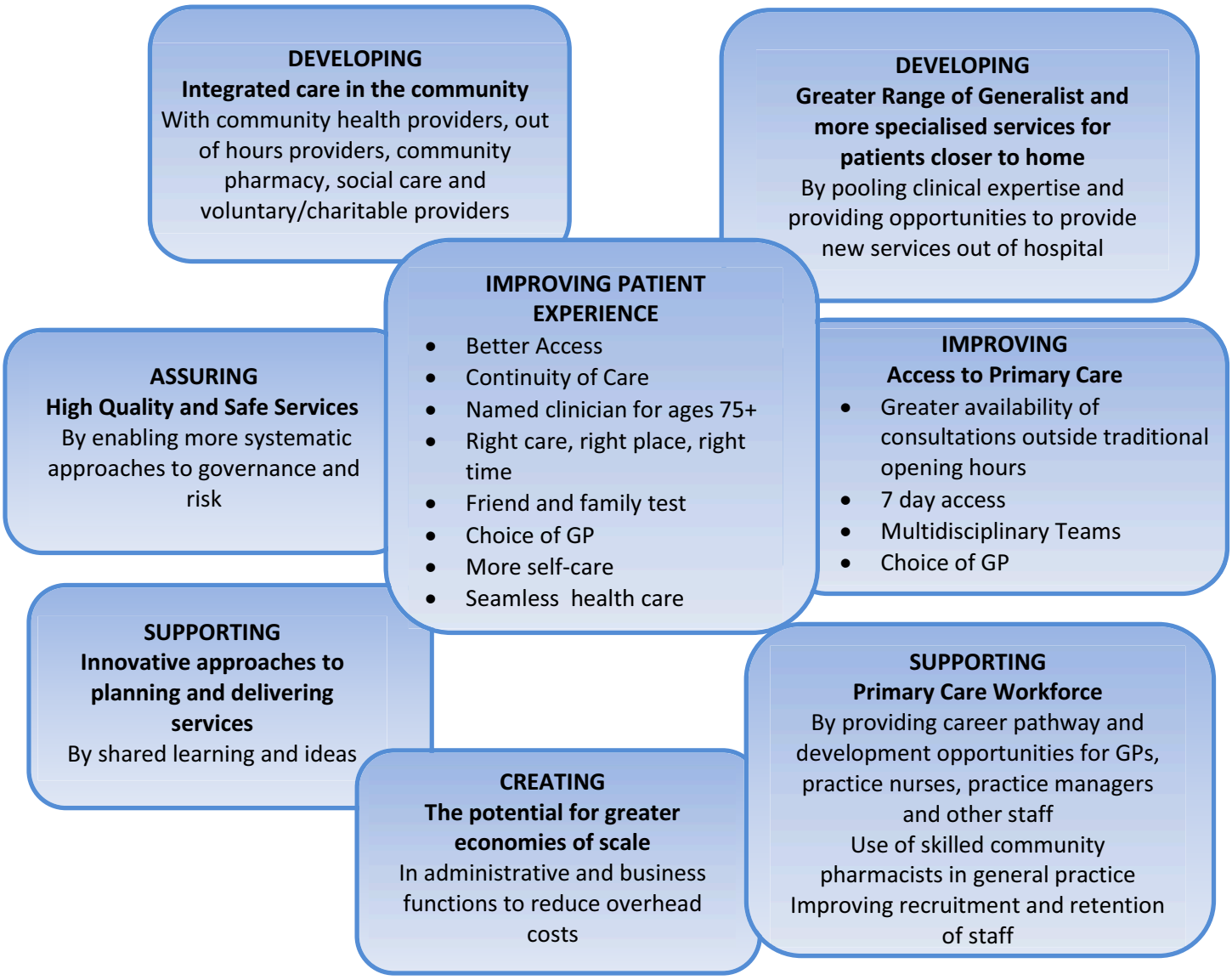


Patients, Doctors and the NHS in 2022 – Compendium of Evidence.[2]

Our local discussions have confirmed that there is no single blueprint for how general practice and the wider primary care community can best meet our shared ambition. It is clear that it will not be achieved simply or primarily by adopting new organisational forms. Our focus will therefore be on working collaboratively to understand how best we can work with primary care professionals to enable them to provide services for patients more effectively and productively, and how we can help practices benefit from collective expertise and resources.

Our Strategy is aligned to the CCG plans that have some common themes and objectives around improved access to a wider range of services; developing multi-disciplinary teams; supporting the workforce to improve patient experience.

Locally there are discussions taking place to consider how primary care providers can work more collaboratively through coming together by merging partnerships, in locality groupings, federations, networks or 'super-partnerships' that reflects their local circumstances that would enable the following:



9 Achieving Our Ambition

Achieving our ambition will depend on harnessing the energy and enthusiasm of all those who work in and with primary care. There is also strong recognition that there are key areas of work that can, and must, be progressed locally.

These fall in to two key areas:

- Progressing work that supports the operational excellence of primary care services.

- Developing, with Clinical Commissioning Groups, a service model that supports the delivery of primary care at scale;

9.1 Priorities for Supporting Operational Excellence

9.1.1 Workforce Planning and Development

What are we doing?

- We will continue to work with Health Education England and local Workforce Partnerships to develop practical proposals to address the immediate and longer term challenges. This will include:

    - A comprehensive review of the general practice workforce across East Anglia

- Proposals for a package of measures to improve recruitment in those areas which are experiencing difficult, e.g. incentives to come to the area
- Proposals for new ways of working e.g. role of clinical pharmacists, consultant nurses within the General Practice Team
- Proposals to raise the profile of general practice across East Anglia, focusing on the opportunities that exist, with specific reference to research and development etc.,
- Ensure access to appropriate professional training and development of primary care staff.

9.1.2 Enabling the Sharing of Information

What are we doing?

- We will establish a Task and Finish Group to provide a clear framework to support the sharing of information across health and social care in East Anglia, building local expertise and champions.

9.1.3 Fair Funding

What are we doing?

- We will continue to work with the three LMCs and CCGs to ensure an open and transparent approach to the funding of primary care services across East Anglia. This includes:
  - Collaboratively agreed process around PMS reviews and transitional support to practices that will be significantly disadvantaged to ensure service sustainability
  - Clear criteria around addressing health inequalities, work force issues and quality improvement/innovation in primary care to enable integrated service delivery for reinvestment of released primary care funding.

9.1.4 Investment in Infrastructure

What are we doing?

- We are progressing with the agreed high priority estates developments across East Anglia; ensuring developments promote integrated service delivery where possible.
- We will continue to work with CCGs to ensure that the planned investment in priority primary care infrastructure achieves real benefits to patients.

9.1.5 Improving Access

What are we doing?

- We will continue to work with Patient Groups, Practices and Healthwatch to review current access to general practice services across East Anglia and patient experience and develop proposals for improvement. We expect this to include:
    - Locally agreed access standards for urgent and routine care
    - Sharing of best practice to improve access for patients
    - Learning from the Prime Minister Challenge Fund sites

9.1.6 Tackling Variation

What are we doing?

- We are working with partners across the Region to develop a toolkit to promote best practice and tackle poor performance;
- We are developing and agreeing a Quality Improvement Framework within General practice to allow identification of outliers against a matrix of information areas in collaboration with our CCGs

9.1.7 Supporting New Models of Primary Care

The current model of primary care is such that the four primary care services (general practice, community pharmacy, dental practices and opticians) all work independently of each other, both professionally and geographically. Their links with other services, such as social care, district nursing and health visiting, which support people in maintaining their health and independence in the community, also tend to be fragmented.

Already new models of delivering primary care are beginning to emerge across East Anglia and while there are different approaches being taken by each of the Clinical Commissioning Groups there is a general theme emerging that is focused on the delivery of more integrated services for local populations by forming “locality networks”.

This new model of primary care will eventually have these characteristics:

- Primary care providers will work at larger scale within “locality networks” for provide a wider range of services to patients closer to their homes – many of which are currently only accessed in acute hospitals.
- These locality networks will be integrated with community services and aligned with social services resulting in more coordinated care for individuals
- Dentists, Community Pharmacists and Optometrists will be become a fundamental part of the primary care team within the “locality networks” to provide more integrated care

- The demand on urgent hospital care will reduce once primary care is reshaped.
- Patients will be able to access primary care services, seven days a week within the “locality networks”.
- The primary care workforce will change and respond to the changing needs of patients – with enhanced roles for nurses, community pharmacists and health care assistants. There will be staff development opportunities within the locality networks – making them able to attract and retain primary care staff, including GPs.

SECTION 2 – STRATEGIC PLANS FOR PRIMARY CARE BY CCG AREA

This section of the strategic documents has been developed in partnership with the Clinical Commissioning Groups across East Anglia as an integral part of their 5 year planning.

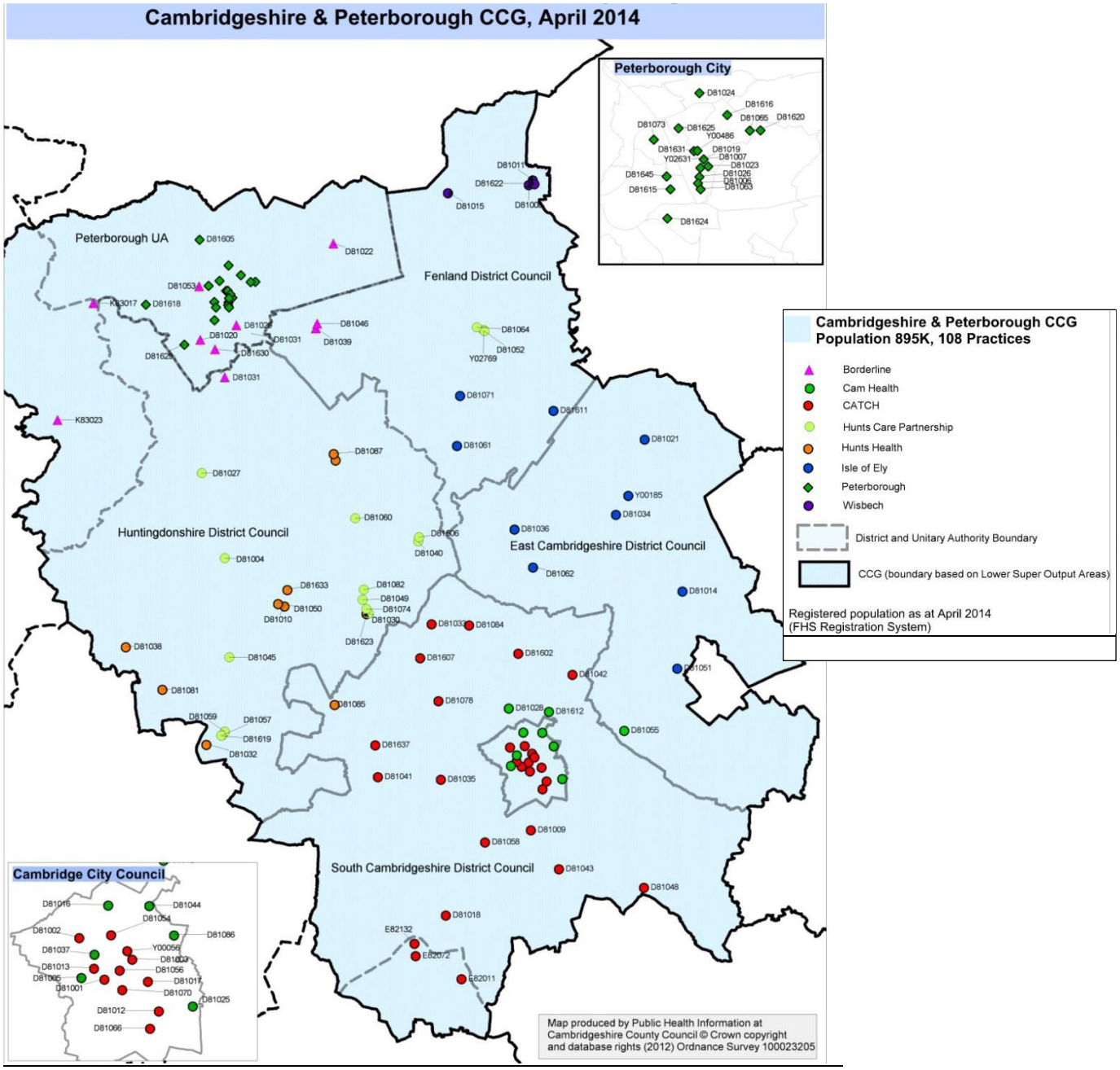
Each CCG Chapter:

- Provides an overview of primary care services in the CCG area
- Sets out the opportunities, challenges and issues specific to the CCG area and context for the development of primary care services, with particular focus on general medical practice services;
- Describes how, through working in partnership the CCG and NHS England will support the development of primary care, and specifically general medical services, to meet the needs of the local population with specific consideration of:
    - The approach to developing primary care to be able to deliver “at scale”
    - The practical actions that will be taken to improve support high quality, sustainable primary care services

10 Cambridge and Peterborough Clinical Commissioning Group

10.1 Overview of Primary Care Services

The main health care commissioner in the Cambridgeshire and Peterborough health system is Cambridgeshire and Peterborough Clinical Commissioning Group (CCG). The CCG is the third largest in England covering a population of over 890,000 across 108 GP practices. The CCG is responsible for ensuring that high quality NHS services are provided to people living in the local area. The following map shows where the CCG's practices are situated:



In Cambridgeshire and Peterborough, local GPs have formed Local Commissioning Groups (LCGs) which ensure a local focus when decisions about health services are made. This means that decision making is shifted closer to patients, enabling local change to happen quickly. Every GP practice across Cambridgeshire and Peterborough, plus two practices in Northamptonshire and three practices in Hertfordshire, is a member of one of the eight LCGs.

Borderline	Peterborough
CATCH	Cam Health
Hunts Health	Hunts Care Partners
Isle of Ely	Wisbech

The table below illustrates how GP services fits into the wider spectrum of settings of care offered to our population.

Patient's home	GP	Community	Ambulatory	Hospital	Tertiary
Ambulance service see and treat. Early supported discharge. GP advice and care (phone and/or in person). Home rehabilitation/ recuperation. Hospital aftercare package. Integrated virtual ward. IV therapy. Pallative care. Primary care, mental health and community input into nursing homes. Rapid response team. Self care following advice. Telephone advice from case manager/ other specialist professional.	Advice and signposting from social care assessment team. Available for advice to hospital staff to support decision making. Early supported discharge. Enhanced unscheduled care access and provision by individual GP practices. Rapid access to advance from hospital specialist. Voluntary sector signposting.	Broader access to nursing homes to return patients where this is their home. Early supported discharge. Enhanced primary care service. Social care assessment providing advice and signposting. Intermediate care in a residential setting. IV therapy. Palliative care. Rapid access to social care assessment to facilitate discharge. Rapid response. Community rehabilitation/ recuperation. Step up/ down.	Certain procedures provided in an ambulatory centre or day surgery unit. Enhanced primary care service.	A&E. Drug, alcohol & mental health liaison. Early supported discharge. ICU/ HDU. MAU/ SAU. Medical and surgical inpatient care. Multi-disciplinary discharge planning from admisison. Primary care led minor injury/ illness service. Theatres.	Specialist cardiothoracic services. Specialist trauma services. Specialist drug and alcohol interventions. Specialist input provided via telemedicine. Specialist medical& surgical input. Specialist psychiatric interventions.
Virtual					
999 including hear and treat, 111, online information, directory of services.					
Source: PwC					

10.2 Opportunities, challenges and issues specific to the Cambridgeshire and Peterborough system

Historically primary care has been a strong aspect of the healthcare system across Cambridgeshire and Peterborough. However NHS England has recognised at a national level that general practice and wider primary care services (pharmacy, optometry and dental services) face increasingly unsustainable pressures and that there is a need to transform the way primary care is provided to reflect these growing challenges.

Challenges facing General Practice nationally include:

- growing reports of workforce pressures including retirement, recruitment and retention problems particularly in general medical practice combined with significant pressures with rising workload demands
- increasing demand due to an aging population, growing co-morbidities and increasing patient expectations resulting in increasing consultations;
- increasing pressure on NHS financial resources, which will intensify further from 2015/16;
- continued dissatisfaction with access to services – both in-hours and out-of-hours;
- persistent inequalities in access and quality of primary care;

These issues are intensified across Cambridgeshire and Peterborough by the effect of the removal of the minimum practice income guarantee over the next 7 years. This System Blueprint therefore needs to take account of the impact of these changes on our practices as both members of the CCG and also crucial providers in the local health economy.

10.3 Vision for Primary Care

The Cambridgeshire and Peterborough health system has broadly agreed to a set of strategic aims for the next 5 years and strategic goals that will move us to them:

Aims March 2014	Strategic Goals April 2014	Care Design Groups by July 2014	Finalised design and system implementation plan by April 2015		Implementation for outcomes May 2015 on
Empowering people to stay healthy	Prevention of ill health and promotion of wellbeing for all	Prevention and self care	System blueprint	Detailed Implementation Plan	Reducing PYLL from causes amenable to healthcare
	Keeping people safe				Improving health related quality of life for people with Long term conditions
	People have trust and confidence in our NHS and help shape their healthcare	Older People and Vulnerable Adults			Reducing avoidable hospital admissions
Improving quality, improving outcomes	People are listened to throughout their care	Women's and Children's			Increasing the proportion of people living independently at home following discharge from hospital
	Making the best use of our NHS by giving the right care, in the right place at the right time	Mental Health			Increasing the number of people with a positive experience of hospital care
Developing a sustainable health and social care system	Services are seamless, integrated and centred around the person	Elective care			Increasing the positive experience of care in general practice and the community
	The services we commission match the needs of our population ensuring fair access in relation to need	Non elective care (including cancer)			Reducing avoidable deaths in our hospitals

We have identified that our biggest challenge is to ensure that we make the best use of our NHS by giving the right care, in the right place and at the right time. To do this we need to ensure clinical effectiveness, cost- effectiveness and health system efficiency.

The CCG has worked with GPs at Member Practice events, Provider Stakeholder events, through discussion at Local Commissioning Group Board meetings, discussions with the Area Team and through the elective and non-elective Care Design Groups to identify a set of critical success factors for primary care. These success factors are as follows:

- Generate a greater sense of individual responsibility to remain well and choose health lifestyle choices to avoid ill health
- Reduce unwarranted variation and address inequalities (evidence shows that primary care can reduce inequalities and improve health outcomes[5])
- Deliver quality improvement
- Improve access to GPs
- Develop capability and capacity to meet the demands of a rapidly increasing population, and a greater number of older people with associated frailty and long term conditions

As the CCG moves into Phase 2 of the 5 year strategic planning work, the critical success factors will be discussed in detail and plans developed to ensure their delivery.

10.4 Key Enablers to Achieve Vision

To enable these changes to happen the following the following enables need to be considered:

- Closer working with Public Health England to promote self-care and healthy lifestyles
- Exploration of options to deliver primary care at scale through, for example, increased collaboration between GP practices
- Review of capacity within primary care including mapping against demand
- Better signposting of services
- Improved communication between GPs and secondary care clinicians

[5] Contribution of Primary Care to health systems and Health, Barbara Starfield, Leiyu Shi, and James Macinko, The Milbank Quarterly, Vol. 83, No. 3, 2005 (pp. 457–502)

11 Ipswich and East Suffolk Clinical Commissioning Group

Ipswich and East Suffolk CCG is embarking on the development of a primary care strategy. Some of the building blocks for the strategy inform this Chapter but it should be noted this work will not be complete until September 2014. Therefore some of the statements contained within this chapter will be revised.

11.1 Overview of Primary Care Services

There are 41 GP practices in Ipswich and East Suffolk within four localities: Ipswich; Suffolk Brett Stour; Deben Health Group and the Commissioning Ideals Alliance.

The overall quality of primary care services exceeds the England average for:

- overall experience;
- ability to get through to a surgery by phone,
- ability to get an appointment to see or speak to someone
- enough support from local services to manage their conditions

Emergency admission rates per 1000 population are also below the England average. This is provided within the context of an aging population with higher percentages than the England average for patients with long term conditions and people registered in nursing homes.

This position is supported by GPs involved in the re-design of services, planning and prioritisation decisions.

All 41 practices are members of the Suffolk GP Federation, a not for profit federation of 61 independent practices covering 540,000 patients. Practices remain independent organisations whilst collaborating in further development of primary care including service delivery.

Primary care services in Ipswich and East Suffolk, particularly GP services now face, however, some significant challenges including:

- GP, nurse, practice manager retention and recruitment
- Capacity to respond to changes required by service and contractual changes
- Financial viability (the scale of which will be dependent on contractual changes).

11.2 Opportunities, challenges and issues

11.2.1 Opportunities

11.2.1.1 Enhanced Integration

The CCG is ambitious to sustain and further enhance care through greater integration and alignment. This is an essential element of the Health and Independence Strategic Programme. Models which can be built upon include:

- local neighbourhood teams of social care, GPs, mental health services and community service providers
- integrated diabetes service which joins the primary and secondary care services
- dementia diagnosis services which join primary and mental health services.

11.2.1.2 Delivery at scale

The CCG, through the development of a primary care strategy will explore opportunities and constraints for delivery of services at three levels:

- Practice provided, locally delivered, list based care offering local access and continuity of care
- Practices working together on a locality basis to enable greater specialisation, achieve economies of scale and provide a wider range of services in a more local setting
- Practices working across the CCG, potentially facilitated by the local GP Federation to deliver a wider range of services at scale.

11.2.2 Challenges

A number of challenges facing primary care will be examined through the strategy development process.

11.2.2.1 Recruitment and retention

The increasing age and profile of GPs and Nurses in Suffolk means that recruiting and retaining primary care staff is increasingly critical to the continued delivery of high quality of general practice.

As part of the work on developing a primary care strategy it is planned to identify (and implement) approaches which respond to this issue.

11.2.2.2 Practice Viability

There are a number of drivers having an impact upon practice viability, the main ones being;

- Phasing out of MPIG
- Seniority allowances
- Potential reductions in PMS income
- The small uplift to contract relative to practice costs
- Reduction in investment in ICT
- Increasing operating costs

The CCG will examine these issues and action required to ameliorate these risks and enhance viability.

11.2.2.3 Service changes

The scale of changes to national policy and local ambition for improvements to the quality of services and outcomes for patients provide opportunities but also immense implementation challenges for primary care. How to ensure successful implementation of this immense change programme will be a key feature of the primary care strategy.

11.2.2.4 Growth in demand

There are a number of factors driving an increase in demand for primary care services, including:

- Overall population in line with Local Plans
- the needs of a growing elderly population
- a higher than England average of patients with multiple long term conditions
- an increase in patient expectation
- 'medicalisation' of non-medical conditions.

The CCG is examining these issues through its health and social care review and this will again inform the primary care strategy.

11.3 Vision for Primary Care

Ipswich and East Suffolk CCG is ambitious and wants to support its local practices to develop in such a way as to meet the existing and future challenges. Our primary care strategy development process will set out a clear vision and goals for the next five years in the context of our overall commissioning strategy.

11.4 Key Enablers to Achieve Vision

There are a number of enablers that need to be aligned with the CCG ambitions for primary care. These are described below;

11.4.1 Scale of delivery

Our primary care strategy will include clear statements on elements of service that need to be undertaken at a very local level and those which may be better delivered by a group of practices. This may be at a small cluster, locality or CCG wide scale.

11.4.2 Models of delivery

The strategy development process will also consider possible options for new models of delivery to respond to long term commissioning opportunities and constraints. This will include consideration of local, national and international examples.

11.4.3 Clinically-led Change Leadership

Clinically-led change leadership will be an essential element of successful implementation. Ipswich and East Suffolk CCG Clinical Executive includes 14 GP leaders and the Federation Board includes a further seven GP leaders. There is a vibrant wider leadership community. This leadership needs to be supported and sustained. The CCG's education and training events and system-wide Clinical Leaders Programme are just two platforms for this.

11.4.4 Co-commissioning

The CCG had previously agreed that it was right to take greater ownership of the issues facing primary care and to help shape the future models of primary care in East Suffolk. Co-commissioning with the Area Team provides a further potential vehicle for this ambition to be realised.

11.4.5 Recruitment, retention and workforce development

Recruitment, retention and workforce development are critical to delivery of the primary care strategy. The CCG is currently issuing a survey to understand the scale of the recruitment and retention challenge to supplement the data provided in Section 4. The CCGs will develop responsive plans with practices the LETB and Area Team and partners, as appropriate.

11.4.6 Estates and IT

Strategic planning and investment in estates and ICT are fundamental to delivery. The CCG already has an ICT strategy which includes primary care. This will be reviewed in the context of the five year strategy.

12 West Suffolk Clinical Commissioning Group

12.1 Introduction

West Suffolk CCG has 25 member practices, organised in 3 localities, with around 160 GPs. The CCG enjoys high quality GP services. There is an experienced and high quality workforce in place who provide high quality services – for example, a recent study has shown that West Suffolk GPs are in the top 5 nationally for the early diagnosis of cancer.

This position is supported by GPs involved in the re-design of services and planning and prioritisation decisions. In addition the CCG facilitates a programme of education, GP practice visits and locality meetings.

The CCG is committed to providing access to a broader range of services in the community to support those patients with moderate mental or physical long-term conditions. This entails transforming community-based services with an expanded role for GPs to coordinate and deliver comprehensive care – putting those healthcare professionals at the heart of a more integrated system of community-based services.

12.2 Opportunities and enablers, challenges and issues specific to West Suffolk

12.2.1 Opportunities and enablers

12.2.1.1 Enhanced Integration

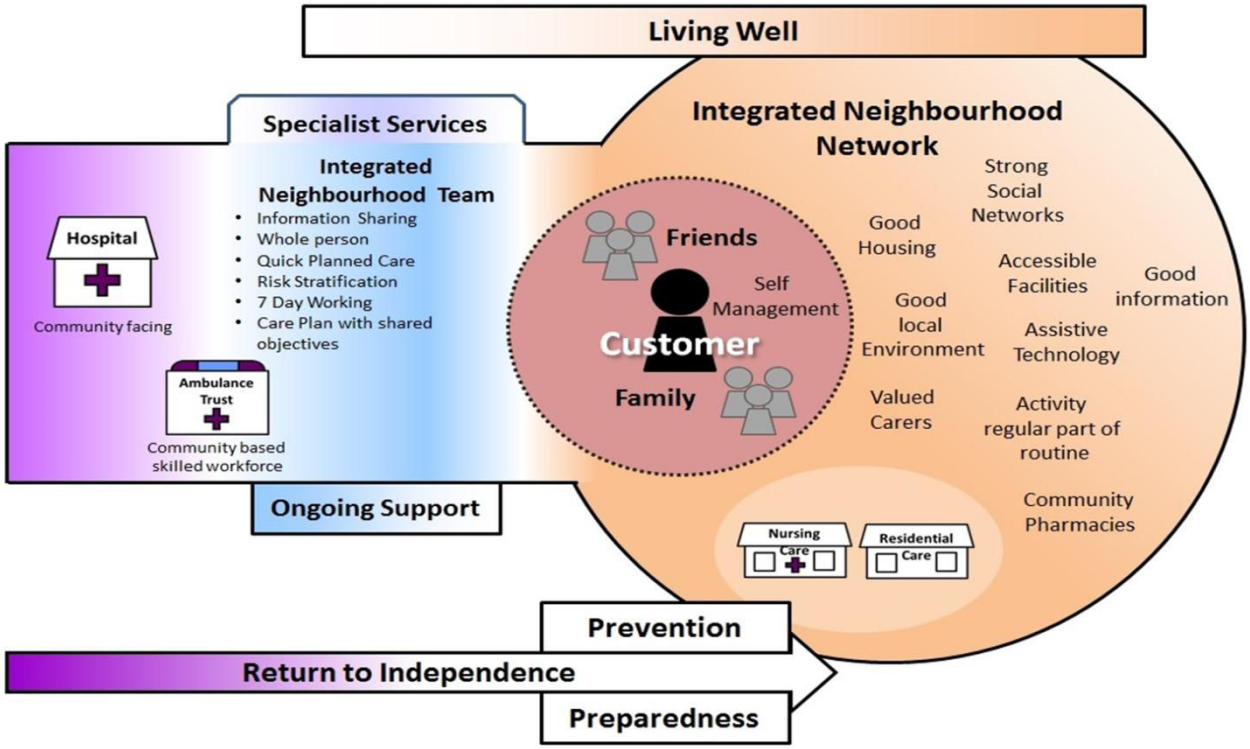
GP services sits at the heart of the 'Health and Independence' model being developed in its 5 year plan (see diagram below). The CCG recognises that it plays a critical role in the prevention of ill health and the management of people with long term conditions. The CCG places GP services at the heart of its joint plan with all partners in Suffolk to support people at home through the implementation of risk stratification, integrated neighbourhood teams, case management and care coordination.

GPs will be a key part of the integrated neighbourhood teams, which will include local mental health, social, community, and specialist out-reach services. These teams will access local neighbourhood networks which bring together local community assets.

The integrated neighbourhood teams' role will be to maintain individuals' independence, enable self-management and support admission prevention activity and effective hospital discharge. The integrated neighbourhood teams will build local health profiles, including the profiles of urgent care/admissions, cross population spend and possible cost profiles and develop shared market intelligence, business

intelligence and performance metrics. The integrated neighbourhood teams will work to the following principles:

- Holistic assessment
    - Creating an outcome focused plan with patients
    - Coordinating the health, care and other inputs into the plan
- Identifying patterns of activity in order to allocate resources to areas of high impact
- Responding to need – arrangement of services and opportunities: with social work, health interventions and therapies
- Encouraging and enabling self-management



To support the 'Health and Independence' model, the CCG is also building a Comprehensive Geriatric Assessment (CGA) pathway across West Suffolk, where GPs are central. It is a continuum of support for individuals and their family carer to reach and maintain their optimum health and well-being, so as not to hit crisis where possible.

The intention is to identify in the community, appropriate support and identify those individuals who, without intervention may tip into crisis within the next year (this will be further advanced by Risk Stratification thus turning unplanned care into planned care).

The additional components that form the CGA offer are:

- Same day diagnostics (to be offered as locally to the person as possible) with acute assessment, clinical review and a shared care plan.

- Enhanced community clinical workforce – additional advanced care practitioners (ACPs); Interface Geriatrician (IG) time to support the Community Intervention Service (CIS) and community teams for special advice; nurse consultant; rotational and secondment posts between WSFT and SCH for therapy; increased nursing within the CIS for additional IV therapy.

- Specialist advice via the Geriatrician of the Day – this service can be accessed by key healthcare professional involved in an individual patients care including GPs, ACPs, CIS and duty social care officers.

- Management of step-up/step-down and rehabilitation beds.

- Intense high level intervention and review at point of need – system-wide.

- A Care-coordinator for case management. Each person entering the CGA pathway will have an identified professional who will ensure that the shared care plan is delivered.

- The individual and their family carer may also be further supported by the voluntary and community sector. Age UK Suffolk, Suffolk Family Carers and Crossroads Care East Anglia have all been commissioned

- to provide home support services, social networking, information and advice.

There are two ways to enter the CGA pathway:

1. Through identification by the GP and/or community practitioner via a MDT approach. This will be discussed with the patient (their family carer) and any other support service they require input from.

2. Post an intense intervention period with the CIS or post an admission to the acute trust where CGA will be available at ward level across specialities. Both require timely pro-active discharge planning.

This planned approach allows the CGA to proactively work with the person and their family carers so as to optimise health and well-being. If whilst on the CGA pathway the person requires a more intensive intervention, then this will be delivered within 2 hours. The person may well remain in their own home or step up into a community bed, but diagnostics will be available on the day. This element of the pathway is known as the 'virtual ward' and will be managed by the ACP and the individuals GP under the specialist advice of the IG.

For those on the 'virtual ward', there will be twice weekly ward rounds and weekly Multi-Disciplinary Team meetings.

12.2.1.2 Delivering at scale

The CCG is currently supporting practices to find local solutions to the challenge of scale where it is helpful and encourage locality based working. There are 3 localities in West Suffolk and we would like to strengthen them further to influence the local shape of community services.

Learning will also be taken from Ipswich and East Suffolk, who are developing a vision based upon three areas:

- Practice provided, locally delivered, list based care offering local access and continuity of care
- Practices working together on a locality basis to enable greater specialisation, achieve economies of scale and provide a wider range of services in a more local setting
- Practices working across the CCG patch, potentially facilitated by the Suffolk GP Federation to deliver a wider range of services at scale. This approach also facilitates the delivery of other strategies and plans, for example the process to ensure that only activity that has to take place in hospital is delivered in a secondary care setting.

12.2.1.3 Working with NHS England

The CCG has expressed an interest in co-commissioning GP services with NHS England. It sees this opportunity as an enabler to support the CCG's vision for integration by shaping our out of hospital services and stabilising primary care where possible. It will also enable the CCG to support the Area Team's wider strategic framework for primary care.

12.2.2 Challenges

There are a number of challenges facing local GP services. Some are significant and require swift and clear action, others are equally important however will come to the fore over the next few years.

12.2.2.1 Recruitment and retention of GPs and practice nurses

The profile of GPs and practice nurses in Suffolk shows that we will have a significant number of retirements in the next 5 years. This demonstrates that recruiting and retaining primary care staff is becoming increasingly critical to the continued smooth functioning of general practice.

12.2.2.2 Practice Viability

There are a number of drivers having an impact upon practice viability, the main ones being:

- Phasing out of MPIG
- Seniority allowances
- Proposed redistribution of PMS income
- Small uplift to contract relative to practice costs
- Reduction for support in IT systems

12.2.2.3 Service changes

There are two drivers that are having and will have a significant impact on practices ability to deliver services; the continuing move to provide more care in a community setting and the related shorter lengths of stay for hospital patients with the consequent impact on their acuity. This will be added to as the move to 7 day working is implemented

12.2.2.4 Growth in demand

As the population ages and lives longer this increases the demand on local primary care services as patients in older age are often suffering for multiple long term conditions.

In Suffolk it is estimated:

- 153,000 (20.9%) people are aged over 65
- 71,700 (9.8%) are aged over 75
- 21,500 (2.9%) are aged over 85
- 78,000 people are informal unpaid carers of people with health and care needs

By 2031, it is projected that there will be a 55% increase in the number of persons over the age of 65 in Suffolk, and a 72% increase in the number of persons over 75. In addition, the number of people with dementia will double by 2030.

This GP workload is exacerbated by increasing patient expectation in response what local GP services can deliver and the increasing 'medicalisation' of some social problems.

12.2.2.5 Population growth

St Edmundsbury Borough Council, in consultation with residents, businesses and a range of organisations with a local interest, has created a blueprint for how the borough will develop to the year 2031. This is part of the process of developing the Local Plan (previously called the Local Development Framework) for St Edmundsbury. The Vision describes significant housing growth in areas of West Suffolk, notably Haverhill and Bury St Edmunds, that will require forward planning around primary care provision.

13 Great Yarmouth and Waveney Clinical Commissioning Group

13.1 Opportunities, Challenges and Specific Issues

Great Yarmouth and Waveney CCG (also known as HealthEast) has an ambitious and transformational vision to develop an integrated care system to cover all of our population.

Our 5 year strategy sets out the steps we are taking in partnership with Norfolk and Suffolk County Councils, Great Yarmouth Borough Council and Waveney District Council, our local patient groups, the third sector and our providers to create a system of Integrated Care.

Our vision is founded on full citizen design and 'buy in', to make our Health and Social Care system sustainable, affordable, and able to deliver flexible high quality services for our population. With our co-commissioners locally we are seeking to commission transformed services which can deliver:

- A high quality of care sensitive to the needs of different populations in the CCG
- Affordable care for our populations' needs - now and for the future
- Continuity of care
- A single point of entry – no more "being passed around the system"
- Seamless pathways
- A focus on prevention - "anticipatory care" and reablement
- Transparent, trustworthy and compassionate care.

Primary Care is – as noted earlier in the Area Team strategy – absolutely foundational to these plans, and we are pleased to see the themes of integration, continuity, sustainability and equity featuring strongly in the East Anglian Area Team's strategic framework. We strongly support these intentions and will work with NHS England to achieve them.

We recognise and fully concur with the Area Team's analysis that Primary Care is facing a range of increasingly unsustainable pressures. We also agree that workforce pressures are the most significant threat to sustainability that we face.

In this context we are working with our practices to help develop more robust and sustainable primary care and consider how they can collaborate, share learning and resource, and consider consolidation. These conversations are already well

developed locally with 3 practices merging in Great Yarmouth, and discussions on greater collaboration well advanced in Gorleston (discussed further below). We believe that scale is an essential part of the answer to the challenges faced by this vital sector of our health system.

The leadership displayed by three of our local practices in merging is cause for optimism that the agility and dynamism at the heart of the Independent Contractor model will meet the challenge and can deliver improved quality (including improved accessibility) and integration while preserving the continuity and localism that our population value so highly. We believe that the potential for both innovation and continuous improvement which comes from independent contractor status has been one of UK Primary Care's great unsung strengths, and we wish to preserve these strengths in our local provider market. We therefore remain committed to partner-led independent contractor models of provision, while recognising that different organisational and indeed different provider forms or contracts may be appropriate in specific circumstances. Where these circumstances arise we will work to ensure that the same principles of continuous quality improvement, clinical leadership and ongoing innovation benefit the populations served.

Discussions with our member practices about what scale means for them will continue over the years ahead. We do not believe that one size will fit all, in line with the Area Team's approach. In particular the solutions right for our urbanised areas are likely to be different for the market towns of the Waveney valley and the northern villages.

In addition to the challenges of scale, we recognise the profound challenges of an aging population and the need to "wrap" community and outreach specialist services around our vulnerable populations. We recognise the centrality of Primary Care in delivering these integrated approaches, and have already been incentivising multi-disciplinary team working. However our 2 year operational plan sets out how we will commission "Out of Hospital Teams" across our whole area (implemented in 13/14 in Lowestoft) to support general Practice in looking after patients closer to/in their own homes. This will require different ways of working which see the Primary Healthcare Team in a wider and more multidisciplinary fashion. We will work with our practices locality by locality to explore how best to do this in their contexts and will continue to invest (for example via the £5/head) to support them as they do.

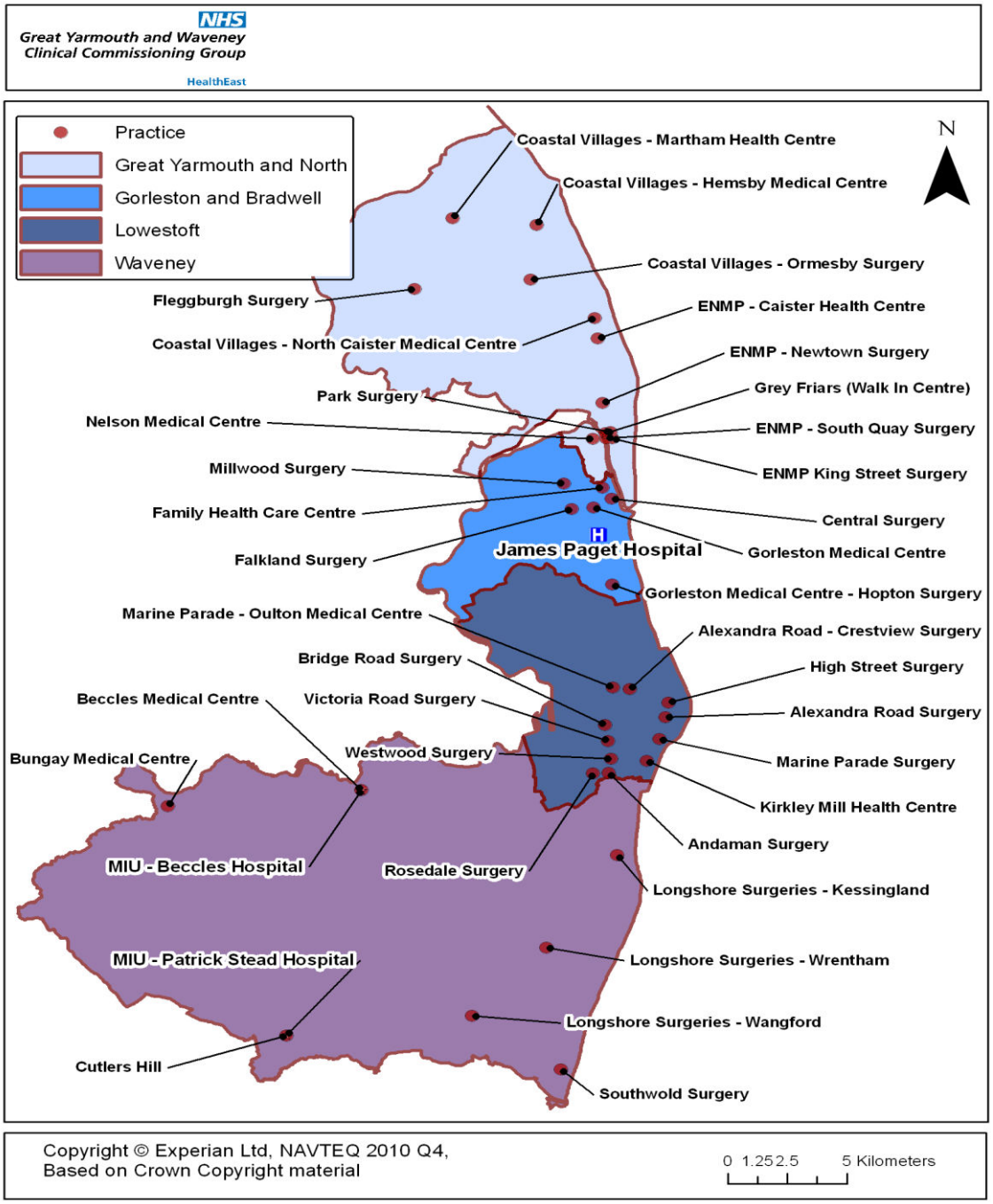
We are also considering what the implications of the Keogh urgent care review and what opportunities this may offer given the challenges of scale discussed above. Our draft Urgent Care strategy seeks to interpret the direction of travel regarding more integrated and co-located Urgent Care centres in the context of Great Yarmouth and Waveney. We will be discussing this, and the options that flow from it during the months of June and July.

13.2 Vision for Primary Care

We will work with the area team to commission robust, high quality, highly accessible Primary Care services for our whole population. We recognise that our localities have different populations and needs, each warranting focus and attention. We do not believe that "one size fits all" localities, but that all services should be able to demonstrate strategic fit with our overall intentions set out above.

13.2.1 Map of Primary Care

The Great Yarmouth and Waveney area is divided into four localities – Yarmouth and North, Gorleston and Bradwell, Lowestoft and Waveney valley.



The primary care facilities in each of the localities are:

Great Yarmouth and North	Gorleston and Bradwell	Lowestoft	Waveney Valley
12 GP Sites	6 GP Sites	11 GP Sites	7 GP Sites
1 Walk in Centre			2 Minor Injury Units

Recently we have seen services co-locate to facilitate smoother cross-agency and inter provider working, to benefit the patients of

- Lowestoft via the new Kirkley Mill Health Centre (co-locating 2 practices, Community Services and Social Care)

- Gorleston via the Shrublands site (1 practice, community services, social services and a pilot site for Multidisciplinary team working drawing in Mental Health and childrens services)

- Southwold via the new Reydon Healthy Living Centre (1 practice, community services)

We believe that there are further opportunities – mentioned above – for co-location of health and social care services on the James Paget Hospital site, as recognised by the Keogh Urgent Care review. However, to focus solely on integration between sectors would, we believe, miss an important opportunity to consider closer working between practices in Gorleston and Bradwell to provide different, more robust and integrated Primary Care services at scale on this site. We will support our practices as they explore these thoughts, and consider working more closely together.

13.2.2 The role of primary care in delivering integrated out of hospital care

GPs across Great Yarmouth and Waveney will work closely with Out of Hospital Teams (OHTs) through regular communication and attendance at Multi-disciplinary team meetings. Out of Hospital teams are made up of health and social care professionals for whom the objective of their service will be to provide care at home whenever it is safe, sensible and affordable to do so and reduce avoidable emergency admissions. The care the team is expected to provide will be organised around the patient, focusing on individual need and reablement. We have already implemented the OHT model in Lowestoft and are rolling this model out – adjusting to locality specifics and learning from each implementation – across our whole area in 2014/15.

13.2.3 Increased access for urgent and routine care

HealthEast is in the process of developing its urgent care strategy for the residents of GYW and the visiting population, ensuring a quality safe sustainable urgent care system is in place for patients when they have an urgent need. This strategy aims to help people get the right advice or treatment in the right place first time.

Patients value the advice provided by their own GP and the strategy for urgent care is underpinned by improving access to Primary Care along with maximising the services provided by GPs including the promotion of self-care, prevention and minimising ill health, provision of care plans for those with long term conditions, and encouraging patients to make the 'smart choice' when they have an urgent care need.

Our local model for urgent care, supported by the Urgent Care Board and in line with Sir Bruce Keogh's Urgent Care Review, includes the development of community hubs which will incorporate a range of services with Primary Care being core to the integration of care across a range of pathways.

These sites will be promoted as 'Urgent Care Centres' – the place for patients to go if they have an urgent care need - and will include in and out of hours GP services, minor illness and injury services, pharmacy, and out of hospital teams. Through co-locating these services patients will receive the right advice or treatment in the right place by the right professional first time.

Hubs will be strategically sited across Great Yarmouth and Waveney including an Urgent Care Centre at the James Paget University Hospital site. As noted above, this may provide a base for the co-location of a number of local practices whose current premises allow no room for increasing the numbers of patients they are caring for, and may also provide opportunities for primary care streaming at the 'front door' to ensure those patients with minor conditions are seen and treated by the most appropriate professional. This model might also address the practice capacity constraint in Gorleston and Bradwell which will arise from the home building programme being undertaken there.

Hubs will provide an opportunity for the development of outreach/hot clinics for ambulatory care to which GPs will be able to refer for those patients not requiring urgent care but some intervention/advice from specialists.

Through the development of services at these urgent care centres local provision of urgent care will be streamlined and coordinated, placing Primary Care very much at the heart of the new system, recognising the value that our population rightly place on their GP services, while simplifying and streamlining the Urgent Care system.

Our review of Urgent Care Strategy for Great Yarmouth and Waveney includes a review of services at the Greyfriars Walk In Centre in Great Yarmouth, working with the Area Team who currently commission this service. To date, a piece of market research insight work has been commissioned by the Area Team across all three walk in centres in Cambridgeshire and Norfolk. The results of this work along with a data review and detailed inquiry into the way patients use the walk-in element of this service will inform the way forward. Any proposals to substantively change how services are provided at Greyfriars will be subject to a full public consultation as appropriate.

13.3 Key Enablers to Achieve Vision

13.3.1 Priorities for Investment

New Multidisciplinary facility sited at the front door of the JPUH

North/Central Yarmouth Urgent Care Centre

Roll out of the Out of Hospital Teams across Great Yarmouth and Waveney

13.3.2 New Service Models and provider development

As discussed above we believe that the challenge of scale and need for increased access (including 7 day services) which the NHS is facing will require the development of new models of collaboration and provision. We do not believe one size fits all and we also believe in the ability of our providers to shape their thoughts on this in collaboration across the system as we integrate to the benefit of the patients of Great Yarmouth and Waveney. We do not therefore at present plan to impose new provider models but will work with our whole market and provider landscape within the area to facilitate the emergence of models fit for the future.

We also recognise that our localities have differing populations, and that these populations have different needs. The needs of the population must lead the shaping of the delivery model – in line with the overall strategic aims set out above, for example integration.

13.3.3 Workforce developments

In line with Health Education England (HEE) Primary Care Workforce plans, we can identify with the main CPD priorities HEE have set. The data is in accord with NHS England demographic information which clearly shows the ageing population we serve in Health East and the subsequent pressures on GP Practices, magnified by an aging and thinly spread workforce. Successful recruitment of GPs and Nurses into the area is crucial.

Our ambition for recruitment is linked to our vision, set out above, for strong primary care provider organisations, delivering high quality attractive services in environments which are fit for purpose; organisations which can stimulate clinical

innovation and are marked by clinical ownership and leadership of the services they provide. We expect to invest in such services, delivered by such a provider landscape, and will invest to help our provider landscape meet these challenges. We believe that such providers will be able to attract and retain high quality clinical staff of all grades.

We will work with HEE, Practices, and local workforce leads in our acute and community providers to develop training and development opportunities to increase the potential for skill mixing in Primary Care. We believe that the Primary Care nursing workforce are a vitally important professional group whose profound skills and strengths in patient care could be better utilised for some populations.

Having recently engaged with our Practice Nurses and Managers to carry out a training needs analysis, a new pathway to training and CPD funding has been developed. This has been provided to Practices to support and ensure Practice Nurses and Healthcare assistants following appraisal and assessment of needs, are aware how to access and apply for help towards their CPD.

To address priorities, such as Dementia, Learning Disabilities and COPD local training has been arranged by HealthEast for Practice Staff. Training around COPD has already begun with sessions taking place at HealthEast by a Specialist Respiratory Nurse, then followed up in Practices with a more tailored package. Learning Disability training has also been arranged and facilitated to ensure that this vulnerable and deprived population have equal access to high quality and appropriately skilled primary care.

13.4 Summary

In summary we believe Primary care is the foundation of the delivery of high quality care to our CCG population, and is central to our overall aim of integrating care and drawing multidisciplinary teams around those with ongoing care needs. We see a future shape for services where primary care sits at the heart of these integrated teams, frequently co-located with them, and where all providers work much more closely together to ensure highly accessible sustainable quality of care.

14 West Norfolk

14.1 Overview

'Future characteristic 2':
'Wider primary care, provided at scale'

Relevant elements	WNCCG current initiatives	WNCCG future initiatives
•Patients with a moderate mental or physical LTC to secure access to support and care from wider primary care •General practice, community pharmacy and other primary care services to play a stronger role at heart of integrated system of community-based services •Development of new models of primary care •Greater collaboration between general practice and other health and care organisations	•Active GP and practice member engagement via Council of Members, Practice Managers Group and GP bulletin •Integrated Care Organisation 1st wave pilot, centred on primary and community integrated care delivery •GP DES and LES initiatives to support wider WNCCG commissioning agenda •GP education programme to improve condition and referral management	•Primary Care strategy, to comprise a number of elements including support to GP practices to enable more effective commissioning, £5 per head utilisation, GP education strategy, prescribing initiatives, DES and LES alignment, NHS England interface •Exploration with NHS England of 'co-commissioning', to align commissioning activities of primary care •Wider Primary Care engagement in the 'Alliance' programme •Further exploration of innovative GP Federation, and primary/community care delivery models, to provide primary care at scale, across networks or localities

The **role of primary care** will need to adapt to link effectively with other providers of care and this could include hospital outreach of services as well as community providers. General Practice is facing a number of significant challenges including financial pressures, recruitment difficulties and increasing contractual requirements such as extended hours and pro-active care planning for vulnerable patients. As a consequence, practices will have to develop new partnerships and styles of working to continue to provide a full range of high quality medical services. WNCCG will support the development of primary care, through;

- promoting clinical networks with other professionals such as hospital consultants for advice and support on clinical decision-making in the community,
- providing activity and financial data at practice level to facilitate a better understanding of practice referrals and utilisation of health care resources,
- establishing an education programme to support GPs to make high quality referrals, adhering to best practice pathways and making best use of resources,
- consulting with practices about the most innovative and effective ways to commission services that support patients with complex health needs to receive the care they need in the community,

- developing a frailty assessment score that is universal across health and social care, negating the need for multiple assessments,
- sharing data about patients safely using ‘Eclipse Live’ and the Smart Card scheme,
- improving care home education and links with other services

West Norfolk CCG will work with NHS England Area Team to explore opportunities to ‘co-commission’ primary care where this benefits the local population, with full consideration of delegation of responsibilities, management of conflicts of interest, and resource implications.

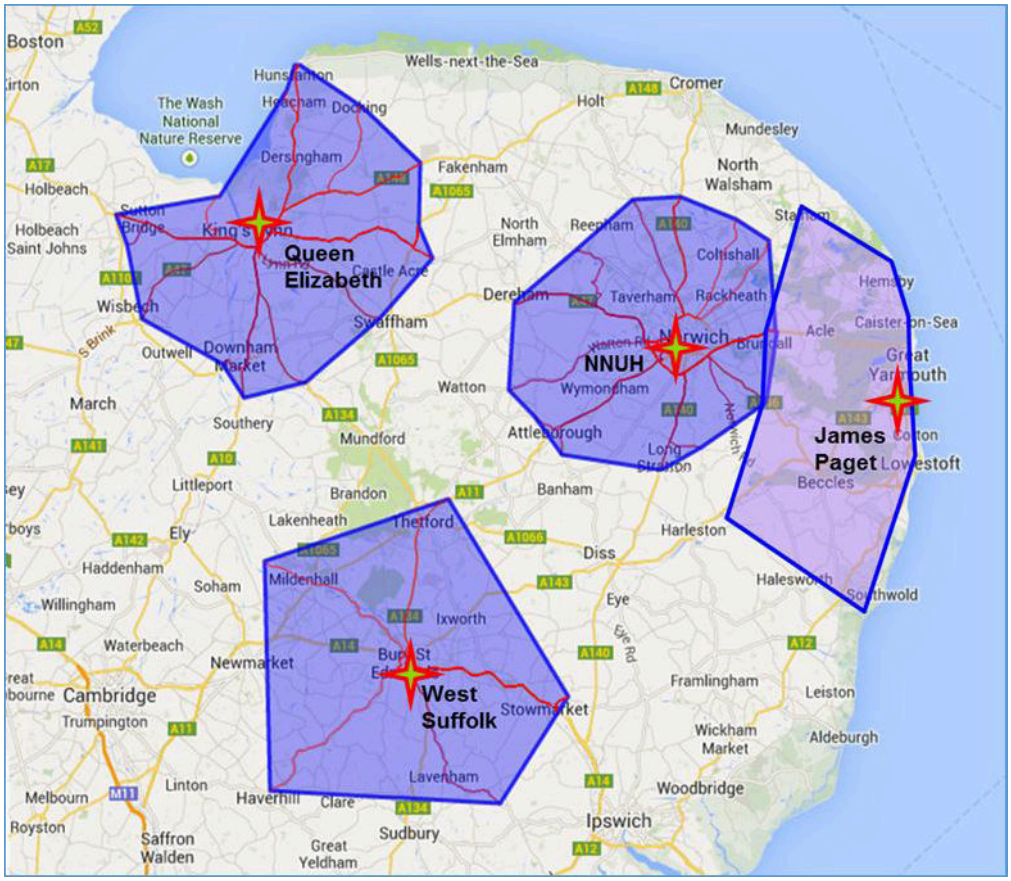
15 North Norfolk Clinical Commissioning Group

15.1 Overview of Primary Care Services in North Norfolk

North Norfolk CCG serves a large, mainly rural area with a dispersed population spread across a network of market towns and villages. The CCG has the oldest population of any CCG in England with all age groups over the age of 50 representing a greater proportion of the population than the national average, with 27% over the age of 65. Public transport links between population centres in North Norfolk are very poor and people are heavily dependent on access to private transport to access services. Locally accessible primary care is therefore an essential pre- requisite to good quality healthcare.

People have to travel significant distances to access secondary care in predominately Norwich, but also in Kings Lynn and Great Yarmouth for the populations on the west and eastern border of the CCG. Large parts of the CCG population live more than 30 minutes travel time to an acute hospital.

Map showing areas that are 30 minutes travel from acute hospitals



Primary care in North Norfolk performs well when measured by the majority of clinical indicators and patient satisfaction. Clinical indicators covering Potential Years of Life lost from causes amenable to healthcare, Under 75 Mortality Rate from cancer, and Emergency Admission rates for conditions not usually requiring admission to hospital are all better than national/comparator group averages. In the 2012/13 GP Survey 90.5% of people rated their overall experience of GP services in North Norfolk as “Very Good” or “Fairly Good”

The vast majority of practices in North Norfolk are stable, long established multi – partner practices based in the market towns and large villages, with distinct catchment areas. Most practices offer a range of extended services such as Near Patient Testing, Phlebotomy, Anti- coagulation, Minor injury, and DVT. Access to these services locally at GP Practices is consistently scored highly in patient experience questionnaires.

15.2 Opportunities, challenges & local issues

The greatest challenge facing primary care in North Norfolk is to maintain its current level of access and performance in the face of growing workload pressure from a rapidly ageing population, in some areas to expand for likely significant housing growth, whilst dealing with a chronic workforce shortage and little financial investment.

The age of the population in North Norfolk means that the prevalence of long term conditions and diseases such as CHD and cancer are particularly high.

Disease prevalence (QOF)	North Norfolk CCG	South Norfolk CCG	Norwich CCG
Asthma	🔴	🔴	🔴
Atrial fibrillation	🔴	🔴	🟡
Cancer	🔴	🔴	🟡
Chronic kidney disease (18+)	🔴	🟡	🟢
CHD	🔴	🟡	🟡
Dementia	🔴	🔴	🟡
Epilepsy (18+)	🟡	🟡	🔴
Heart failure	🔴	🔴	🟡
Hypertension	🔴	🔴	🟢
Hypothyroidism	🔴	🔴	🟡
Learning disabilities (18+)	🔴	🟡	🔴
Mental health	🟡	🟢	🔴
Palliative care	🔴	🔴	🟡
Stroke	🔴	🟡	🟡

Key	Worst quartile	Middle quartiles	Best quartile
Compared to all CCGs in England	🔴	🟡	🟢

There are plans for significant new housing developments in the Broadland District Council area, on the east side of Norwich, which will create new demands for Primary Care in that area. The development of the new Northern Distributor Road to the north of Norwich is likely to drive further significant housing growth in the Northern suburbs of Norwich served by the CCG practices.

Perhaps the greatest challenge however is workforce. Practices are already struggling to recruit new partners, salaried doctors, and even locum cover, as well as Practice Nurses. The age profile of the Primary Care workforce in the area is a cause for concern with a significant number of staff aged 50 plus.

To date the relatively recent establishment of the Medical School at UEA has done little to assist Primary Care recruitment despite a strong primary care focus on the course. The CCG believes that some urgent work on recruitment – and retention – across Norfolk is an essential short term action required of NHS England.

Access to local education programmes for Practice Nurses and Nurse Practitioners is needed to increase skills and knowledge especially to create capacity in managing patients with Long Term Conditions

15.3 Vision for Primary Care

The CCGs vision for 2019 is for North Norfolk to be nationally recognised for excellence in the quality of care and support offered to its population of older people. The CCG sees the provision of high quality, local primary care as being the bedrock of a fully integrated system of primary, community and social care. Practices are already working in a series of hubs with fully integrated community and social care teams wrapping their services around the practice grouping to better support patients at high risk of admission.

Practices will form an integral part of regular multi-disciplinary approaches to supporting complex patients. For the high risk patients practices will support one another to offer access to GP advice and support 7 days a week.
Practices will continue and extend the range of services offered locally through enhanced service arrangements either on an individual practice basis or as part of the newly formed Norfolk Federation.

Practices will be routinely using digital technology to both support patients and also communicate clinical information with other providers.

15.4 Key enablers to Achieve vision

For this vision to be realised there are a number of enablers which require to be in place:

- As highlighted above workforce shortages in Primary Care are starting to bite. There is an urgent to need to commission a review of the current recruitment, training and deployment of GPs in order to attract more applicants to the area. This should be done on a Norfolk-wide basis.

- Action is also necessary to ensure that experienced GPs are not lost to the NHS. Action should be taken to create roles which are sustainable for senior professionals and offer a balance of direct patient facing with other roles around commissioning, research and development, or training.

- In a similar vein urgent work needs to be undertaken to both recruit more Primary Care nurses and develop career structures which help retain the most experienced staff.

- Practices require certainty to make commitments and invest in their own futures. Therefore uncertainties around contract reviews need to be minimised wherever possible.

- The future of clinically focused commissioning is dependent on GPs having the opportunity to develop an interest in commissioning and understand how this can impact positively on the quality and safety of care and patient experience in North Norfolk. Again this requires workforce capacity and planning to create these opportunities.

- Though in general practice premises in North Norfolk are relatively good and there is little to be gained from major change in the physical infrastructure of primary care given the geography of the area, a number of practices are in need of significant modernisation and expansion, especially Cromer (for which NHS England has approved the Outline Business Case).A number of other practices are likely to need relatively small scale expansion and improvements to meet registration standards and keep pace with growing demand, such as is the case currently at Hoveton and Wroxham.

16 Norwich Clinical Commissioning Group

16.1 Overview of Primary Care Services in Norwich

Norwich CCG has a registered population of approximately 208,600 people. This includes males: 103,500, (49.5%); females: 105,100 (50.5%).

There are 23 general practices in Norwich CCG; practice list sizes range from 1,887 persons to 17,028 persons with an average list size of 8,922 persons.

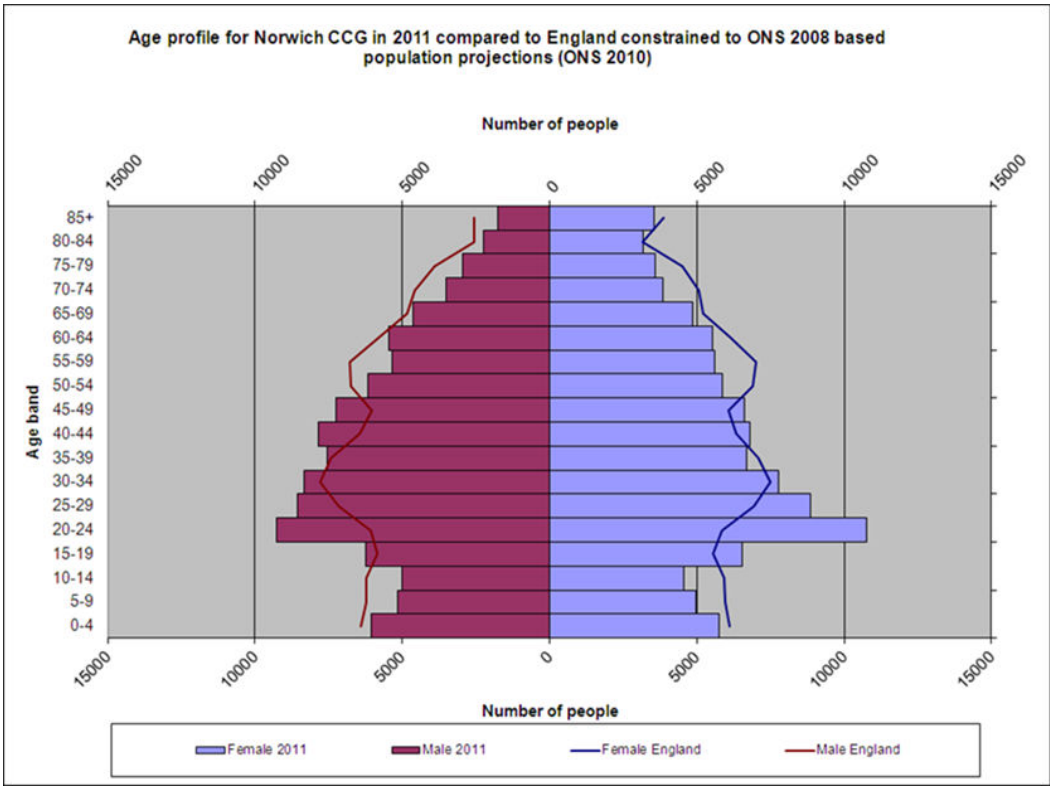
16.2 Opportunities, challenges and issues specific to Norwich

16.2.1 Our Population

Norwich has a youthful age profile, with large proportions of younger people (particularly 20 to 29 year-olds) in the population compared with the county rate. 69% of the population are of working age; well above county and national rates. Norwich has lower proportions of children and older people particularly in comparison with Norfolk as a whole.

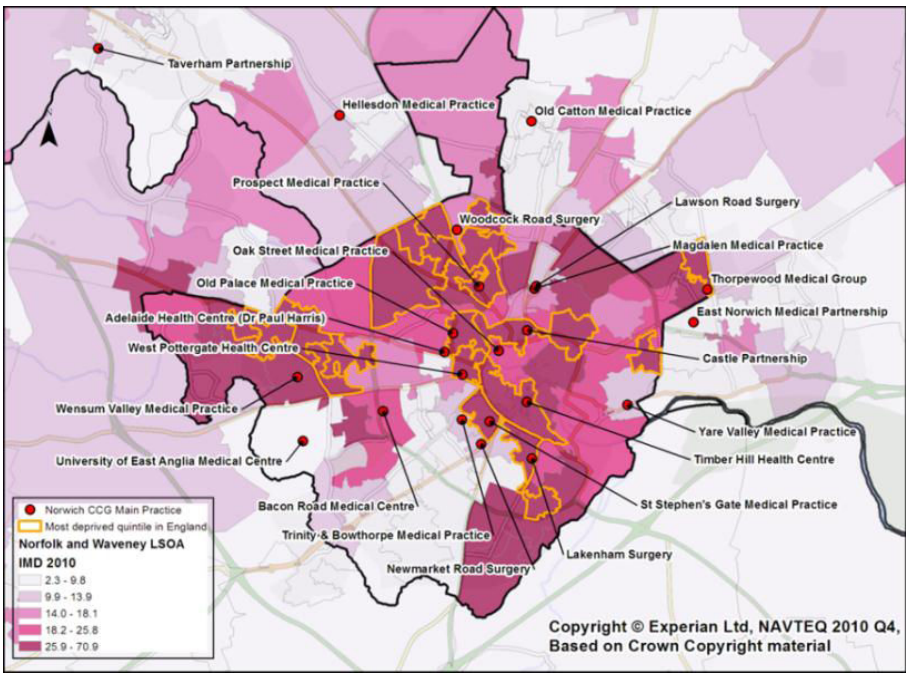
Over the next 20 years, Norwich is likely to see much larger increases in working age population as a proportion of the total population.

Norwich has the highest number and proportion of people belonging to ethnic minorities in the county.



16.2.2 Deprivation

- Deprivation is higher than average and Norwich city is the 70th most deprived district in England.
- Norwich CCG has 1 practice in the most deprived quintile in England, 2 practices in the most deprived 10 in Norfolk and Waveney
- Out of the ten per cent most deprived LSOAs in England in terms of the IMD, 27 are in Norfolk and seven of these are in Norwich. If we look at the most deprived quintile in England, 23 LSOAs fall in this category.
- The 23 Norwich LSOAs in the most deprived 20% in England have the following characteristics on average:
    - over a third of people (35.4%) are income deprived
    - one in five of women aged 18-59 and men aged 18-64 (20.3%) are employment deprived
    - Nearly 1 in 2 children (48.8%) live in families that are income deprived
    - 37.5% of older people are income deprived
- The most deprived MSOAs in Norwich include Mancroft, Milecross, Lakenham and Wensum these are areas with greatest health need.
- At 32.5%, the proportion of children affected by income deprivation in Norwich is higher than that of Norfolk as a whole (based on 2007 Indices). This means that close to 7000 children in Norwich live in poverty.



Index of Multiple Deprivation 2010, Norwich by Lower Super Output Area.

16.2.3 Life expectancy

- Life expectancy for men is lower and for women higher than the England average for people resident in Norwich. Life expectancy for both men and women is higher than the England average for people resident in Broadland.
- Life expectancy is 6.7 years lower for men and 3.2 years lower for women in the most deprived areas of Norwich than in the least deprived areas (Health profile 2012). Life expectancy is not significantly different for men and women in the most deprived areas of Broadland compared to the least deprived areas.
- Over the past ten years, death rates from all causes have fallen. The early death rate from heart disease and stroke has improved in Norwich and Broadland. They are now similar to the England average in Norwich and better than England average in Broadland.
- There is a 3 fold variation between practices for cancer mortality among females. Although the male premature cancer mortality (DSRs) are significantly worse than county, regional and national averages, the variation is less than that observed for females at approximately 2 fold.
- Premature circulatory mortality has been increasing among females over the 4 year period observed (05-07 to 08-10). This is in contrast to county, regional and national trends. There is also a 5 fold variation in circulatory mortality between constituent practices.

16.3 Vision for Primary Care

As part of the development of a combined 5-year strategic plan with NNCCG and SNCCG (See Section xx) 9 areas of intervention have been agreed to support the ambitions and outcomes framework and will form part of our strategic plan on a page. They are as follows:

Intervention 1	Development of primary care localities
Intervention 2	Implementation of integrated community care teams (based on primary care locality footprints)
Intervention 3	Proactive use of predictive modelling and risk stratification
Intervention 4	Easy to access, seven day health and social care provision for people with complex mental and physical health and care needs
Intervention 5	Enable independence, self care and self management
Intervention 6	Improved support for people with Dementia and their carers
Intervention 7	Deliver major redesign of urgent care system
Intervention 8	Ensuring effective end of life pathways and support
Intervention 9	Ensuring effective workforce planning

NHS Norwich CCG has established a strong vision and model for the delivery of integrated care, focused around primary care hubs in the city. Our Commissioning intentions are grouped around these nine areas of intervention.

Intervention 1	**Development of primary care localities**
Principle	GP Practices will be supported to develop locality clusters around populations of approximately 50,000 registered patients (4 localities within the Norwich CCG boundary). These practices will cooperate to develop shared Primary Care services for older patients, and those with long term conditions; with a particular focus on keeping patients independent, well, and at home. Enhanced care for nursing homes, coordinated domiciliary visits, and a shared model of seven day access will be developed.

Intervention 2	**Implementation of integrated community care teams (based on primary care locality footprints)**
Principle	Integrated Community Services - Community, Mental Health, and Social Care Services will be reshaped to the same locality footprints. The locality model will enable a multi-disciplinary approach to care, and build relationships, coordination, and mutual confidence between provider organisations. Through improved communication technology and the development of care coordination (below) we will place the responsible GP at the heart of an integrated virtual health and care team.

Intervention 3	**Proactive use of predictive modelling and risk stratification**
Principle	Practices will be supported to identify and manage patients at high risk of hospital admission through the implementation of risk stratification modelling. We will work with our technology partner to incorporate Primary Care and Social Care data into the model. The model will be launched in 2014, and developed and refined in preparation for the Better Care Fund investments in 2015.

Intervention 6	**Improved support for people with Dementia and their carers**
Principle	Increased awareness and diagnosis rates across Norwich practices with improved supporting networks

Intervention 8	**Ensuring effective end of life pathways and support**
Principle	Choice, control, care and support towards the end of life

Intervention 9	**Ensuring effective workforce planning**
Principle	Ensuring capacity and capability of Primary care workforce

16.4 Key Enablers to Achieve Vision

NHS Norwich CCG will support the development of our localities into 4 city teams. It is our intention that each locality will have the following:

- A named development manager whose role will be to support the locality in the development of community based teams
- A named representative (either managerial or clinical)
- A clinical lead for each locality

- The same ‘core’ services commissioned by the CCG
- The option of developing other services or ways of working depending on the needs of their population, the wishes and interest of member practices and stakeholders
- Include key delivery partners from across all sectors

There are a number of activities that will be considered by the city teams either as part of the ‘core service’ or as part of the option to develop enhanced services depending on the needs of the locality.

Medibites Education programme	Enhanced Primary Care for care Homes	Sustainable Workforce Development	Re-procurement of Community Mental health (including IAPT)
Integrated Diabetes Care	Falls Prevention	Integrated Heart failure Service	Risk Stratification
7 Day Case Management for Patients with Complex Health and Care Needs	Care Co-Ordination Teams (CCG Localities)	Unified Electronic Patient Record	Communication Technology, Virtual Team
Integrated End of Life care	Integrated dementia care	Sustainable Workforce Development	

Norwich CCG identifies that the key system constraints for Norwich as with other systems will be investment levels, workforce supply, and infrastructure.

Norwich CCG will continue to work with North Norfolk and South Norfolk CCG on development and implementation of our combined 5 year strategic plan as well engaging with our membership to produce a plan for Primary Care in Norwich that had the active support of local GPs.

17 South Norfolk

17.1 Overview of Primary Care Services in South Norfolk

South Norfolk CCG (SNCCG) comprises 26 General Practices and has a population of 223,000 (weighted 227,000). The CCG covers a predominantly rural area to the south and west of the city of Norwich and the main district towns are: Thetford, Dereham, Attleborough, Watton and Diss.

The current model of delivery in SNCCG is locality based. Its constituent member Practices are organised into four localities:

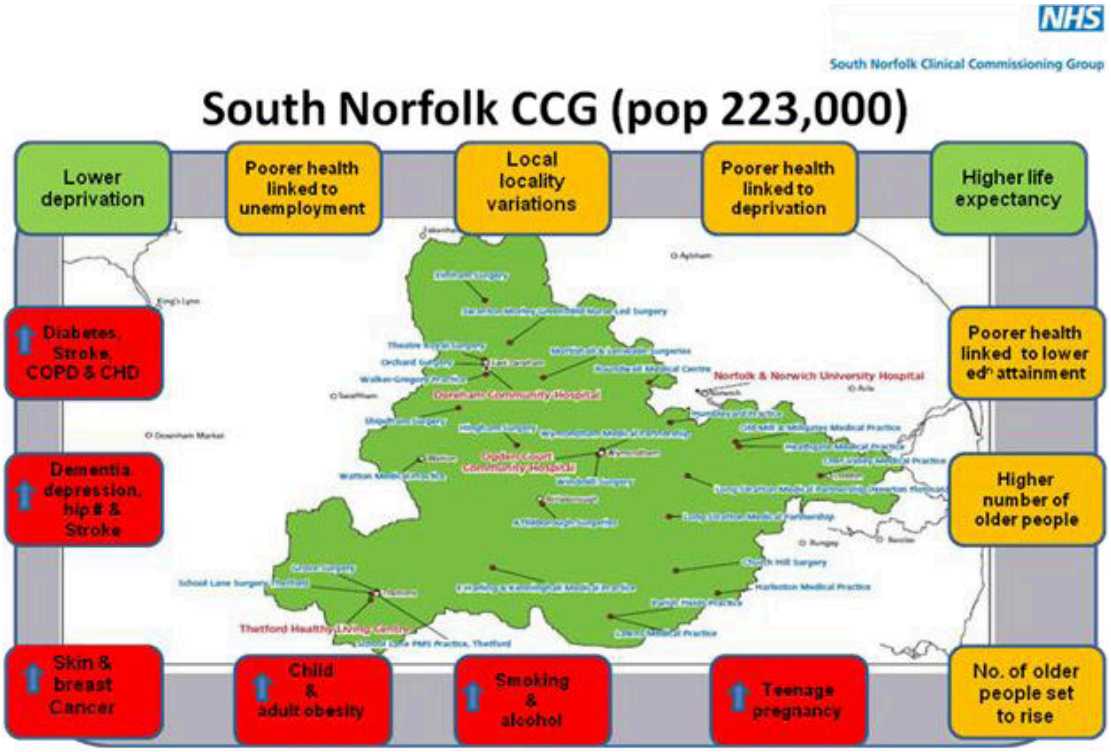
- Breckland,
- Ketts Oak,
- Mid-Norfolk,
- South Norfolk Health Improvement Partnership (SNHIP)

The Council of Members consists of 24 clinical delegates representing the 26 Practices of South Norfolk CCG, chaired by Dr Tony Palframan.

Member Practices work together in smaller localities to ensure there is a focus on local need. These groups have worked together as Practice-based Commissioning Groups and are each chaired by a local GP:

- Ketts Oak - Dr Andrew Hayward from East Harling and Kenninghall Medical Practice
- Breckland – Dr Mike Leeper from Grove Surgery, Thetford
- Mid Norfolk – Dr Elizabeth Jones from Mattishall and Lenwade Surgeries
- South Norfolk Health Improvement Partnership – Dr Tony Palframan, from Heathgate Medical Practice, Poringland.

SNCCG also commissions services for a section of population who live in Suffolk, but registered to a SNCCG Thetford Practice.



The population enjoys relatively good health compared with the rest of England. Deprivation is lower than average and life expectancy is higher than average. There is considerable variation between localities though, with some poor health largely linked to deprivation, unemployment and low educational attainment.

More than half the population is of working age, there are higher numbers of older people than across Norfolk as a whole and the number of older people is set to rise over the next 20 years. All-cause mortality rates have fallen over the last ten years but there is a high incidence of diabetes, chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD), dementia, depression, stroke, cancer (skin & breast) and hip fracture. Other health improvement issues include adult and childhood obesity, smoking, alcohol consumption and teenage pregnancy.

South Norfolk has a relatively larger proportion in the 40-70 year age group compared to England and a lower proportion of all age groups under 40, except for ages 16-19, compared to England. However, the male/female ratio is comparable to the England ratio.

Around 57% of the population in SNCCG are of working age, below the county and national figures, with a higher proportion of children than Norfolk, but lower than England. There also a higher proportion of older people, particularly in comparison with England. As already mentioned there is a 6.9% of our population that are non UK residents and 3.8% from the European Union, particularly Portuguese, Lithuanian and Ukrainian

Age profile for South Norfolk CCG in 2011 compared to England (ONS 2012)

17.2 Key priorities

Although South Norfolk is overall less deprived, there are pockets of deprivation which lead to health inequalities. Health profiles published in 2012 show that while South Norfolk has relatively better scores for health indicators, Breckland has a significantly higher number of people diagnosed with Diabetes and the educational achievement is significantly lower than England average.

South Norfolk has a relatively lower prevalence of adult and childhood obesity, however, the proportion of overweight and obese children is increasing. Similarly, though the ward level teenage conception rates in Norfolk and South Norfolk are generally low, there are some wards which have levels above the England upper quartile. With an ageing population, there will be an increase in Dementia, depression and learning difficulties.

Priorities for improving health in SNCCG include:

- Stopping smoking
- Tackling alcohol misuse
- Addressing obesity by promoting healthy lifestyles.

For the ageing population the CCG will have an increased focus on:

- Prevention and management of age related LTCs such as Dementia, Diabetes, cancer and falls. The following table illustrates the predicted increase in the incidence of Dementia over the next eight years

17.3 Key challenges emerging from population demography and epidemiology

SNCCG recognise the following key challenges:

- Reducing health inequalities within the population – whilst SNCCG covers a population which enjoys relatively good health, the district population data mask variations at super output level.
- An ageing population and the percentage of older people with one or more LTCs, such as Diabetes, COPD and Dementia.
- Rurality and access to treatment and care.

17.4 Opportunities, challenges and issues specific to South Norfolk

Primary care, and in particular care delivered by general practice, is the lynchpin of the health and care system, and acts as the gatekeeper to, General Practitioner (GP), dentist, pharmacist and optician onward referral, as well as community services such as health visiting, district nursing and more specialist community services.

Whilst GP services are commissioned by NHS England, it will be imperative that South Norfolk Clinical Commissioning Group (SNCCG), Norwich Clinical Commissioning Group (NCCG) and North Norfolk Clinical Commissioning Group (NNCCG) support and encourage the development of primary care services across Norfolk.

We need to commission strong and robust primary care services that reduce inequalities of service and access, making improvements in quality and patient satisfaction. All patients should have access to the same range and quality of services to meet their health needs. We plan to make it easier for patients to get the care they need when they need it, as close to their home as possible. To achieve this, we will commission more consistent community based services.

Our strategic vision is built around redesigning and improving services in order to realise three essential deliverables in the next five years:

- High quality and equitable primary care services that improve patient outcomes
- Reduction in health inequalities
- Value for money to our residents.

Our case for change focuses on the following factors:

- Demographic changes in the population
- High health and wellbeing needs
- Variations in access to primary care medical services
- Variations in clinical quality and patient health outcomes
- A changing workforce profile and skills set needed for new models of care

GPs and their practices will play a key role in influencing the strategy and will need to understand how a primary care strategy will affect their commissioning decisions for acute, mental health and community services. The strategy will succeed with the clinical ownership of GPs and working in conjunction with our local authority and health partners.

17.5 Vision for Primary Care

17.5.1 Promoting patient choice

SNCCG will continue to ensure that it meets all of its statutory duties in relation to patient choice and decision making and will work with local Practices to promote and publicise patient entitlement to choice. The rights of patients set out in the NHS Constitution are vital and SCCCG will strive to ensure they are effectively delivered.

Our plans include:

- **Choice in Primary Care** – including choice of Any Qualified Provider (AQP) in community and MH services, providing support to people with long term conditions,
- **Choice before Diagnosis** – choice of diagnostic test provider,
- **Choice at Referral** – choice of provider, named consultant led team, MH and maternity services,
- **Choice after Diagnosis** – choice of treatment, choice of alternative provider at 18 weeks, and end of life care.

As part of the development of a combined 5-year strategic plan with NNCCG and NCCG nine areas of intervention have been agreed to support the ambitions and outcomes framework. They are as follows:

Intervention 1	Development of primary care localities
Intervention 2	Implementation of integrated community care teams (based on primary care locality footprints)
Intervention 3	Proactive use of predictive modelling and risk stratification
Intervention 4	Easy to access, seven day health and social care provision for people with complex mental and physical health and care needs
Intervention 5	Enable independence, self care and self management
Intervention 6	Improved support for people with Dementia and their carers
Intervention 7	Deliver major redesign of urgent care system
Intervention 8	Ensuring effective end of life pathways and support
Intervention 9	Ensuring effective workforce planning

SNCCG has established a strong vision and model for the delivery of integrated care, focused around our localities and commissioning intentions are grouped around these nine areas of intervention as follows:

Intervention 1	Development of primary care localities
Principle	GP Practices will be supported to continue to develop within their current localities. These practices will cooperate to develop shared Primary Care services for older patients, and those with long term conditions; with a particular focus on keeping patients independent, well, and at home. Enhanced care for nursing homes, coordinated domiciliary visits, and a shared model of seven day access will be developed.

Intervention 2	Implementation of integrated community care teams (based on primary care locality footprints)
Principle	Integrated Community Services - Community, Mental Health, and Social Care Services will be reshaped to the same locality footprints. The locality model will enable a multi-disciplinary approach to care, and build relationships, coordination, and mutual confidence between provider organisations. Through improved communication technology and the development of care coordination we will place the responsible GP at the heart of an integrated virtual health and care team.

Intervention 3	Proactive use of predictive modelling and risk stratification
Principle	Practices will be supported to identify and manage patients at high risk of hospital admission through the implementation of risk stratification modelling.

Intervention 6	Improved support for people with Dementia and their carers
Principle	Increased awareness and diagnosis rates across SNCCG practices with improved supporting networks

Intervention 8	Ensuring effective end of life pathways and support
Principle	Choice, control, care and support towards the end of life

Intervention 9	Ensuring effective workforce planning
Principle	Ensuring capacity and capability of Primary care workforce

17.6 Key Enablers to Achieve Vision

For this vision to be realised there are a number of enablers which are required:

- Workforce shortages in Primary Care require urgent attention. SNCCG support the need to commission a review of the current recruitment, training and deployment of GPs in order to attract more applicants to the area. This should be done on a Norfolk-wide basis.

- Action is also necessary to ensure that experienced GPs are not lost to the NHS. Action should be taken to create roles which are sustainable for senior professionals and offer a balance of direct patient facing with other roles around commissioning, research and development, or training.

- Urgent work also needs to be undertaken to both recruit more Primary Care nurses and develop career structures which help retain the most experienced staff.

- Practices require certainty to make commitments and invest in their own futures. Therefore uncertainties around contract reviews need to be minimised wherever possible.

- The future of clinically focused commissioning is dependent on GPs having the opportunity to develop an interest in commissioning and understand how this can impact positively on the quality and safety of care and patient experience. Again this requires workforce capacity and planning to create these opportunities.

- SNCCG will continue to work with North Norfolk and Norwich CCG on development and implementation of our combined 5 year strategic plan as well engaging with our membership to produce a plan for Primary Care in South Norfolk that had the active support of local GPs.
- SNCCG will seek to develop the primary care provider market and explore new forms of primary care cooperation and collaboration. Some of this may include the formation of new businesses.

18 North Norfolk, Norwich and South Norfolk Clinical Commissioning Groups –combined 5 year Strategic Plan

18.1 Primary care

Primary care, and in particular care delivered by general practice, is the lynchpin of the health and care system, and acts as the gatekeeper to, General Practitioner (GP), dentist, pharmacist and optician onward referral, as well as community services such as health visiting, district nursing and more specialist community services.

Whilst GP services are commissioned by NHS England, it will be imperative that South Norfolk Clinical Commissioning Group (SNCCG), Norwich Clinical Commissioning Group (NCCG) and North Norfolk Clinical Commissioning Group (NNCCG) support and encourage the development of primary care services across Norfolk.

We need to commission strong and robust primary care services that reduce inequalities of service and access, making improvements in quality and patient satisfaction. All patients should have access to the same range and quality of services to meet their health needs. We plan to make it easier for patients to get the care they need when they need it, as close to their home as possible. To achieve this, we will commission more consistent community based services.

Our strategic vision is built around redesigning and improving services in order to realise three essential deliverables in the next five years:

- High quality and equitable primary care services that improve patient outcomes
- Reduction in health inequalities
- Value for money to our residents.

Our case for change focuses on the following factors:

- Demographic changes in the populations of SNCCG, NCCG and NCCG
- High health and wellbeing needs
- Variations in access to primary care medical services
- Variations in clinical quality and patient health outcomes
- A changing workforce profile and skills set needed for new models of care

GPs and their practices will play a key role in influencing the strategy and will need to understand how a primary care strategy will affect their commissioning decisions

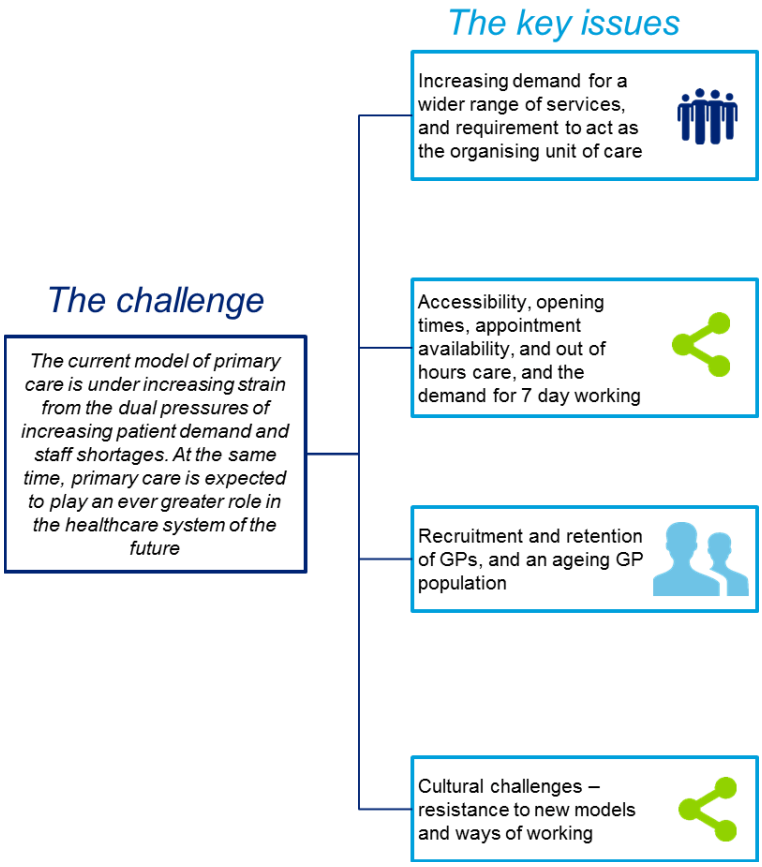
for acute, mental health and community services. The strategy will succeed with the clinical ownership of GPs and working in conjunction with our local authority and health partners.

18.2 Challenges in primary care

The heart of the challenge for primary care is the combination of rising patient demand for rapid access to primary care, an ageing population, more complex health needs, tighter financial controls and increasing staff shortages in the GP and primary care nursing workforce.

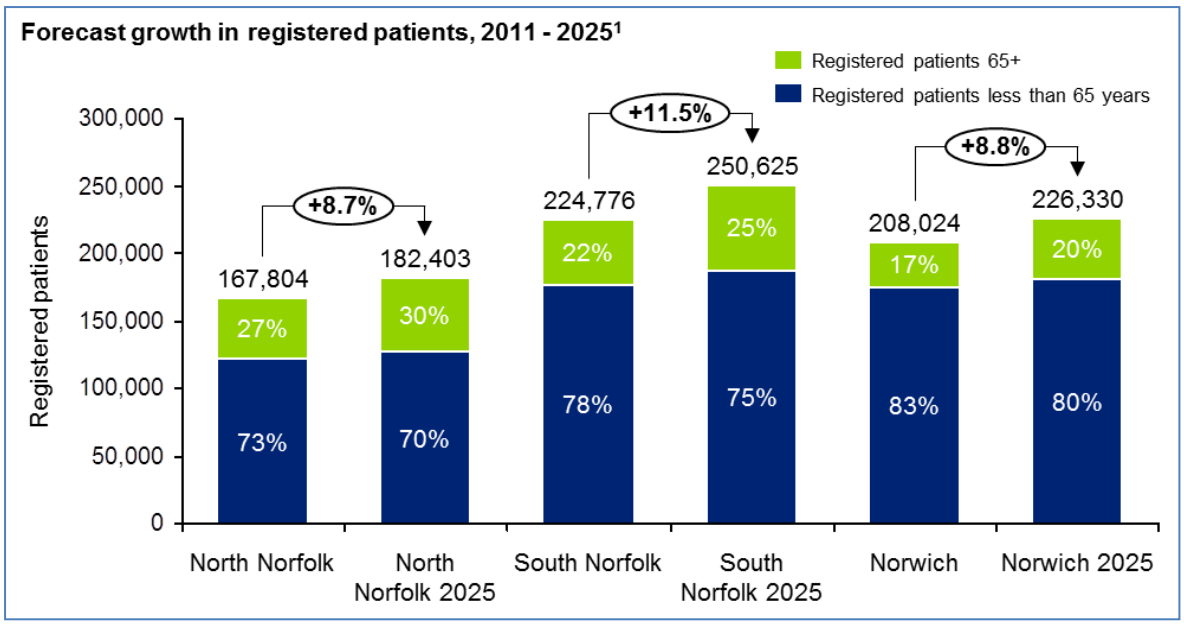
This comes at a time of rising expectations regarding the role of primary care in the health and care system, with GPs increasingly expected to act as care co-ordinators and as the named accountable health professionals for patients with LTCs.

The key challenges confronting primary care in SNCCG, NNCCG and NCCG are shown below.



18.2.1 Rising demand

GP patient numbers are forecast to rise over the coming years, with a greater proportion of patients over 65 years old, according to East Anglia Area Team projections. Between 2011 and 2025 there is estimated to be growth of in excess of 35,000 over 65s. By 2025 over 65s are estimated to comprise 30% of registered patients in North Norfolk CCG, and 25% in South Norfolk CCG, up from 27% and 22% respectively in 2011.

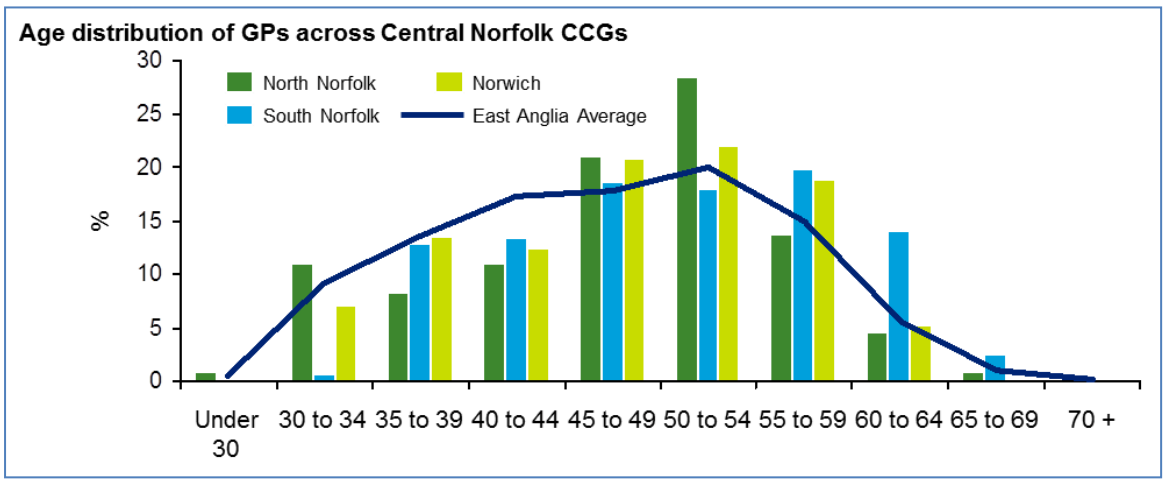


The ageing of the population in SNCCG, NNCCG and NCCG is likely to place a disproportionate pressure on GP services, within the context of rising per capita demand for primary care. Since 1995, the national average number of consultations per patient has risen from 3.9 to 5.5 in 2008. This was most pronounced in the over 65's, especially among the over 75s, among whom demand rose from an average of 7.9 consultations in 2000 to 12.3 in 2008.

18.2.2 Workforce shortages

In tandem with rising demand, there is an increasing shortage of GPs. In general, the GP workforce has not grown in line with other specialties: between 2002 and 2012 there was an average 2% increase in GPs compared to an average 4% increase in hospital consultants.

The workforce challenge is likely to intensify as the age profile of Norfolk's GPs moves towards retirement. Central Norfolk already has a GP age profile which is significantly older than the national average.



In part these workforce challenges need to be seen within a national skills and recruitment context, and are not unique to SNCCG, NNCCG and NCCG. For

example, it is reported that newly trained GPs are increasingly unwilling to become partners, and seek alternative working arrangements such as part time working, which makes sustainable provision of primary care services more challenging. However, these national trends are exacerbated by local conditions. The relative isolation of Norfolk, and other factors such as property prices, makes recruitment particularly challenging. Attracting new staff to Norfolk is therefore a key challenge in building a primary care system with sufficient capacity to meet future demand.

18.2.3 Quality and outcomes in 2014

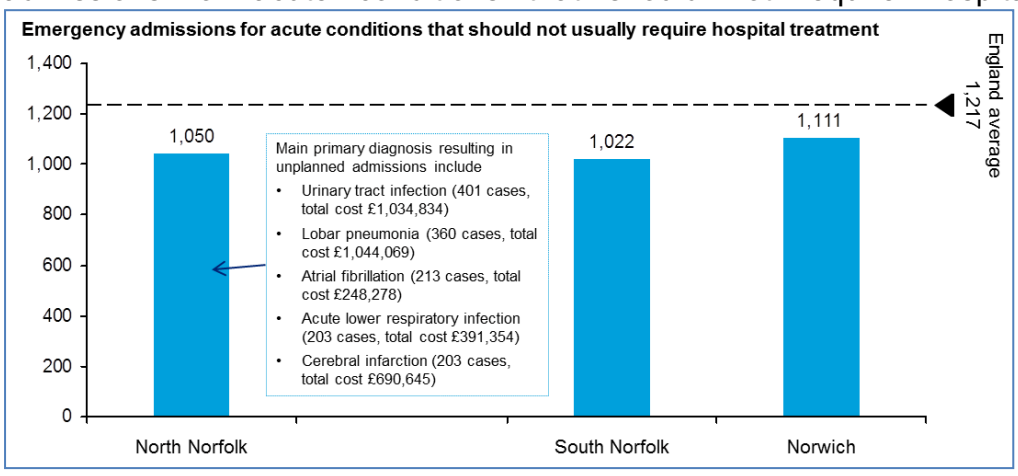
In general primary care in Norfolk is relatively accessible and patients report a good overall experience. SNCCG, NNCCG and NCCG all score above the England average for good overall experience of GP surgery, although North Norfolk and Norwich CCGs score below average for the proportion of patients who were able to see their preferred GP on most occasions.

Where the three CCGs perform less strongly is patient experience of out of hours GP care, for which all score below both the England and East Anglia averages. SNCCG and NNCCG in particular, score particularly poorly on this metric, suggesting that provision of out of hours primary care should be a key area of focus for quality improvement.

Primary care access indicators

	North Norfolk	South Norfolk	Norwich	East Anglia Average	England Average
Good overall experience of GP surgery	90.53	85.44	88.26	89.14	86.74
Good overall experience of out of hours GP	62.07	62.70	69.00	66.38	70.21
% of patients who were able to see preferred GP on most occasions	60.51	63.39	58.35	64.26	62.78
% of practices not open core hours (08:00 – 18:30)	50	36	27	58	-

The interface with secondary care, and overall demand management is a crucial area for consideration given the pressure on acute providers and demographic profile. All three CCGs perform better than the national average for emergency admissions for acute conditions that should not require hospital treatment.



Quality and outcomes in primary care will come under pressure with increasing demands on the primary care system, including 7 day working and the demand to provide personalised, proactive and joined up care (see box below on Transforming Primary Care). However, SNCCG, NNCCG and NCCG are in a strong position to build upon it existing high quality primary care services.

Transforming Primary Care

A new reports sets out plans for more proactive, personalised and joined up care

Overview

- *Transforming Primary Care* (April 2014) is the Department of Health and NHS England's joint plan to provide personalised, proactive and joined up care for people who need it most
- The initial focus will be on 800,000 people with the most complex care needs
- The key features of the proposals include:
  - a personal care and support plan (from September 2014)
  - a named accountable GP (by the end of June 2014)
  - a professional to coordinate their care
  - same-day telephone consultations
  - Improved information and support for people caring for family or friends
- These changes will be supported through the Care Quality Commission (CQCs) new approach to regulating, inspecting and rating GP practices, along with assurance via patient feedback and NHS Choices
- Access to care (such as via online appointment booking) will be enabled through improvements to technology

Implications

- *Transforming Primary Care* details a range of support which is to be provided to staff working in health and care. This includes:
  - removing some bureaucratic tasks to free up GP time for proactive care, e.g. removing some task-based payments
  - improved provision of training to staff via Health Education England, e.g. development of the skills needed to meet people's changing needs
  - New ways of working to enable staff to work across professional boundaries, ensuring staff are able to take on different roles where necessary
  - Improved information sharing across health and social care settings, e.g. timely access to information and GPs for staff in other settings
- To support joined up working this year, CCGs will provide £250m to commission services which support GPs in improving quality of care for older people and people with complex needs
- The Better Care Fund will be used to support the integration of health and social care services from next year
- A £50m challenge fund will support local pilots to explore ways to improve access to GP services over the coming year
- There will be a focus on improving recruitment and retention in primary and community care, with around 10,000 primary and community health professionals intended to be made available by 2020

18.3 The vision for primary care in 2019

Reflecting the challenges identified, the vision for primary care in 2019 is one where enhanced patient access, including extended hours and out of hours, is supported through measures to improve GP productivity and offer new ways of working. GP practices sit at the centre of a wider network of care professionals, with whom they are linked both physically, through co-location, and through improved IT system interoperability and sharing of patient records. The key components of this vision are summarised below

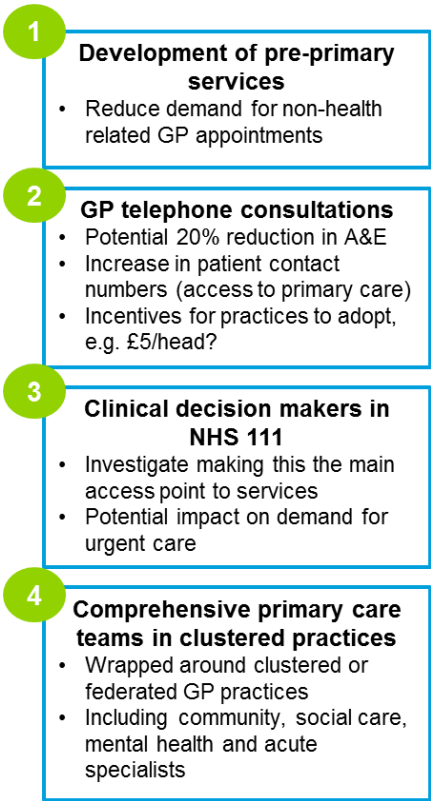
In 2019, a sustainable primary care system in central Norfolk is characterised by…

1. A network of GP practices which have **consolidated and federated** (where appropriate), enabling provision of primary care at scale
2. GP practices as the **organising unit of care**, including named accountable GPs for those patients who need them and wrapping of other services around general practices
3. **New ways of working**, via including telephone consultations, which improve the productivity of primary care and increase patient access
4. Information systems which enable **rapid sharing and updating of patient records** across the healthcare system and which enable GPs to be informed of the latest developments regarding their patients

In order to deliver this vision for primary care, a number of key transformational interventions will be implemented.

18.3.1 Transformational interventions

Following a workshop with commissioners and providers on 7th May, four key transformational schemes were identified as the main initiatives to take forward within primary care. These are focused on delivering the vision by tackling demand and increasing GP productivity, while placing primary care at the heart of integrated health and social care services. These transformational interventions are outlined below.



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