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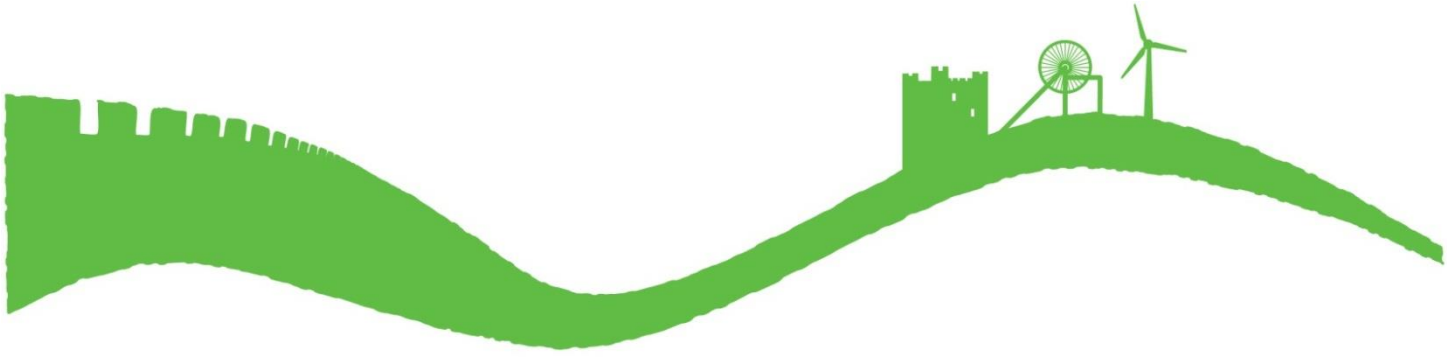
Northumberland Local Medical Committee

NHS
Northumberland
Clinical Commissioning Group

# A Primary Care Strategy for Northumberland 2016-2020

## A vision for a vibrant and sustainable future for primary care



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# Executive Summary

The Primary Care Strategy tells the 'story' of general practice in Northumberland, looks at the challenges ahead and provides a vision for the future. It recognises that the status quo is probably no longer an option. In the face of rising demand and finite budgets, the model of general practice must change if the challenges of preventing ill health, easier access to healthcare and the rising demand of complex technological healthcare are to be met. The strategy discusses initiatives designed to improve provision in a number of key areas and has been designed under the overarching principle of delivering safe and effective health services which patients value and trust.

The vision is that all clinicians will be working in practices that they are proud of, delivering care to patients in wider truly integrated teams. The key components of the strategy are:

- Improving patient access: The strategy proposes the delivery of primary care at scale through the development of a seven day access model via primary care 'hubs'. The hubs will need to be slightly different across localities but core components and standards of access will be the same across each. The model sees nurse practitioners, clinical pharmacists and community paramedics working more closely with GP practices, releasing more GP time to deliver care for complex patients.

- Workforce: The strategy considers this a key area for development and seeks to blur the traditional healthcare professional boundaries. GPs will have a clear understanding of their role in the future and there will be new innovative roles for other healthcare professionals working closely alongside GPs. This will create more capacity to look after patients in the community, provide continuity of care and timely access.

- Quality: The current burden on General Practice created by quality incentive schemes requires addressing. Focussing payments to practices on a smaller number of substantial changes programmes may be the key that is needed to unlock the required transformation.

- Information Technology: Joined up communication between different healthcare providers and the wider social care system is of critical importance to an integrated healthcare model. Significant work is being undertaken to develop a truly integrated clinical IT system which eradicates waste, reduces duplication and maximises the time spent by GPs with their patients.

- Estates: Operating under the banner of 'first class buildings for a world class service' the strategy seeks to develop and deliver a physical environment that matches the service aspirations of the future.

The Northumberland population benefits from strong primary care provision across

its 44 practices. Northumberland GPs have long been leaders in primary care development, innovation, education and research. For the last two decades there has been a strong culture of collaboration between practices and with the wider healthcare system.

General practice in Northumberland and nationally is at a cross-road. There are significant challenges but also the opportunities associated with additional funding available through the Vanguard programme. Primary care has a vision for the future of healthcare in the county, and the choices that are made will allow a number of different models of delivery to flourish. Providers will however need to adapt and innovate along the journey and also determine what role they play in continuing to shape the future.

# Forewords

## Dr Robin Hudson: Northumberland Vanguard Programme

General practice has been my medical career choice for 16 years. The lure of being a 'jack of all trades' generalist family doctor working in a community has always appealed to me. I have been in my community for long enough now to recognise my patients in the street and remember their very personal stories. **It has been a privilege to share these journeys with my patients, even right up to the end of their lives.**

General practice does not publicise itself enough. Communities have always had a practice to serve the local area since the inception of the NHS. Until recently, most patients would not exercise the right to choose which practice they will register with. However, if patients are unable to access their 'corner shop' they may decide to go to the 'supermarket' up the road and the 'corner shop' becomes less relevant.

General practices have become sophisticated and complex organisations. However, we are being expected to deliver healthcare whilst having to deal with reduced funding, rising workloads, huge patient expectation, heavy regulation and falling numbers of GPs. **If we do not re-think how we are going to deliver strong and effective primary care then we risk becoming irrelevant in the future.**

**I am absolutely convinced that strong and effective general practice can serve the majority of health needs in Northumberland**. To think about this I have had to think less about my own self-interest and more about the interests of my patients and those doctors and nurses following me into my profession in the next 10-20 years.

**Dr Robin Hudson FRCGP**
**GP Clinical Director, Northumberland Vanguard Programme**
**Primary Care Development Lead, NHS Northumberland CCG**

# Northumberland Local Medical Committee

Northumberland Local Medical Committee has supported fully, the production of this strategy for primary care in our county, and endorses the principles described.

The time is right in this rapidly changing environment to articulate our aims. We are facing a perfect storm of an aging population, spiralling demand, plus recruitment and retention problems not of our own making. All these contribute to unremitting pressure on our primary care workforce. In times of pressure, our profession has found resilience in collaborative work, to a degree rarely paralleled in the NHS.

This document provides a positive and realistic vision of future primary care provision, whilst recognising the value of local knowledge and skills, and the commonly held objective of preserving the specialist generalist component of medical practice. As such, the strategy provides a framework that will be the way that will be probably be the main vehicle in which practices will survive the turbulent years that inevitably lie ahead.

We must remember however that change is not always easy and all individuals and organisations may need to compromise to achieve common goals.

Northumberland LMC exists to represent the professional and personal wellbeing of GPs who base their work in Northumberland and therefore welcomes this constructive approach.

**Dr David Brown**
**Chair**
**Northumberland LMC**

**Dr Jane Lothian**
**Medical Secretary**
**Northumberland LMC**

# Introduction

Northumberland has never had a strategic document for general practice. This strategy should be seen as a document which tells the 'story' about general practice in Northumberland. Huge challenges remain to provide healthcare to a population that is living for longer with complex health needs whilst at the same time addressing huge issues in preventative healthcare. Our strategy must fit the over-riding principles of delivering safe and effective health services which patients value and trust.

The Northumberland population benefits from strong primary care provision across its 44 practices. We intend to scale up and integrate primary care working further across Northumberland to achieve efficiencies, improved health outcomes and provide responsive care that meets the needs of the population.

In March 2015 Northumberland was awarded Vanguard status which will allow us to implement change through the integration of different emerging models of care. Individual practices will not be able to solve these problems alone. However if groups of practices can work more closely with larger stakeholders with clear boundaries and ground-rules, then real progress can be made. Certain 'freedoms' will need to created in terms of integrated clinical IT systems and in our workforce development. More front line service need to be delivered by nurses, clinical pharmacists and community paramedics with GPs retaining oversight and control.

> "We have a vision for the future of healthcare in our county, and the choices that we make will allow a number of different models of delivery to flourish. **The status quo is no longer an option, if general practice is to survive it will have to adapt and innovate.** The challenge to all of us is what role we can play and what voice can we use to shape the future."

# The Vision for Primary Care

Primary care is a fundamental part of the Northumberland healthcare system and creating a sustainable future for primary care is a high priority as articulated in the Northumberland five year strategic vision below:

**Providing seamless high quality care for the people of Northumberland**
**Empowering our communities to live long and healthy lives at home**

| Health and care in Northumberland: the seven elements of care | | | | | | |
|---|---|---|---|---|---|---|
| **Building a caring future** | **Building care in our communities** | **Care closer to home** | **Care without wall** | **Blurring the boundaries** | **Patient at the centre** | **Personal care led by the patient** |
| Providing the best care delivered by the best people to achieve the best outcomes | We now need to focus on building capacity in primary care and in our communities | Turning our services to face and become embedded in the community: including base hospitals, mental health, learning disabilities | Care is delivered in an integrated way where needed and is not limited by buildings or professional boundaries | Between secondary and primary care/physical and mental health/social care and healthcare | Single points of access. Easy navigation of the system. Focus on full life course. Reduction of variation. Doing things once | People are fully engaged and truly empowered to make decisions and take control of their own health and care |
| We already have the plans for our hospital settings | | | Transformation | Parity of esteem | Innovation | Self-care |

The following vision has been written to open up the debate about the possible future direction of general practice.

Imagine a world where patients still belong to their own local practice list and their own team of doctors and nurses. However all the practices have been updated and are modern, clean and efficiently run. Each practice retains its identity but also belongs to a wider practice network with a clear ‘brand’ and uniform access arrangements. With patient consent, clinicians have access to the patient’s clinical IT record regardless of where they are being seen within the healthcare system. This ensures better and safer clinical care within that system.

GPs work the majority of their time in their own practice but can also choose to spend some time in other practices in their network by doing weekend and out-of-hours work. Practice nurses and healthcare assistants also work in this way. All clinicians have job plans and they are given protected time for continuing professional development and quality improvement work. Numerous opportunities

are available to develop special interests and to work alongside specialists both in the community and in hospital.

Clinical systems are fully integrated between primary care, secondary care and community services and all clinical guidelines are collated and disseminated throughout the organisations. New access arrangements mean that patients with new undifferentiated problems can easily get a same-day appointment in their practice during working hours or they can choose another clinical setting in the network at a more convenient time across seven days a week.

GPs now only visit those patients who have complex problems or who need end of life care. Routine visits are now performed by a team made up of nurses, clinical pharmacists and community paramedics who can diagnose and treat a number of common sub-acute medical conditions. Social care provides a rapid response service and works closely with GPs and these community visiting teams. GPs have oversight of this team and will only visit if a hospital admission can be avoided. Hospital consultants are often in the community and ambulatory care has been rolled out to seven days a week to keep patients with complex health needs out of hospital.

Patients with long-term chronic illnesses have an annual health review with their practice nurse and GP. Together, a healthcare plan is agreed which patients can access at all times. In their care plan, patients can review their health goals and they can access links which will advise them about what to do should they become ill. Those patients who struggle to cope with their long-term conditions have access to support from clinical psychology and the voluntary sector. High risk patients with chronic illnesses are case managed by a long-term conditions' team who can ring the 'named GP' for advice regarding management decisions or liase directly with the hospital.

GPs now spend on average 30 minutes with patients with long-term conditions and will spend several days a week doing only this kind of work. During other days of the week GPs and nurses deal with the workload generated by same day demand. All patients who attend A&E are flagged for the practice and within 24 hours patients receive a telephone call from their GP to review the reasons for that attendance and to learn any lessons. A large number of routine hypertensive patients are now given portable BP machines for home use. They email the practice every three to six months, these emails being reviewed by the most appropriate clinician.

Patients took a while to get used to this new system however the patient participation group has fed back that patient satisfaction rates are now high. The number of complaints are the lowest for years and staff morale has improved overall. Patients can obtain same day appointments when needed whilst patients with long-term illness feel better looked after as they receive regular planned co-ordinated care visits whilst knowing that their GP has oversight and control. They especially like the care plan booklet given to them each year which explains the nature of their conditions, what each medication is for and advice about what to do if they are not feeling well. The fact that they can access this online or via their phone app is also a very useful option for some patients.

In summary:

- Clinicians are working in practices they are proud of, delivering care to patients in a wider truly integrated team.
- Networks of practices are working together; integrated with care teams from community, secondary care, social care and the voluntary sector.
- New structures and workforce models are in place to allow clinicians to spend more time with their patients, with greater continuity of care and higher quality care for their patients.
- The system allows easy access to the right clinician at the right time, whilst patients with complex needs are managed proactively in the community by a wider multidisciplinary team headed up by their GP and appropriate specialist.
- Everything is underpinned by a shared clinical record.

# Strategic and Policy Context

The Nuffield Trust produced a report entitled *Securing the future of general practice*[1] which made a number of important points.

## Key Points

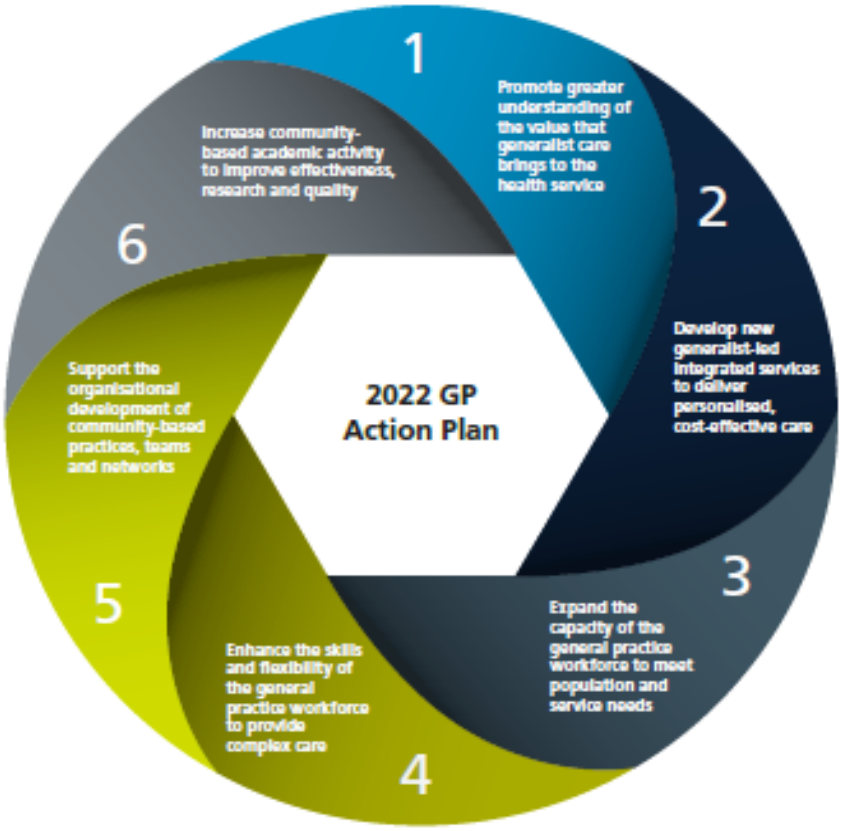
- Primary care in England is under significant strain. GPs and their teams are caught on a treadmill of trying to meet demand from patients while lacking time to reflect on how they provide and organise care.

- New models of care organisation are emerging organically in some areas to meet the challenges facing primary care. It will be a fine balance between the benefits of organisational scale with the preservation of the local nature of general practice which patients highly value. It is really important to state that while we extend the scope and scale of primary care, we must avoid advocating just one organisational model.

- Local context will play an important role in determining organisational form and the precise mix of services will depend upon the nature and priorities of the local population. It is inevitable that practices will need to work in federations, networks or merged partnerships in order to increase their scale, scope and organisational capacity.

- Change at this level will require support and incentives, as well as permission for GPs and other primary care practitioners to test out new approaches to the delivery and organisation of care. It is likely that the pressure to change will remain the direction of travel long term. This is echoed in the Royal College of General Practitioners' (RCGP) 2020 Vision for Primary Care document which outlines six steps in an action plan for primary care.

**The RCGP 2020 GP Action Plan** defines six clear tasks that primary care, in partnership with its stakeholders, must aspire to achieve:




**The Five Year Forward view,** written by Simon Stephens (CEO, NHS England) and published in October 2014 sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers.

## Key Points

- The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain **all now depend on a radical upgrade in prevention and public health**.
- **When people do need health services, patients will gain far greater control of their own care** – including the option of shared budgets combining health and social care.
- **The NHS will take decisive steps to break down the barriers** in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care. The future will see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions, not just single diseases.

- **England is too diverse for a 'one size fits all' care model** to apply everywhere. But nor is the answer simply to let 'a thousand flowers bloom'. Different local health communities will instead be supported by the NHS' national leadership to choose from amongst a small number of radical new care delivery options, and then given the resources and support to implement them where that makes sense.

# The Five Year Forward View and new models of care

**The foundation of NHS care will remain list-based primary care**. Given the pressures we are all are under, we need a 'new deal' for GPs. Over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years. GP-led Clinical Commissioning Groups will have the option of more control over the wider NHS budget, enabling a shift in investment from acute to primary and community services. The number of GPs in training needs to be increased as fast as possible, with new options to encourage retention.

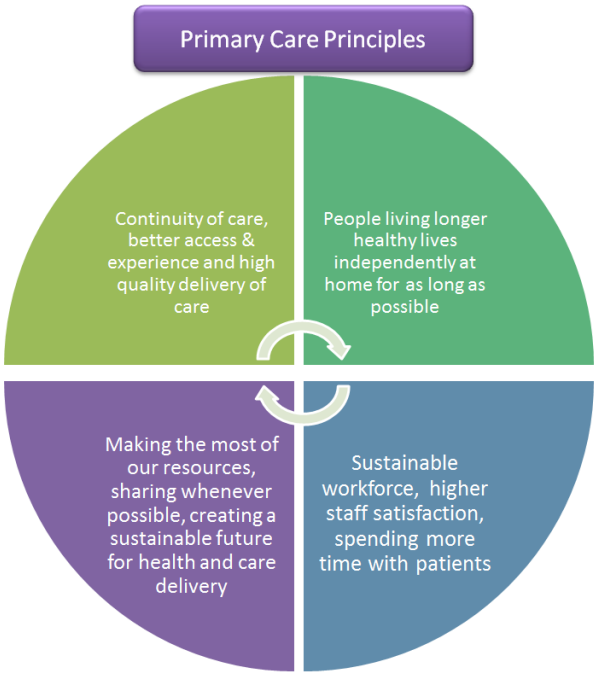
In order to support these changes, the **national leadership** of the NHS will need to act coherently together, and provide **meaningful local flexibility** in the way payment rules, regulatory requirements and other mechanisms are applied. We will back diverse solutions and local leadership, in place of the distraction of further national structural reorganisation.

**Integrated care** means health and social care professionals working seamlessly as one team with a joint health record and a co-ordinated plan for each patient. Patients see the professional who can most meet their needs at any one time, in effect as one single team regardless of the organisation that professional works for. For this to happen, individuals, organisations, contracts and priorities need to be correctly aligned and all workers within the system having a wider public health responsibility to reduce the variation in quality in health and social care.

Fundamental changes[1] will be required to general practice. **Practices need to be linked together into networks, federations, merged partnerships or wholly-owned subsidiaries of foundation trusts.** This will increase the scale and scope of practices enabling them to invest in new workforce models and in new technologies in order to improve the health of their patients and the wider population.

# Components of the primary care strategy

The next five sections address the future of primary care in relation to access, workforce, quality, information technology and estates, underpinned by these principles:




## 1. Patient access

The challenges we are facing in Northumberland when it comes to developing a strategy for GP access is that there is not one single definition of what 'access' means. The RCGP[2] has stated that we need to exercise care when trying to develop such a definition as this can imply that there is only one model of GP access when we know that there are a number of models being used. It would be attractive to state that there is a 'one-size-fits all' model but this would not reflect reality.

Broadly speaking there are three aspects to access in general practice:

- Availability and proximity of care
- Timeliness of care
- Ability to see a preferred GP or nurse

The most recent GP Patient Survey conducted by Ipsos MORI on behalf of the CCG (published July 2015) shows that Northumberland practices compare very favourably with national performance in a number of key areas (eg overall experience of GP surgeries in Northumberland is 87% positive against a national average of 85%). These results are a testament to the diligence and hard work of practices in our county. However, despite considerable effort at practice level, regional performance

continues to slightly decline (eg overall experience of making an appointment was 76% positive in 2015 against 77% in 2014).

Despite headline statistics that show that the region continues to perform well overall, with a high percentage of patients reporting confidence and trust in Northumberland GPs and their teams, the survey also reveals regional variation in patient satisfaction in some key areas, including the ability to get through to GP surgeries on the phone and current opening hours. The general feedback on access also backs up the locally held view that patients want better access to in hours appointments rather than the focus solely being on extended access outside core hours.

The RCGP in Scotland produced a toolkit in 2014[3] and they observed that **continuity of care is very important for cost effective care and patient satisfaction however** it has been undermined by the development of larger practices, part time working, increasing mobility of both staff and patients, as well as many practice and CCG-led disease management initiatives.

The challenges for us in Northumberland are profound but not insurmountable. How do we balance the provision of continuity of care with the demand to provide same day and extended access? **Currently there is no county-wide data available which allows us to understand how practices match activity against patient demand.** If all practices in Northumberland allowed this analysis to take place, we could understand the problem further and any new models could be evaluated transparently and effectively.

By 2020 the Department of Health has indicated that extended GP hours seven days a week should be available. However we need to ask our patients what they want. If patients want this kind of service then this can only be delivered in larger organisational groups. The evolution and development of these groups must be supported by the Vanguard programme.

## Redesign of GP same-day access to create greater capacity in general practice

In the five year forward view[4] it talks about the delivery of primary care at scale. As part of the Northumberland vanguard programme this will translate into primary care being delivered in the community across seven days via primary care ‘hubs’. We do recognise that due to the geography and the demographics in Northumberland, the locality hub model will need to be slightly different across localities, with core components and standards of access being the same across each hub. We should also acknowledge that current evidence nationally has shown low patient demand for GP services on a Sunday. This will need to be evaluated carefully.

The project proposes a number of operating hubs that will encompass the 44 practices in Northumberland, with the three integrated hospital primary care hubs adding additional access points for local communities and minor injuries work.
It is clear that extended primary care access requires the support of alternative workforce models to ensure that the right persons with the appropriate skillsets are used to treat the full range of patients that can be seen in primary care.

### Outcome

- To obtain practice level data on activity and demand for each practice with an analysis of the access system being used.
- The development of primary care hubs to expand acute and same day access across localities.
- To develop models of care within practices for patients with long-term conditions i.e. one-stop shops. This will allow greater access for patients needing continuity of care and may reduce access demand though greater patient self-management and empowerment.

### Actions

- CCG/Vanguard audit of activity and demand across the county.
- Engagement with each practice to understand access system.
- Review of data as new extended access models are started in test sites.
- The Vanguard programme to implement test sites across all localities.
- To create freedoms in terms of NHSE governance and IT interoperability.
- Effective engagement with practices and patients paramount.
- To test new models of the one-stop shop with more time allocated to the GP and practice nurse.
- To develop risk-stratification tools to help manage the workload of complex patients.
- To create capacity within general practice by developing community multi-disciplinary team (MDT) visiting teams to do more of the visiting to housebound and care home patients.

## Expansion of community teams to create greater capacity in general practice

We need to explore alternative workforce solutions to help deliver primary care access at scale, prevent admissions to hospital and also to ensure rapid discharge from hospital with support in the community. The system needs to wrap around our patients rather than our patients having to fit into the system provided.

A community model could be developed whereby nurse practitioners, clinical pharmacists and community paramedics could work more closely with GP practices, thereby releasing GP time to deliver care for more complex patients and to increase capacity to deliver a seven day service to the local population. Depending on locality needs, the community/primary care practitioner could support the routine nursing home caseload and provide a home visiting service to those patients who have an acute, but non serious illness or injury and are unable to attend a GP practice. The split of this workload will depend on the rurality and demographic of each of the four localities and will involve the introduction of a new model for rapid response services to respond to urgent demand.

This model replicates a something seen both in the acute hospital setting and within palliative care services which are currently delivered across the hospital and community.

The current hospital model focuses consultant time to see the sickest patients and uses junior doctors and nurse practitioners to deliver more routine work. This model

is not entirely transferable to general practice as **GPs still need to be seeing patients at the frontline of the NHS** however other professionals could take on some of this routine work. The capacity created will give GPs more time to care for their sickest patients or those presenting with the most acute and complex conditions in the community.

With the current lack of GP training posts being filled in the North East, the predicted retirement of 20% of the GP workforce and the problems with retention of GPs, a new way forward has to be considered. A significant expansion of the GP workforce is unlikely to materialise soon so the way that GPs work and perceive their role needs to be discussed and then developed for the future in a sustainable way.

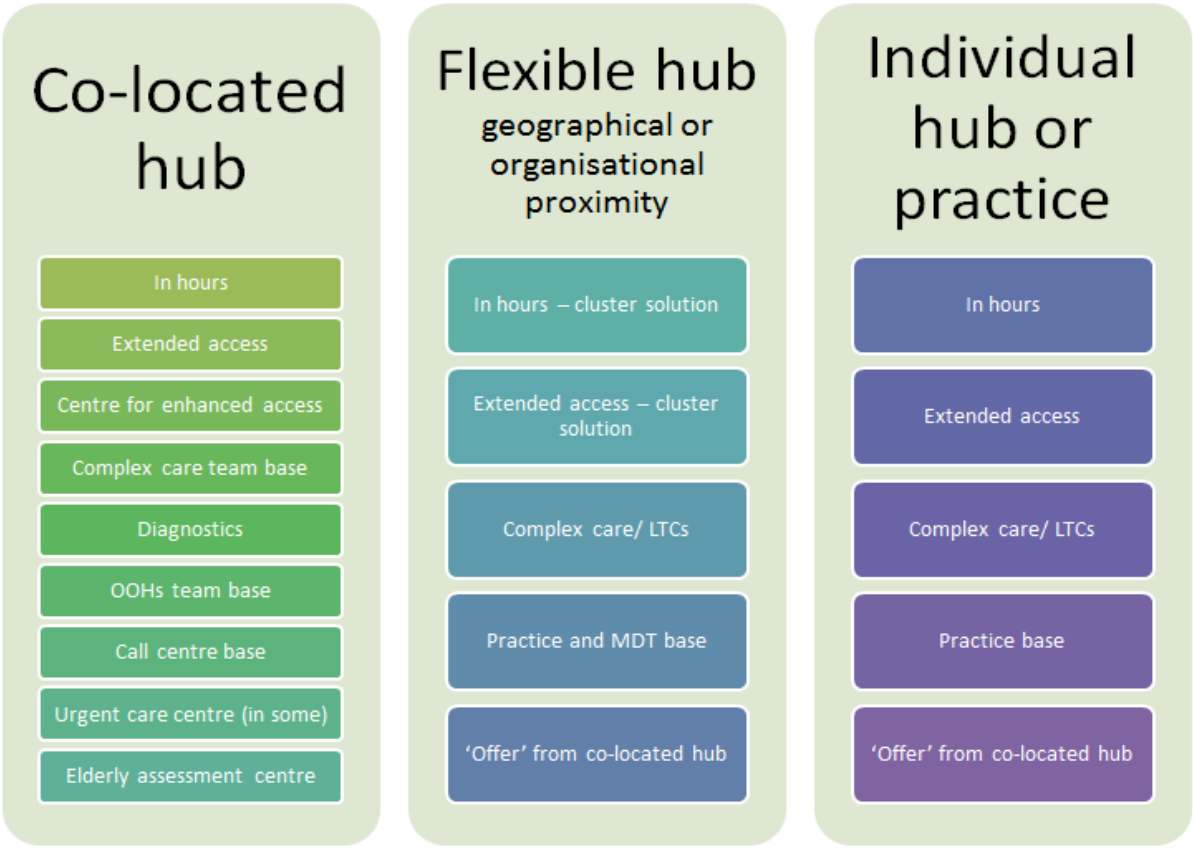
## Redesign of pathways for chronic disease management

New models of delivering care within practices to those with complex needs and co-morbidities do exist, but the capacity to test these new models is limited due to the workload of same day demand, visiting and clinical administration. Our patients with long-term conditions require a different type of access to their GPs and practice teams. This group needs longer appointments with a clinician for the opportunity to discuss all of their conditions and they need intensive support during phases of serious illness or better support in self-managing their stable long-term conditions. The innovations highlighted and which are about to be tested through the Vanguard programme are all attempting to create capacity within primary care in order to allow practices to think about new ways of delivering care to their patients.

**The challenge for us in general practice is clear. We could legitimately continue to provide the services we currently have, within the current framework, but with diminishing resources, increasing burden and a workforce model which is tiring and inflexible. Or we can seek out new ways of delivering primary care which may allow us to spend more time with our complex and vulnerable patients, whilst dealing with the pressures of same day demand in new ways, with a wider pool of clinicians.**

### The framework for primary care development

The developing framework for primary care in Northumberland will allow a variety of models to flourish as outlined in the diagram below.




## 2. Workforce

All authorities agree that primary and community care are central to the delivery of a safe, effective and highly regarded health service. This has been set out in the Five Year Forward View document and has been highlighted in recent reports by the King's Fund.

This aspiration for general practice lies far from the reality of the present day situation. National modelling by the RCGP has stated that the number of GPs being trained will not be sufficient in order to meet future demands. Indeed the Centre for Workforce Intelligence has said that there will be a significant undersupply of GPs by 2020 unless significant steps are taken to address this imbalance between supply and demand. The predicted numbers of practice nurses due to retire in the near future is also a significant concern.

It is interesting to note that there was a significant expansion in medical consultants by the acute sector after 2000 caused by the pressure to reduce waiting times. General practice however has seemingly 'drifted' into crisis, partly due to the difficulty in balancing supply and demand.

The King's Fund[5] has postulated that there are two factors which have contributed to this.

Firstly there are no clear ways to measure demand for primary care services. There is a distinct absence of any measures of activity and as a consequence policy-makers have been unable to have a clear view of the pressures that practices are working under, whilst they add more responsibilities upon their shoulders. A clearer view of workload and workforce would allow better planning and more creative use of skill-mix in order to deliver primary care on a more sustainable footing. This mirrors what has already been stated in the issue on GP access.

Secondly the proportion of NHS resources spent on primary care has been falling in recent years which is a failure at both a national and regional level to commission general practice adequately and fairly.

Nationally the number of support staff increased by 5.2 per cent between 2010 and 2013, from 82,802 to 87,144 FTEs. This was predominantly driven by an increase in the number of administrative staff and, to a lesser extent, those in the 'direct patient care' staff category (defined as 'anyone who is directly involved in delivering patient care but who is not a nurse or GP', which includes physiotherapists or pharmacists within the practice).

## Traditional boundaries

The Northumberland Vanguard programme wants to explore alternatives to traditional workforce roles. The challenges in providing seven day working across an acute and a more integrated care system are significant and will require us to engage with a number of educational and regulatory bodies. This may fundamentally change the traditional ways of working and teaching however these novel workforce solutions may generate significant internal efficiencies which can be re-invested in the workforce in the long term.

Blurring the traditional professional boundaries that currently exist within healthcare will challenge existing pre-conceptions around our medical training system. This challenge of existing roles and responsibilities is needed if we are to have a workforce that is fit for the future, one that can deliver the requirements needed in an integrated healthcare system.

As an example, there is an urgent need to develop roles and training across the traditional primary and community nursing boundaries that currently exist. Building capacity within the community may require the development of new nurse practitioner roles and the development of multi-skilled community professionals along with support staff who can work across a number of currently distinct roles.

### Outcome

- A clear analysis and map of the workforce configuraton within Northumberland.

### Action

- Roll out Health Education North East's (HENE) Primary Care Workforce Collection tool.
- The Vanguard programme to develop the freedoms needed to enable cross working between primary, secondary and community services.
- An engagement exercise with GPs to help deliver new non-medical roles within the workforce.

## Practice and community nursing

As the population ages, there is a pressing need to cost effectively manage the care of increasing numbers of people with long-term conditions and prevent unnecessary hospitalisation.

In an editorial in the BJGP[6] it stated that in the ten years since the introduction of the Quality and Outcomes Framework the numbers of registered nurses employed by GP practices is estimated to have increased by 15% and stands at 23,833 in the equivalent of 14,943 FTE. Practice nurses therefore make up 37% of the clinicians in general practice.

The workload of practice nurses has changed over the last 10 years with many of them dealing with more complex patient care through chronic disease clinics and health promotion. With the increase in this delegated work it will be increasingly important to ensure that this group are properly supported to fulfil these roles safely. To what extent their roles expand and take the place of GPs remains debatable[6.]

### Outcome

- To align the skills and training of practice and community nurses which will enable them to take on greater clinical roles within practices.

### Action

- To scope out the possible ways to support practice and community nurses through joint learning and peer-led appraisal.
- The Vanguard team will create the workforce freedoms needed with HENE and the relevant royal colleges.
- To develop new models of cross-boundary working.

## Clinical Pharmacists

This group of professionals have the training and capability to take on more roles within primary care.

They can provide support to practices to review repeat medication systems, support for practice medicines managers, medicines reconciliation post-discharge, nursing home medications review and work to improve anti-microbial stewardship.

Interestingly other roles they could provide include face-to-face patient care for those patients with long-term conditions with the ability to liase directly with secondary care, rather than relying on a GP referral.

### Outcome

- To roll out and extend the use of clinical pharmacists within the community through closer working with practices and care homes. Sustainably and long term.

### Action

- To continue to evaluate the pilot within care homes and to re-invest the savings in the service.
- Clinical governance arrangements needed for these clinicians to work across practices.
- To engage and educate GPs and their teams on the role and value of these clinicians.
- To bid for new money being made available nationally to develop clinical pharmacists in primary care.

## Community Paramedics

This group of professionals could have an increasingly important role within primary care. Community paramedics already provide a vital role in the more remote parts of Northumberland where they can undertake home visits, minor injuries and minor illness work. Developing their roles within more urban settings should be explored.

Advanced practitioner (AP) roles are also developing, which are made up of experienced nurses and paramedics who can provide higher level diagnostic skills in the community as well as the ability to offer independent prescribing.

### Outcome

To align the skills and training of community paramedics and APs which will enable them to take on greater clinical roles within practices.

### Action

- To evaluate and test how these clinicians could be integrated into primary care.
- Clinical governance arrangements needed for these clinicians to work across practices.
- To engage and educate GPs and their teams on the role and value of these clinicians.

## Physician Associates

The recent research done by Kingston University and St George's University looking at the benefits of physician associates is generating much interest nationally. A growing number of countries have followed the lead from the USA in developing this role, such as Australia, the Netherlands, Canada and Germany. How these clinicians can be deployed alongside GPs needs to be evaluated carefully, however if they can take on tasks traditionally done by GPs they could release time for GPs to concentrate on more complex patient care.

NHS England has announced plans to create more training posts for this role over the next few years but the numbers being talked about are small when compared against the larger GP workforce picture.

## The future GP

What is the future GP? Fundamentally our training enables us to deal with large numbers of patients presenting with undifferentiated medical problems as well as managing patients with complex health needs. We manage these patients along the medical model whilst often having to manage uncertainty, limited resources and patient expectation in a safe and efficient manner.

Can GPs in Northumberland continue being 'all things to all people?' or can we reorganise ourselves by managing streams of work differently within our practices or networks of practices. Can we release more time to spend with those patients with complex needs? If other professionals could help us to manage aspects of our clinical and administrative workload in a safe and efficient way, would this give us the capacity to focus upon quality improvement and public health?

GPs in Northumberland have an opportunity through the Vanguard programme to ask these questions now and to shape the future direction of general practice for the future.

### Outcome

- GPs to have a clearer understanding of their role in the future and to have skills/attributes to fulfill these roles successfully.
- A future model of general practice that is sustainable, attractive and rewarding.
- Practice manager development and their greater role in transformational change.

### Action

- Local Medical Committee (LMC) led events to engage GPs on their future roles in transformational change.
- The expansion of support roles to create greater capacity in GP.
- Career start GP schemes to increase capacity for GP leaders.
- To evaluate the creation of a Northumberland GP development programme (education, research, leadership, portfolio career).

- To develop a practice manager development programme for education, training and strategy.
- Practice manager career start scheme to develop capacity

# 3. Quality in general practice

Strong primary care has been widely recognised as being a bedrock of high performing healthcare systems and UK general practice is regarded highly internationally as being highly accessible and well co-ordinated. However, it has also been recognised that primary care will have to evolve and grow in order to meet the growing demands and expectations of the population, for reasons already highlighted.

The place for a generalist-led service at the heart of a system which is ever-increasingly specialised has resulted in questions being raised about what is the role of general practice in the NHS. In 2008 Lord Darzi defined quality in three key areas:

- Patient safety
- Clinical effectiveness
- Patient experience

Defining quality in general practice is much more complicated however and needs to encompass the different perspectives of patients and professionals. Some patients value access over continuity, whilst politicians focus on waiting times as these are more visible and measurable.

Whilst most GPs in our county understand the importance of quality improvement and the need to further embed this in their practice, there are significant constraints occurring due to workload.

Significant work has occurred within the county to improve the quality of work occurring in three main areas – serious incident reporting (via SEA and SIRMS), better engagement of child and adult safeguarding processes and finally anti-microbial stewardship training in order the reduce the incidence of HCAIs.

NHS England (CNTW team) already monitor practice performance using a primary care web tool which identifies high level outcome measures across a spectrum of indicators which include clinical outcomes data, patient access and experience data. An assurance process has been devised to alert practices if they are outliers across a number of these indicators with an expectation of quality improvement.

Northumberland CCG has modified this approach by ensuring that this process remains formative and supportive to practices at a time of increasing challenge and sensitivity.

To date, five practices in Northumberland have been identified on the web tool as being a ‘practice with review identified’. These have met with the CCG and developed SMART action plans to address the quality improvement issues. An additional nine practices have been identified as ‘approaching review’ and these have been written to in order to highlight these results and encourage reflection on these outlying areas. This formative approach has been successful to date and uses data which is transparent to those practices being measured, which is vital.

Transparency is fundamental to the integrity and spread of high value care. Within Northumberland, comparative data has been used by groups of practices to benchmark clinical practice in areas such as prescribing and end of life care. More recently the CCG has developed tools to assess referral behaviour (Practice Activity Scheme) and a large menu of enhanced services focussing upon patient outcomes.

There are three components which will be required in order to facilitate a transformation in quality within general practice[7]. They are standardising care, measuring performance and transparent reporting. The system must be patient-centred, eliminate unwarranted clinical variation and waste. The plethora of clinical guidelines need to be rationalised into a regionally led, primary care focussed guidelines group once more. Clinicians need to provide guideline supported care tailored to the patient's needs, with transparency built in when guidelines are not followed.

The challenge in order to achieve these components, across 44 different practices, should not be underestimated. Networks of practices or larger practice groups could make this reality more likely.

The regulatory burden which has resulted from the Care Quality Commission (CQC) inspection framework is unlikely to diminish for practices. The CQC purpose is to ensure the standardisation of care so that patients receive safe, effective, compassionate and high-quality care delivered in a culture of quality improvement. The duplication of effort by 44 practices, with varying capacity, needs to be challenged and discussed, as practices seek the way forward through the federated models, practice mergers or vertically integrated models of care.

## Quality in general practice and commissioning

A key issue which needs addressing is the current burden upon general practice created by quality incentive schemes. Many of these incentives are focused on narrow clinical areas and do not focus open the broader strategic change which needs to occur across the health economy.

There are numerous ways to drive change and improve care[8] and these can be delivered through financial incentives such as the Quality and Outcomes Framework (QOF) or enhanced services and contractual levers such as extended opening or new community-based services (i.e. Community DVT pathway).

Many studies which have looked at the financial incentives to drive transformational change are not strong and it is a reality that GP practices in Northumberland are currently being expected to deliver too many initiatives at the same time whilst expending large amounts of clinical and managerial energy to achieve them. They do not have enough time to focus upon transformational change.

The combination of incentives needed for transformational change has yet to be defined[8]. Some incentives may be perceived as unfair as the factors involved often lie outside a GP's control (for example, admission avoidance).

Larger primary care organisations may allow commissioners to have greater flexibility in designing local quality incentives with this money being used to redefine care pathways and reward practices along a gain-share or risk-share arrangement.

Focussing payments to practices on a smaller number of substantial change programmes may be the key we need to unlock the transformation we need.

### Outcome

- To reduce variations of care delivered by general practice.
- Co-commissioning and population health.
- To support practices in quality improvement.

### Actions

- Transparent reporting.
- Outcomes focussed primary care with redesign of the enhanced services to make them simpler and fewer.
- To re-institute the guidelines group.
- Greater funding through working with other partners to provide high quality CPD for all practice staff.
- To develop the GP Tutor network further to support CPD and revalidation issues.
- The CCG to map out the administrative, financial and clinical burden on general practice and develop action plans to stabilise practices.
- To develop new incentives for primary care transformational work and population health.
- To roll out training across all practices on improvement methodology.
- GP career start scheme to create capacity for this training.

# 4. Northumberland Primary Care IT Strategy[9]

## Introduction

The Department of Health has made clear its priorities to move forward the use of information technology, setting a target that the NHS should be paper free by 2020. In primary care, we have well established clinical systems that are the corner stones of the care we provide for our patients. There are key steps we must implement in the coming years to maintain and develop our use of Information technology. In order to further enhance the clinical care we are able to provide, we need to work with our health and social care colleagues to implement and integrate electronic records in these areas.

## Clinical System Support

Primary care is now heavily dependent upon the use of our clinical systems to provide care for our patients when these systems fail we are restricted in the care we can provide and there is the potential for harm to occur when providing patient care.

It is therefore essential that we commission fast and effective access to expert support for our clinical systems. This support needs to be available to provide support throughout all the periods where our services provide patient care.

Further risk of failure is presented with hardware failures and we must ensure that we have a programme in place to replace all computing hardware in a timely fashion to reduce the risk of interruptions to clinical care.

Clinical systems are also vulnerable to security threats including viruses and malware, therefore all computers and servers must have adequate protection from threats that is maintained and updated on a frequent basis to keep our systems safe.

In the event of full system failure each practice must have a disaster recovery solution in place, we should also work with IT services and system providers to look at possible solutions to limit any periods where we are without our clinical systems.

## Information Governance

The data we hold about our patients does not belong to us however, we are responsible for keeping it safe. In order to ensure this we have a responsibility to meet the requirements of the data protection act and the IG toolkit. All practices and organisations should be fully compliant with the IG toolkit and aware of there responsibilities when handling patient data.

We should liaise closely with patient representative groups to discuss any changes in the handling of patient data to maintain their confidence in our services.

## Data Sharing

As already stated the data we hold does not belong to us, it belongs to the patient, but we are responsible for its safe keeping. In keeping with Dame Caldicott's latest recommendations we have a duty to make this data available to other services where this information will enhance the care provided to our patients. We must work to develop models that allow safe and effective sharing of data and communicate this effectively and clearly to our patients, allowing them the opportunity to make an active decision to prevent the sharing of their data.

This process of data sharing should start with other GP practices and community services to enable joint working. This can then be further extended to allow data sharing with secondary care and eventually social care services.

A significant amount of work is being undertaken to develop a truly integrated clinical IT system. The aspiration of this is to provide higher quality care to patients and more seamless communication between different healthcare providers and the wider social care system. Better utilisation of IT whether that be through e-discharge letters or teleconferencing could minimise waste and maximise the time spent by clinicians with their patients.

However, if the clinical systems within Northumberland cannot be truly interoperable then we must decide together whether it would be better to have a single unified system from one single provider.

### Outcome

- To expand the IT infrastructure across primary and secondary care.
- Integration of clinical IT systems leading to higher quality, seamless care.
- Minimising waste.

### Actions

- Roll out of the national IT strategy and development of IT support services.
- Needs investment, patient engagement and clinical engagement.
- Develop the joint vision between primary, secondary care.
- The Vanguard programme to develop the freedoms needed for this to become reality.
- Greater support of teleconferencing, e-discharges and e-prescribing.
- Needs sustained investment and training.

# 5. Estates

The vision for an estates strategy for Northumberland is that we have ‘first class buildings for a world class service’. Essentially the estates strategy should deliver a physical environment which matches the service aspirations of the commissioners of primary care.

Northumberland Care Trust wrote a draft estates strategy for 2012-2017 which undertook a comprehensive review of all the primary care estates in the county. In recent years, with the organisational changes that have occurred, it has become less clear who has the responsibility to plan and develop primary care buildings for the future. There is a perception that the current estate is not flexible enough to cope with the new roles it may be asked to take on. With the new models of care, there will have to be more care in the community, greater integration and co-location of providers and an evolution of primary care based ‘hubs’.

The existing estate needs to be reviewed once more and a strategic plan developed to ensure that the premises are modern and fit for purpose. Aspects of this will include the physical condition of buildings, their functional suitability, how well space is used, the quality of the environment as well as health and safety. We need to create stronger links with the local authority and local planning departments, as they develop their plans for new housing developments, and ask them how these will impact upon the existing primary care services.

We need to understand the balance of free-hold to lease-hold properties and the options available for the future. The current GP workforce who own their buildings will have genuine concerns about the valuation of their premises if new models develop which want to rationalise the existing estate and develop new premises. Younger GPs may not choose the option of owning their own premises and this will have an impact upon those practices who want to recruit in the future. As a matter of urgency, an options appraisal needs to be undertaken in order to describe the solutions available to these existing practices, as the new models of care emerge and develop.

The government announced a £1 billion primary care infrastructure fund as part of its 2014/15 Autumn statement. We need a greater understanding across our county of the strategic direction we need to go in, as part of the Vanguard programme, so that we will be in the best position to bid for a share of some of this funding. NHS England will be hosting stakeholder events over the next year in order to understand how they can best link and prioritise their annual allocation of £250 million. Our county needs to take an active part in these discussions.

### Outcome

- A current primary care estate which is modern and fit for the 21st century.
- Identification of the barriers to change with solutions needed to overcome them.
- To write an estates strategy which supports the new models of care in Northumberland.

### Actions

- To undertake a comprehensive review of the primary care estate.
- To develop a modernisation strategy with plans to bid for money through the Primary Care Transformation Fund.
- To conduct an options appraisal for existing free-hold and lease-hold practices who want to explore new models of care through rationalising their estate.
- To review cost re-imbursement by NHS Property Services and the financial stability of practices.
- To develop links with local planners and authorities, Agree Section 106 funding system with the local authority to provide financial support for GPs based on housing growth.
- To focus upon how to create the flexibilities within the system which will allow greater integration and co-location of different providers.
- A working group to be set up with the relevant stakeholders.

# Conclusion

General practice in Northumberland and nationally is at a significant cross-roads. There is an appetite for change as well as an opportunity with some funding through the Vanguard programme. General practice is struggling to keep up with the demands being placed upon it, greater integration within healthcare could be the solution for all of us.

Integration is not about merging everything into one organisation, there could be many permutations. The World Health Organisation[10] defines it as the delivery and management of health services, where clients receive a continuum of preventative and curative services throughout their lives and across different levels of the system. It is the joining up of these different parts of the system which has to happen and which we hope will make a difference. Integration is not a cure for inadequate resources, however it has the potential to make our system more cost effective and slow down the rate of growth in healthcare spending. The RCGP[11] has written a position statement underlining the challenges being faced to provide comprehensive care 24 hours a day and seven days a week.

For new models of care to emerge we have to provide the time and space for our clinical leaders to think and plan as well as to receive the training they need to fulfill these roles. Larry Casalino[12] identified four key factors needed for successful clinical engagement. They were improved quality of care for patients, assured or improved clinician income, a better quality working day and finally, respect from peers. If we are going to look seriously at developing locally led new models of care then we must be realistic about how we create the capacity for leaders to undertake this work.

The challenge now for commissioners is to create the permissions, the incentives and the support needed to create these new models of care in Northumberland. The challenge now for us as primary care providers will be to adapt and innovate.

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