NHS
Sunderland
Clinical Commissioning Group

Commissioning Strategy for General Practice 2016-2021

Better health for Sunderland

Foreword

NHS Sunderland Clinical Commissioning Group aims to ensure **Better Health for Sunderland,** and that the local NHS improves health and wellbeing in the city, supports us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives.[1]

General practice is often described as the cornerstone of the NHS with roughly a million people visiting their general practice every day.

However, as a clinically led commissioning organisation, we know from our 51 member practices across Sunderland, that they are facing significant challenges (changes in workforce; workload; ageing population with complex medical needs; expectations to deliver more out of hospital care) in the delivery of core primary medical care to patients.

This strategy aims to ensure the sustainability of general practice in Sunderland in light of the challenges, building on existing strengths and ensuring safe, effective and high quality care. Our new responsibility for commissioning general practice services gives us an opportunity to integrate general practice into the wider health and social care system in Sunderland to give greater flexibility and influence at a local level over the way in which services are delivered to patients.

Delivery of this five year strategy will contribute to our strategic objective to transform the way care is delivered out of hospital in Sunderland.

Dr Ian Pattison
Clinical Chair

David Gallagher
Chief Officer

[1] The NHS Constitution, July 2015

Section 1 Executive summary of the general practice strategy for Sunderland

This section sets out the overarching aim of our strategy for General Practice and five important changes to ensure delivery. Further detail is provided in section 6.

We aim **to sustain and transform general practice to ensure the provision of high quality primary medical care delivering improved health outcomes for local people, now and in the future.**

This strategy supports our Vision of **Better Health for Sunderland** and the delivery of our strategic objectives: transforming out of hospital care; transforming in hospital care; and enabling self-care and sustainability.

To realise our aim for general practice, we believe that five changes need to happen.

Objective 1	**Supporting general practice to increase capacity and build the workforce**
Objective 2	**Improving patient access**
Objective 3	**Ensuring the central, co-ordinating role of general practice in delivering out of hospital care**
Objective 4	**Supporting better health through prevention and increasing patients' capacity for self-care**
Objective 5	**Encouraging new working arrangements between practices**

We have identified a number of priorities within each objective for the first two years of the five year strategy, acknowledging however that some initiatives are already in progress. Despite being aligned to one of the five objectives, a number of the priorities will contribute to the delivery of more than one objective. The order in which priorities will be implemented will be influenced by our organisational Operational Plan and the transformational change programmes within this for 2016/17 onward.

	STRATEGIC OBJECTIVES	PRIORITIES FOR 2016/17 – 2017/18
1	**Supporting general practice to increase capacity and build the workforce**	• Review all enhanced services, in conjunction with a review of QoF, to develop and implement a local outcome based Quality Premium • Implement the outcome of the APMS review • Alongside the existing GMS/PMS/APMS contract and funding model, develop a quality and assurance framework for general practice • Review existing roles and skill mix to address capacity, including practice based pharmacy • Evaluate the time limited Career Start and Healthcare Assistant schemes to inform longer term plans • Develop a city wide training and development programme for all staff, with supporting budget
2	**Improving patient access**	• Implement the outcomes of the extended access locality pilots in line with developing an Urgent Care Strategy • Implement any recommendations from the Strategic Estates Plan in respect of general practice estate
3	**Ensuring the central, co-ordinating role of general practice in delivering out of hospital care**	• Continue to improve the Recovery at Home and Community Integrated Teams developments • Design a model of enhanced primary care (primary care 'plus') for people with long term conditions • Develop and implement a multi-agency informatics strategy for a single patient record accessible by all relevant partners
4	**Supporting better health through prevention and increasing patients' capacity for self-care**	• Support practices to provide a structured self-care programme • Promote healthy living through the five localities working with their communities and Public Health
5	**Encouraging new working arrangements between practices**	• Agree a two year plan with GP federations • Review and revise the plan after year 1 in light of learning

Expected benefits

We recognise the five objectives are interdependent and the priorities collectively have the potential to deliver the following benefits:

- Increased capacity (by increasing the capabilities of general practice teams to support GPs, Practice Nurses and Nurse Practitioners in their clinical work);
- Improved patient access to routine and urgent GP appointments. (Patients can be seen by other healthcare professionals and supported by multi-disciplinary teams);
- Patients are engaged in making decisions about their health and are confident to care for themselves;
- Longer consultation time (to support a holistic and pro-active approach to care);
- Increased GP and nurse workforce in Sunderland;
- Increased retention and continuous improvement in the quality of care (through structured training);
- More focus on clinical care through reduced administrative burden on GPs and nurses to enable them to focus on clinical care; and
- Shared information (across all main services to support the provision of high quality care).

To understand whether the strategy is delivering the anticipated benefits a number of metrics will be used as *indicators of success*, which will be refined and revised through implementation as well as taking any national metrics into account that are being developed.

	Outcome	Measure
1	**Improved access**	• National GP patient survey • Routine and urgent appointments available in general practices within localities every day with a range of health care professionals • % of appointments of longer duration • % reduction in A&E attendances for primary care problems
2	**Increased workforce**	• No. of Career Start GPs/Nurses/Health Care Assistants • All GP (HC & FTE) in Sunderland – compared to baseline • Population per GP - compared to baseline • All Nurse (HC & FTE) in Sunderland - compared to baseline • Population per nurse - compared to baseline
3	**Increased capacity**	• Initiatives to upskill workforce and take up
4	**Better Health**	• Reduced emergency admissions • Life expectancy at 75 • Under 75 mortality rate from cancer • Under 75 mortality rate from cardiovascular disease • Under 75 mortality rate from liver disease • Under 75 mortality rate from respiratory disease

Section 2 Introduction

This section sets this commissioning strategy in context and gives an overview of how the strategy has been developed.

2.1 General Practice under pressure

General Practice, both nationally and locally, is under pressure due to rising demand for GP appointments, growing complexity of need, changing patients' expectations, high expectations of policy makers and politicians and constrained financial resources.

When asked to rank the top factors that negatively impact on their personal commitment to a career in general practice, the answers selected most frequently by 15,560 respondents to the British Medical Association[2] (BMA) national survey of GPs in 2015 were:

Factors	North of England	England (overall)
Workload	71%	71%
Inappropriate and unresourced transfer of work into general practice	52%	52%
Insufficient time with each patient	41%	42%

Table 1

At the same time the GP workforce is changing; experienced GPs are nearing retirement and there are difficulties with recruitment. A third (34%) of GPs indicated in the BMA survey that they hope to retire from general practice. Unsurprisingly, this figure is significantly higher amongst those who have been GPs for more than 20 years where nearly two thirds (63%) say they hope to retire in the next five years. 17 per cent of GPs hope to move to part-time working.

Historically, GP practices in Sunderland have had difficulty in attracting and recruiting to vacancies. More than half the GPs who responded to a recent survey, undertaken by Sunderland Local Medical Committee (LMC) in 2014, have considered retiring early citing excessive workload as the main factor influencing this decision.

[2] British Medical Association (2015), National Survey of GPs, The future of General Practice 2015, Second extract of findings (December – February 2015)

2.2 Primary care co-commissioning

The opportunity for Clinical Commissioning Groups to co-commission primary care was introduced in 2014, although the scope is limited to general practice services in 2015/16. Co-commissioning is seen as an enabler in developing seamless, integrated out of hospital services based around the diverse needs of local populations.

We welcomed the offer from NHS England to take on an increased role and in April 2015 we assumed full responsibility for the commissioning of general practice services in Sunderland. We believe that co-commissioning provides an opportunity to further develop an integrated health and social care system in Sunderland by enabling greater local influence over a wider range of services for the benefit of the people of Sunderland. This also brings the potential for greater flexibility with finances and resources and greater determination, at a local level, on how these could be used

We believe co-commissioning will help not only to deliver our overall Vision of Better Health for Sunderland and our three key strategic objectives (section 3.2.1) but also ensure the sustainability and transformation of General Practice.

2.3. Improving the quality of care in general practice

Clinical Commissioning Groups (CCGs) have responsibility to ensure continual improvement in the quality of NHS services for everyone, now and in the future. Quality is at the centre of our Vision and values and we are committed to ensuring that the services that we commission on behalf of the residents of Sunderland are of the highest quality.

As clinical commissioners, our 51 practices are also responsible for ensuring primary medical services are safe and of the quality required for good patient care, as set out in the General Medical Council guidance. Our Quality, Safety and Risk Committee (QSRC) ensures processes are in place to commission, monitor and ensure the delivery of high quality safe patient care in commissioned services and will now be accountable, as part of co-commissioning responsibilities to support, facilitate, monitor and ensure quality improvement in general medical practice.

Quality in general practice is currently measured through a number of indicators (Quality and Outcomes Framework; GP survey; GP practice Friends and Family test; and latterly outcome and ratings from CQC inspections). We now need to develop and agree the key

measures that we will use to monitor quality in primary care and ensure they are robust, relevant and, where possible, evidence based.

2.4 Strategy development

The approach to develop this strategy has been top down and bottom up. Top down recognises that the strategy has been influenced by Sunderland Clinical Commissioning Group (SCCG) as the commissioner of general practice services and as system leader. The bottom up element is the programme of work we have undertaken to develop this strategy. We have adopted an integrated approach of co-production, engaging with our 51 practices, patients, the general public, GP practice representatives, partners and providers (section 5).

Section 3 Setting the Scene

This section describes the national and local context within which this strategy has been developed. It outlines that fundamental change is needed.

It is important to be aware of the external context against which our strategy has been developed.

3. 1 National context

3.1. 1 NHS England's Five Year Forward View

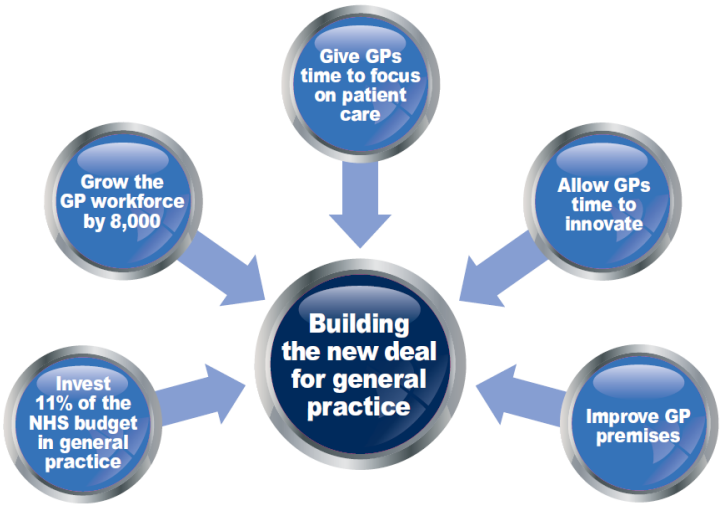
Published in October 2014, NHS England has set out a 'Five Year Forward View' (FYFV) for the NHS. This plan highlights the need to develop primary care, with a particular focus on general practice.

The FYFV puts general practice at the heart of out of hospital care and whilst new care models will be developed and supported, it states that the foundation of NHS care will remain list-based primary care. The FYFV acknowledges the severe strain on general practice and promises to "stabilise core funding for general practice nationally over the next two years" and offers a 'new deal' for general practice including addressing workload pressures.

The FYFV outlines the following expectations of primary care:

- Proactive and personalised care for the most complex patients
- Extended hours/7 days
- Integrated primary care (with secondary care providers) to enable more community based care
- Reduced variation in quality and cost of primary care;
- Investment in the workforce;
- Alignment of IT systems across primary and secondary care;
- Consideration of pooling / federating of GP practice resources;
- Contractual obligations e.g. named and accountable GP for all patients.

Our strategy for general practice will lay the foundations to strengthen general practice services in Sunderland taking account of national policy and the advice of the Royal College of General Practitioners (RCGP).



Source: 'A blueprint for building the new deal for general practice in England'

The RCGP outlines five actions that need to be taken by government in order to deliver better patient care – all of which will support the vision set out in the FYFV and strengthen the NHS for the future.

3.1.2 Primary care co-commissioning

CCGs were invited in 2014 to take on increased responsibility for the commissioning of primary medical care services. The intention was to enable CCGs to improve primary care services locally and create a joined up, clinically-led commissioning system. Some of the potential benefits of co-commissioning to CCGs include:

- Make commissioning of primary medical care more locally sensitive;
- Support integration of care across pathways;
- Support improvement in quality;
- Support the alignment of primary care commissioning with the health and social integration agenda; and
- Reduce inequalities in health provision across localities.

There are three co-commissioning models CCGs could take forward:

1. Greater involvement in primary care decision making
2. Joint commissioning arrangements
3. Delegated commissioning arrangements

We took on delegated commissioning which means that NHS England (NHSE) have delegated responsibility to the CCG for contractual GP performance and budget management. However it is important to make clear that this excludes individual GP

performance management and nationally determined elements of contracts as set out in respective regulations and directives.

3.1.3 System Resilience – 8 High Impact Interventions

The planning guidance for 2015/16 was clear that CCGs needed to include year round resilience planning, with a specific focus on winter, as part of CCGs' operational plans. The national tripartite - NHSE, Monitor and the Trust Development Authority (TDA) - wrote to CCG Clinical Leaders, CCG Accountable Officers and System Resilience Group (SRG) chairs in April 2015 to advise of the requirement to address '8 high impact interventions' within the operational resilience elements of 15/16 Operational Plans. The first high impact intervention relates to **access to general practices services** when patients have an **urgent need:**

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

3.2 Local context

This strategy has been developed taking account of our overall five year Strategic Plan.

3.2.1 Our Vision and strategic objectives

Our Vision is to achieve **Better Health for Sunderland.** We aim to deliver this through:

- **Transforming out of hospital care** (through integration and 7 day working)
- **Transforming in hospital care**, specifically urgent and emergency care (including 7 day working)
- **Enabling self-care and sustainability**

Our model for transforming out of hospital care

In March 2015, SCCG was chosen as one of 11 first wave Vanguard sites to take the lead on the development of the new 'multi-speciality community provider' care model and act as a blueprint for the NHS moving forward. We will test this care model through our programme to transform out of hospital care. There are 3 key work streams:

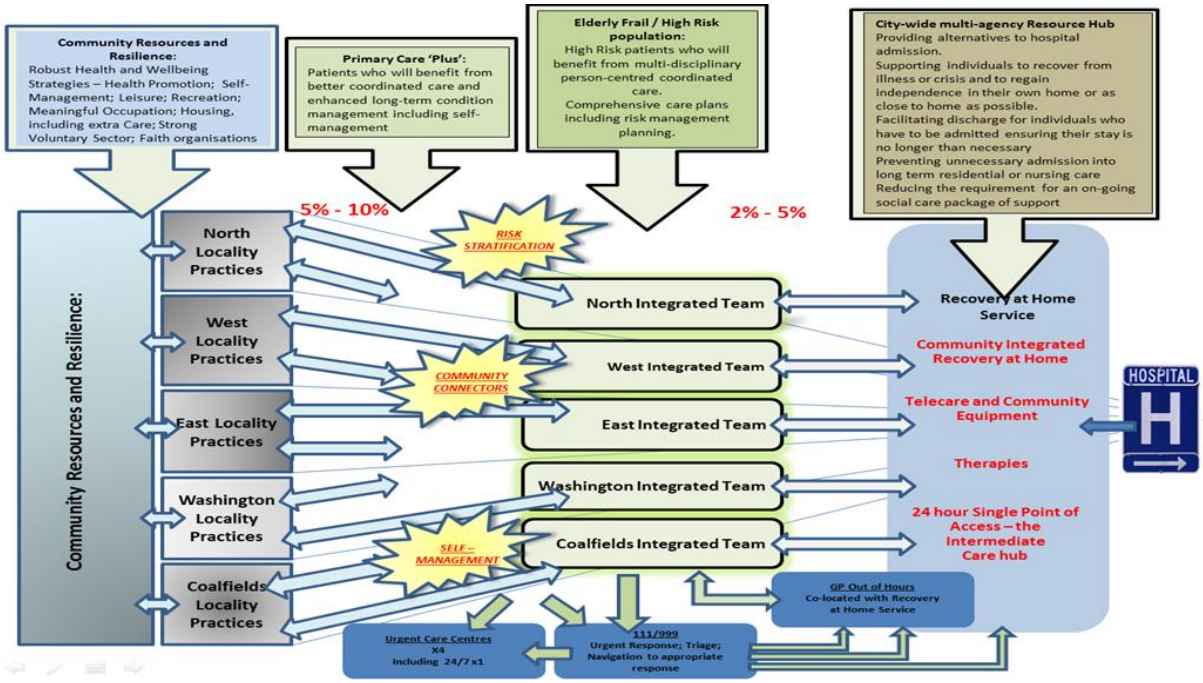
1. Enhanced primary care
2. Integrated community teams
3. Recovery at home

The 3 work streams are at different stages of development with work stream 2 and 3 delivered in 2015/16 with a focus on the top 3% of patients most at risk and spending 50% of our health and social care resources. The enhanced primary care work stream is in the early stages and will need to be designed later this year for implementation over 16/17 to 17/18. The GP strategy will support the delivery of all of the out of hospital transformation, recognising the key role of general practice in the community.

Diagram 1 outlines the desired future state for out of hospital care in Sunderland. Patients who will benefit from 'Primary Care Plus' (enhanced primary care) are those with a long term condition and who can self-care most of the time but would benefit from prevention and care interventions as required in the community. The aim is to reduce the likelihood of these patients becoming high risk of frequent, but avoidable, emergency admissions. This group represent 12% of our population.

Developing and implementing a general practice strategy across the city is one of the transformation changes for 2015/16 required to deliver our Vision and the strategic objectives.

Diagram 1



In hospital care

With the national drive for seven day services and in the face of increasing A&E attendances, timeliness in how and when general practice services are accessed is becoming crucial in managing demand for urgent and emergency care.

Access is an area where there is variation across practices. We commission practices to extend opening hours however sign up is voluntary which means that some patients benefit and others don't. In addition there is no consistent approach to how these additional hours are utilised, i.e. for urgent or routine appointments.

However, we have also commissioned extended access pilots across three localities in Sunderland (North, East and West). The models implemented in the localities differ but we are evaluating these pilots to inform the next steps in seeking to increase access to general practice services to support system wide resilience.

The urgent care system in Sunderland has seen some major transformation over the last 2 years, for example a new GP Out of Hours Service and 4 GP led Urgent Care Centres. The outcomes of the pilot evaluation will need to inform the Urgent Care Strategy for the next few years.

3.2.2 Our Quality Strategy 2014-2017

Our **Vision** for quality is that our patients should:

- receive clinically **effective care** and treatments that deliver the best outcomes for them;
- have a **positive experience** of their treatment and care which meets their expectations; and
- be **safe** and the most vulnerable protected.

We recognise that to be successful in delivering the aims of our quality strategy and effective in improving the quality of care, we must take a whole system approach to quality. Delegated responsibility for general practice services enables us to do this and lead improvement in quality in primary medical care in Sunderland in partnership with our practices.

3.2.3 Meeting the needs of local people – big challenges for Sunderland

This strategy needs to be understood in the context of the challenges facing the NHS in Sunderland and the role and contribution of general practice in addressing these. These

challenges are described in detail in our current five year strategic plan, 2014 – 2019 and our operational plan, 2014 – 2016. A summary is set out below:

- A growing population of elderly people with increased care needs and increasing prevalence of disease, who need to be supported to live independently;
- Health is generally worse than the rest of England;
- Average life expectancy in Sunderland is consistently poorer than the national average;
- Excess deaths particularly from cancer, respiratory and circulatory disease;
- Over-reliance on hospital care.

3.2.4 General Practice in Sunderland

There are currently 51 practices in Sunderland. Up until March 2015, 34 practices held PMS (personal medical services) contracts which are locally agreed contracts. 14 held GMS contracts (nationally negotiated general medical services contracts) and 3 have APMS contracts (alternative provider medical services).

The total actual list size in Sunderland is 283,434 and the total weighted list size is 315,210. Generally, list sizes for each practice across the city range from 1,909 to 14,008 with over half less than 5,000 patients. Smaller practices may lack resources and capacity to flex their workforce in the same way as larger ones and therefore may be less able to take on additional services.

As a result of the review of PMS contracts initiated by NHSE, all 34 practices opted to revert to GMS equivalent funding with a 7 year pace of change (funding deducted over 5 years commencing April 2016). The level of individual practice income will be impacted and we campaigned along with the LMC for the current funding allocated to practices in total to remain within Sunderland. The funding that is released will be reinvested across general practice across Sunderland in line with the aim and objectives of this Strategy.

Alternative provider medical services (APMS) review

The first major commissioning task for the CCG, having assumed delegated responsibility in April 2015, was a review of three APMS contracts which are due to come to an end on the 30 September 2016 after a number of contract extensions.

After careful consideration, we propose to procure a single APMS contract (providing the same primary medical services as any other practice in the city), instead of the current three contracts, to cover a minimum of five years. This contractual change is likely to make the tender more attractive to bidders and therefore ensure the services are more sustainable for patients in the future. As with PMS, there is a national steer to ensure equitable funding amongst practices. All practices, irrespective of the contract that they hold, are to receive the same fee per patient for providing the same core service. This procurement will deliver this requirement and will release financial resources that will be reinvested back into general practice in Sunderland.

Enhanced services

We commission a range of enhanced services across general practice in Sunderland. Delivery of enhanced services is voluntary; practices can opt to provide any of the 20 national enhanced services and any of the 9 local enhanced services. The difficulty involved in commissioning an array of services across 51 practices means that often contract management focuses on activity rather than outcomes.

3.2.5 National GP survey

The GP Patient Survey is an independent survey, run by Ipsos MORI on behalf of NHS England. The survey measures patients' experiences across a range of areas, including making appointments; waiting times; perception of care; practice opening hours; and out-of-hours services.

Our GP practices collectively were above the national results on all questions answered by the 5,588 respondents in Sunderland (response rate of 31%). That said, there has been a slight deterioration in scores comparing July 2015 to July 2014.

Overall experience

Diagram 2 below shows the results in relation to the overall experience of GP Surgery. In July 2015, 88% of people in Sunderland would describe their experience of their GP surgery as good, in comparison to 89% the previous year. This is compared with 85% nationally.

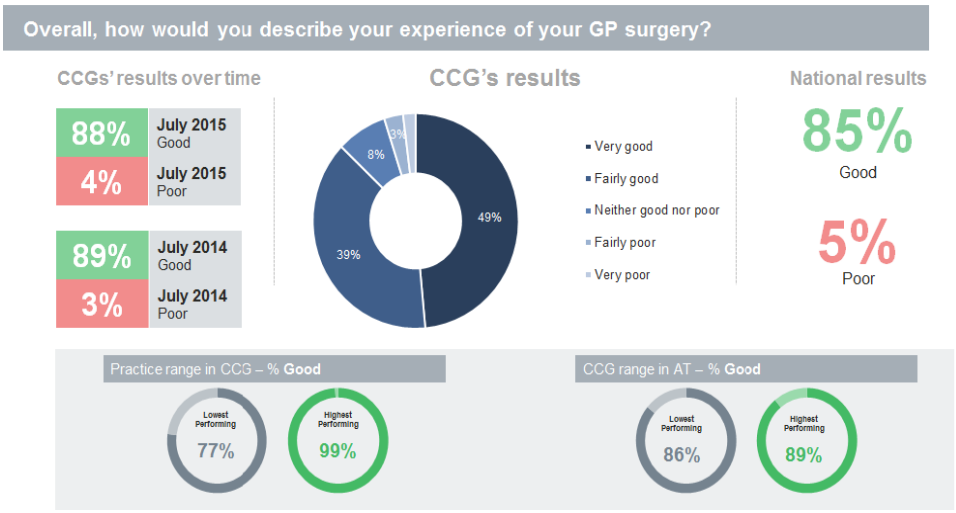


Diagram 2

Perceptions of care

In terms of quality of care, 94% of people did have confidence and trust in the GP they saw or spoke to and 90% had confidence and trust in the nurse (see diagrams 3 and 4 below):

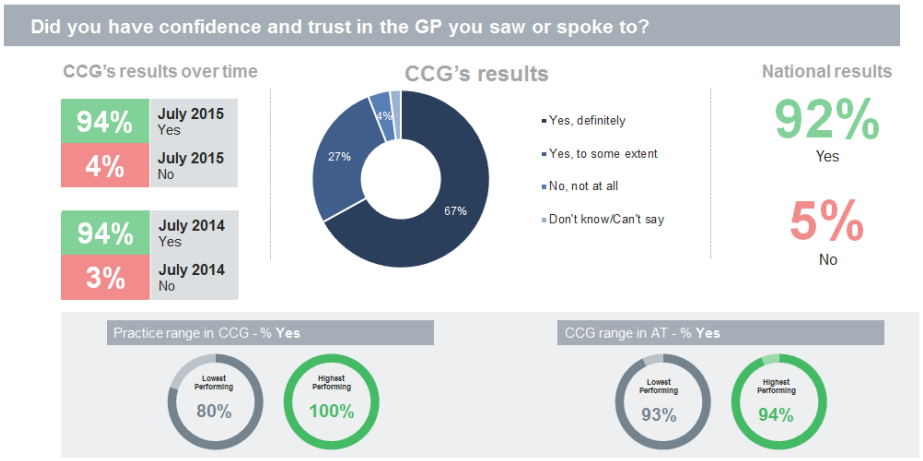


Diagram 3

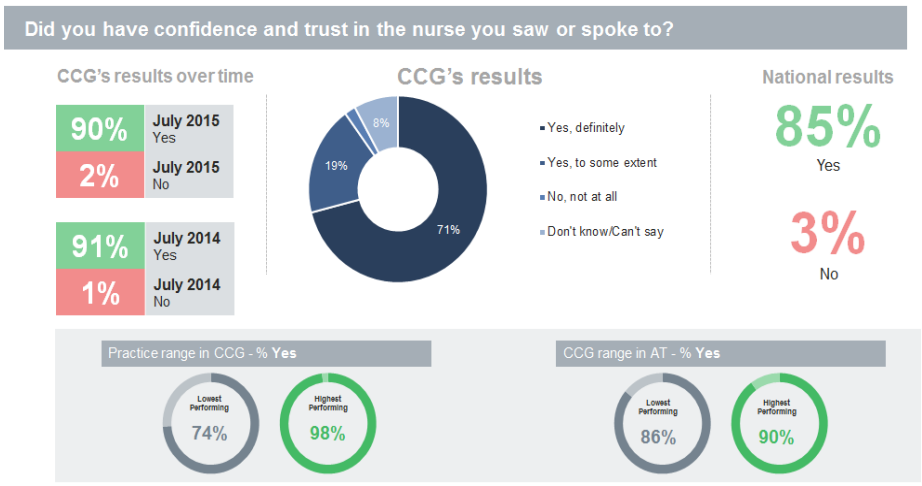


Diagram 4

Making an appointment and waiting times

Diagrams 5 and 6 summarise patients' views on ease of getting an appointment and how long they have to wait.

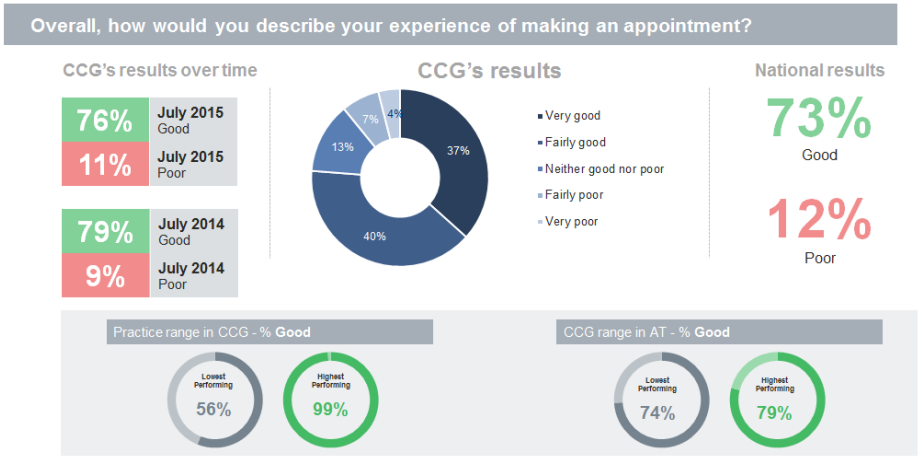


Diagram 5

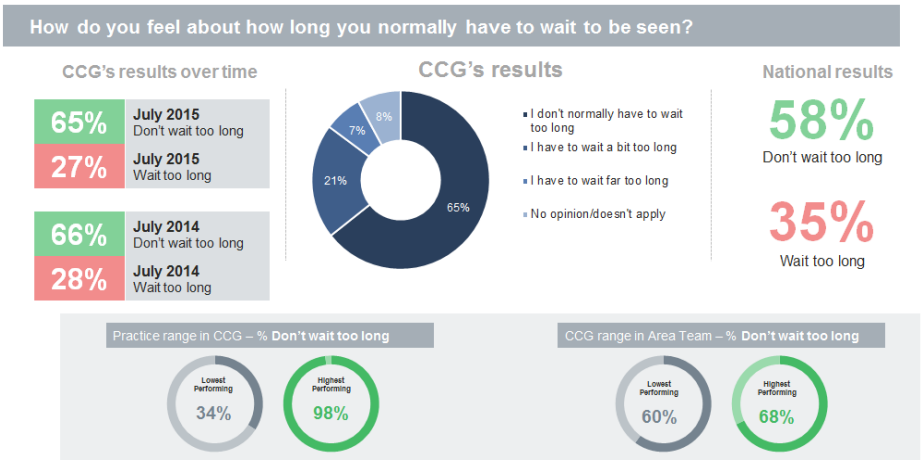


Diagram 6

3.2.6 General Practice Workforce

Tables 2 to 5, based on the September 2014 census and population at that time, (available on the Health and Social Care Information website[3]) illustrate the issues facing general practice services in Sunderland:

- Shrinking GP workforce in the face of a growing and ageing population with increasingly complex health needs and a government ambition to increase access to general practice services 7 days a week.
- Workforce demography – almost 27% of our GP workforce are aged over 55. We also know from the local LMC survey that 19% of the respondents (forecast to be approximately 35 GPs) have set a retirement date within the next 3 years. As well as putting plans in place to proactively recruit new GPs, we need to seek to retain these experienced GPs.
- There seems to be less of an issue in terms of the numbers of nurses in general practice compared to other areas.
- 19.2% of our practices (n=10 out of 51) are single handed.

GPs

	Staff In Post				Population	Population per GP			
	GPs (All)		GPs (excluding registrars and retainers)			GPs (All)		GPs (excluding registrars and retainers)	
	HC[4]	FTE	HC	FTE		HC	FTE[5]	HC	FTE
England	40,584	36,920	35,819	32,628	56,469,999	1,391.44	1,529.52	1,576.53	1,727.86
CNTW	1,644	1,559	1,463	1,398	1,997,605	1,215.08	1,281	1,365.41	1,429
NHS Sunderland	190	186	172	170	283,081	1,489.9	1,521.94	1,645.81	1,665
NHS Gateshead	186	180	164	160	205,822	1,106.56	1,143.45	1,2550	1,286.38
NHS South Tyneside	120	119	110	110	154,941	1291.18	1302.03	1,408.55	1,408.55

Table 2

[3] http://www.hscic.gov.uk/workforce

[4] Headcount is the simple count of actual people/staff working within a practice regardless of the hours they may work

[5] Full time equivalent (FTE) is a standardised measure of the workload of an employed person.

Area	All patients	Patients per GP*	All GPs* headcount per 100,000 population
England	56,469,999	1,577	66.5
CNTW	1,997,605	1,365	75.7
NHS Sunderland	283,081	1,646	62.3
NHS Gateshead	205,822	1,255	82.0
NHS South Tyneside	154,941	1,409	74.1

* excluding retainers and registrars

Table 3

Area	All GPs *	% under 30	% under 35	% 55 and over
England	32,628	1.3	13.3	22.0
CNTW	1,398	2.2	13.1	18.5
NHS Sunderland	170	1.2	9.5	26.7
NHS Gateshead	160	2.5	18.1	15.8
NHS South Tyneside	110	5.5	19.1	21.1

* excluding retainers and registrars

Table 4

Nurses

	Advanced Nurse		Practice Nurse		All nurses		Average No. patients
	HC	FTE	HC	FTE	HC	FTE	Per HC Nurse
England	4,734	3,507	14,423	8,592	23,832	15,062	2,370
CNTW	173	104	542	353	847	578	2,358
NHS Gateshead	13	10	48	33	77	55	2,673
NHS South Tyneside	11	10	47	31	60	43	2.582
NHS Sunderland	27	23	72	51	113	84	2,505

Table 5

Prior to the development of this strategy, work had already started on the development of the general practice workforce in Sunderland as we recognised its importance to the development of a strong future model for general practice. A Workforce Steering Group has been established to focus attention on workforce planning for Sunderland, specifically recruitment and retention and succession planning in light of pending retirement for some GPs.

Investment of £1.8m has been made into a GP Career Start Programme over 2 years which has resulted in the recruitment of an additional 8 GPs. £278,000 has been invested in a Nursing Assistant Career Start Programme resulting in the recruitment of 9 apprentice Nurse Assistants placed in GP practices in Sunderland. We have also committed to match funding pilot practice based pharmacy bids to the national pilot and are awaiting the outcome.
A Career Start scheme to improve the recruitment and retention of Practice Nursing staff is also in development in partnership with Sunderland University. A support service provided through Northumberland, Tyne and Wear NHS Foundation Trust for GPs with significant mental health and addiction problems is also now in place. A range of support services are also in development including:

- a childcare co-ordinator service for GPs - 42% (n 84 out of the 190) of Sunderland GPs (including retainers and registrars) are female[6]
- a step down/retirement support programme to help retain clinical skills within the GP workforce and allow for succession planning.
- financial support to maintain and increase the number of training practices

3.2.6 Financial Context

We are currently deemed to be 12% over funded compared to the fair share of the total NHS allocation which we should receive i.e. we receive £46m per annum in excess of our fair share of the NHS funding in England. NHS England has expressed a clear intention to move CCGs that are more than 5% over funded closer to their fair share of the total NHS allocation at a fast pace of change. It is anticipated this pace of change will be no longer than five years.

Historically we, and the Primary Care Trust before us, have benefited from this 'over funded' position, in terms of providing opportunities for additional recurrent and non-recurrent investment into services in Sunderland. The Pace of Change Policy adopted by NHS England will present challenges in terms of identifying additional transformation programmes to release efficiencies and limitations on the availability of resources.

We have identified that in order to successfully manage the Pace of Change Policy there will be a need to identify and implement efficiencies across services in order to live within our means. Hence any additional investments will need, in effect, to be at least self-funding.

[6] based on the September 2014 census available on the HSIC website

There is also a separate allocation process, which is currently being developed by NHS England, for general practice services which will inform future growth funding on delegated budgets. In 2015/16 we approved £7.7m of additional investments into out of hospital care (primary and community services) in Sunderland mainly into Community Integrated Teams and Recovery at Home Services including £1.1m for GP input into the services. An additional £500k has also been identified to support the extended access pilots.

Table 6 below shows the primary care delegated budget for NHS Sunderland CCG and the spend per 100,000 population compared regionally and with two local CCGs.

Area	All Patients	Primary Care Delegated Budget £000's	Funding per 100,000 population £000's
England	56,469,999		
CNTW	1,997,605	258,864	12,959
NHS Sunderland	283,081	38,152	13,477
NHS Gateshead	205,822	26,349	12,802
NHS South Tyneside	154,941	19,908	12,849

Table 6

Section 4 The case for change

A key objective of this section is to set out the drivers for change and explains why we need to take a different approach in the future to address the challenges.

4.1 Why does general practice need to change?

- **To meet the changing needs of our population, improve health outcomes and tackle inequalities**

The big challenges for Sunderland are summarised in section 3.2.3.

- **To meet increasing demand and patients' expectations**

Out of hospital care needs to be a larger part of what the NHS does and this has been an ambition for almost 10 years, with the publication of the Government's White Paper for health in 2006. However, investment in primary care has fallen behind investment in hospitals, despite increasing expectations of the work that should be done in primary care.

Demand is increasing particularly for people with multiple complex problems. Workload projections suggest that older people with multiple long term conditions, including people with frailty, will be a major source of increasing work for general practice in coming years. However, section 3.2.5 shows that workforce trends do not support this shift. Workload was ranked top of the list of factors that negatively impact the commitment of seven in ten GPs (71%)[7]. in the North of England on their career. We will aim to address these issues through our strategy.

- **To secure the future of general practice in Sunderland**

The FYFV recommends that the number of GPs in training should be expanded and NHSE, Health Education England (HEE), the Royal College of General Practitioners (RCGP) and the BMA have agreed to a 'ten-point plan' to address the shortage nationally.

Section 3.2.5 presents the local picture in Sunderland compared to England, Cumbria, Northumberland, Tyne and Wear and 2 local CCGs in respect of workforce. When benchmarked nationally, regionally and to other local CCGs, we are under-doctored and need to succession plan due to the demographic structure of the workforce. We have started

[7] National Survey of GPs: The future of General Practice 2015, BMA

to address these issues but we acknowledge that there is much more work to do in collaboration with our partners and practices.

- **To support the achievement of our Vision**

If general practice is to support the delivery of our Vision and the three strategic objectives discussed in section 3.2.1 it needs to transform and this strategy focuses on how to facilitate change and improvement.

Section 5 Developing our strategy

This section describes the programme of engagement that we have undertaken to inform and develop the strategy. It describes our top down and bottom up approach to determining the strategic direction for general practice.

5.1 Engagement: Listening and Feedback

Extensive engagement has been undertaken to inform the content of this strategy and there will be continuous engagement through the implementation.

5.1.1 SCCG Governing Body

Our Governing Body has had a lead role in the development of this commissioning strategy for general practice. During a development session in April 2015 about developing a general practice strategy, the Governing Body identified 6 key components to help define the strategy:

- Sustainable;
- Appropriate skill mix;
- Appropriate access;
- Consistent high quality;
- Self-care; and
- Whole system.

Following this initial session the group identified the next step to be to engage with our member practices, as it was recognised the practices needed to influence and own the strategy and its implementation moving forward. It was agreed that the Time In Time Out (TITO) event in June, attended by all Practices, would be the key method to engage with practices.

A second session was held with the Governing Body on 06 October following the engagement with practices, the general public, patients, partners and practice representative groups. The focus was to share the insights from the engagement and test the proposed aim and strategic objectives, developed through the programme of engagement, against the 6 key components.

The aim and 5 strategic objectives in the Executive Summary in section 1 represent the outcomes from this further challenge session.

4.2.2 Response from our member practices

Ensuring the involvement of member practices in shaping our strategy has been fundamental to ensure the successful implementation of our strategy moving forward.

The table below outlines the key themes identified from our engagement with practices:

Key Themes	Feedback
Workforce	▪ Lack of capacity is a barrier to change; ▪ Recruitment and retention of staff is key; ▪ A review of existing roles within general practice is needed including the standardisation of pay, skill mix etc.
Ways of Working	▪ Maintaining individual practice identity is important; ▪ Continuity of care is important; ▪ The majority of practices recognise that status quo is not an option and are willing to change; ▪ Longer consultation times are needed in order for general practice to have a proactive and holistic approach; ▪ Most would be happy to consider the sharing of back office functions; ▪ Most prefer 'joint working' rather than 'merging'; ▪ There is very little understanding of what 'primary care at scale' means; ▪ Improved integration with community and secondary care is needed; ▪ Improved integration / closer working with pharmacy / pharmacists is needed; ▪ Immediate access to diagnostic services in the community is needed; ▪ A review of existing secondary care services to identify those which could be delivered in general practice should be undertaken.
IT Infrastructure	▪ One IT system, to hold patient information, which all services can access is needed.
Prevention & Self Care	▪ Lifestyle and self-care education across Sunderland is needed.
Premises	▪ A review of existing premises considering future ways of working is needed.
Contractual / Financial arrangements	▪ Consideration of a local QoF would be welcomed; ▪ A review of existing enhanced services would be welcomed; ▪ Too much of 'tick box exercises' which takes away from caring.

Caught on the treadmill trying to meet current pressures (rising patient expectations; rising prevalence of chronic disease; workforce pressures; constrained growth) practices are aware that more of the same is not the answer but they don't have the time to reflect on how the future could be different for the delivery of care as well as for the working lives of practice teams.

A recurrent theme was the lack of professional development opportunities for practice staff with the effect of staff feeling de-skilled, demotivated and lacking a clear sense of career development. The terms and conditions of staff working in general practice was also highlighted as an issue.

Another theme was the limited investment in general practice in contrast to other parts of the system, e.g. secondary care.

Recruitment and retention were also highlighted as issues and a number of suggestions were put forward to recruit to Sunderland as well as make general practice a more appealing career choice for medical students.

The following list of potential initiatives was identified from the feedback, grouped thematically under 6 work streams:

Work stream	Key Elements
Workforce	Standardisation of roles
	Standardisation of pay
	Staff Development including succession planning
	Development of city wide training programme for all staff
	Review of capacity in primary care
	Review of existing roles including GP, Nurse Practitioners
Ways of Working	Shared back office functions including HR, IT, Business Planning, Payroll, Payments etc.
	Explore options for joint working ensuring Practices maintain their identity
	Consider options to improve access
	Improve consultation times to enable a holistic and pro-active approach

	Undertake review of secondary care services which could be delivered in primary care
	Improve integration with community services and secondary care – seamless
	Direct access to diagnostics
	Explore options to work closer with pharmacy
IT Infrastructure	One system
	Shared records across all main services
	One Sunderland website rather than 51 individual practices intranet and internet – All health information in one place
	Explore alternative methods of communication with both patients and partners i.e.: video conferencing, Skype, email.
Premises	Undertake review of existing premises considering future ways of working
Prevention and Self Care	Work with public health to review existing lifestyle services
	Review with public health existing disease prevention services
	Development of a Self-Care awareness programme including the education of school children
Contractual / Financial	Consider implementing a local QoF
	Review of all enhanced services
	Review core contract – consider increased funding rather than existing additional funding options
	Consider activity based rather than list based contracts
	Consider inclusion of budgets for staff development

The above long list was prioritised by the General Practice Group (GPG), under the Vanguard programme; the GPG comprises a GP, Practice Nurse and Practice Manager from each of the five localities. They evaluated each on how **do-able** the initiative is and its **impact**. The table below shows the outcome of this prioritisation process. The 16 initiatives in the white boxes below were identified as the priorities through the process and these were shared with practices for comment.

Summary of Prioritised Initiatives	Do-ability	Impact
Consider inclusion of budgets for staff development	9	36
Review of all enhanced services	6	33
Staff Development including succession planning	7	31
Development of city wide training programme for all staff	6	31
Improve consultation times to enable a holistic and pro-active approach	6	31
Improve integration with community services and secondary care – seamless	6	30
Consider implementing a local QoF	5	30
Explore options to work closer with pharmacy	7	29
Review of capacity in primary care	7	29
Undertake review of secondary care services which could be delivered in primary care	5	29
Consider options to improve access	5	28
Review of existing roles including GP, Nurse Practitioners	7	27
Shared records across all main services	8	26
Development of a Self-Care awareness programme including the education of school children	6	26
Direct access to diagnostics	6	25
Work with public health to review existing lifestyle services	6	25
Review with public health existing disease prevention services	5	25
One system	7	24
Review core contract – consider increased funding rather than existing additional funding options	6	24
Explore options for joint working ensuring Practices maintain their identity	6	23
Standardisation of roles	4	32
Explore alternative methods of communication with both patients and partners i.e.: video conferencing, Skype, email.	4	23
Undertake review of existing premises considering future ways of working	4	22
Consider activity based rather than list based contracts	7	20

One Sunderland website rather than 51 individual practices intranet and internet – All health information in one place	7	18
Shared back office functions including HR, IT, Business Planning, Payroll, Payments etc.	7	12
Standardisation of pay	3	10

At a second TITO event in September 2015 practices were asked to consider the 16 priorities in light of feedback from patients, the general public, partners and general practice representatives and come to a view as to whether there were any changes needed or anything missing. 2 of the 16 were rejected: direct access to diagnostics and undertake review of secondary care services which could be delivered in primary care

4.2.3 Response from patients and the general public

We undertook a piece of market research to build on the national, regional and local data available to inform and develop the general practice strategy.

The methodology used to engage with residents living in Sunderland, included:

- On-street survey with 401 members of the general public; quota sampling was used to map the participant profile to that of Sunderland to ensure the sample is statistically representative of the population of Sunderland.
- An online survey with 32 members of Patient Participation Groups (PPGs).
- Focus groups to provide an opportunity to ask very specific questions and explore responses in much more detail.
- Discussion with patients at Sunderland Health Forum.

Drawing on **past and current perceptions** of General Practice services, Sunderland residents were asked specifically ***how they feel*** about the following areas in General Practice:

- Access and waiting times:
- How and where improvements can be made

Perceived issues

- shortage of doctors and nurses and other healthcare staff;
- high turnover of GPs;
- high use of locums;
- difficulty in making appointments at the GP practice, e.g. unable to book in advance or getting through on the phone;

- waiting times for urgent and non-urgent appointments are too long; and
- the limited opening hours of practice (i.e. the lack of appointments available outside of normal working hours).

Perception of GP practices over the last 5 years

A much greater proportion of participants from PPGs perceived that their GP practice had improved over the last five years compared to the general public (63% and 19% respectively). Most common suggestions for service improvements were:

- Longer opening hours.
- Reduce the length of time patients have to wait for an appointment.
- Greater availability of appointments.
- More GP practices/doctors to cope with demand.
- Less reliance on locum doctors.
- Greater consistency of care.
- Improved attitude of GPs and reception staff.

Most important for the future

In terms of future GP services, **being able to see a doctor** emerged as **the most important factor** in terms of accessing services (91% of the general public & 89% of members of Patient Participant Groups).

4.2.4 Response from practice representatives

Whilst engaging directly with our member practices we have also engaged with practice representative groups including the Local Medical Committee (LMC), Washington Community Health Care, a collaboration of local primary care practices, and the Sunderland GP Alliance. The feedback generally fell into the following themes:

Key Themes	Feedback
Workforce	▪ The single most important thing for general practice is to stabilise the current core function.
Ways of Working	▪ Development of 5 locality groups would be the preferred approach. ▪ A local approach would reflect local differences in patient types, flows and practical issues such as premises, whilst providing a scalable focus for clinicians and others in primary and community care. ▪ GPs need to federate and work collaboratively as advocates for their community. ▪ Primary Care at Home model is a preferred model ▪ Development of locality based commissioning

Contracting / Financial arrangements	▪ The development of a local QoF will cause significant concern.

4.2.5 Partners

We asked our partners to consider what General Practice could do to contribute to **Better Health for Sunderland** over the next five years and how they could support General Practice moving forward as well as how general practice could support them. The feedback generally fell into the following four themes:

Key Themes	Feedback
Workforce	▪ Capacity issues in general practice cannot be ignored ▪ We need to be clear on the skill mix of the workforce required to achieve our five year vision in order that we can start work on developing training now. ▪ Promote benefits of working in Sunderland
Ways of Working	▪ Sharing back office systems would simplify the general practice system ▪ The whole health and care system, not just general practice, needs to be seven days a week ▪ Other services working closely with general practice i.e.: mental health supporting GPs to ensure a clear shared care arrangements. ▪ Organisational boundaries – acute staff may not be acute focused in the future which will ensure continuity of care and reduce handoffs. ▪ Each organization needs to commit to change to wrap services around general practice ▪ Closer working with pharmacists
IT Infrastructure	▪ There is a need to transform to a health and care single data set / shared system – everyone needs to have the same information in order to be responsive ▪ Shared information systems for mental health and physical health
Prevention & Self Care	▪ General practice needs to ensure a focus on prevention and early intervention ▪ GP Champion of public health and early intervention who can support national policy changes ▪ Focus on maximising every health contact ▪ Build on the principles of Live Life Well and address holistic needs

Section 6: Our strategy: to sustain and transform general practice

This section describes what we will do to ensure the future of general practice in Sunderland including any key design principle which will influence what is commissioned.

To realise our aim, to **sustain and transform general practice to ensure the provision of high quality primary medical care delivering improved health outcomes for local people, now and in the future**, we believe that five changes need to happen.

OBJECTIVE 1: Supporting general practice to increase capacity and build the workforce

We recognise that to sustain general practice we need sufficient staff with appropriate skills and access to training to do the work needed. Practices will need to see their workforce evolve to embrace a wider skill mix out of necessity.

Although we have a number of initiatives in place already, as workforce is a significant issue for Sunderland, we will continue to work with the LMC, federations, HENE and Sunderland University to support the recruitment and retention of the clinical and management workforce in Sunderland. Although making general practice a more appealing career of choice for medical students and student nurses is beyond our scope, we will continue to work with partners to address this longer term goal within the context of the RCGP, BMA, NHSE and HEE 'Ten Point Plan' to build the general practice workforce – 'New Deal for General Practice'. In addition, we believe that a stronger focus is also needed on primary care nursing and better support is needed for the professional development of the existing nurses working in general practice including extending their clinical, leadership and management skills.

We will give priority to structured training and professional development for staff in general practice both in terms of continuous professional development and supporting them to develop new roles in order to ensure continuous improvement in the quality of care, support staff retention and address workload and capacity.

We understand that the current combination of national and local enhanced services, and incentive schemes overwhelm GPs in their day to day job as well as limiting their ability to

engage to achieve sustainable, transformational change. Delegated co-commissioning provides the opportunity to reduce bureaucracy and duplication for practices involved in the provision of enhanced services. We will review the enhanced services and learn from national examples of CCGs developing and designing local schemes as an alternative to both the Quality and Outcomes Framework and Directed (and local) Enhanced Services. This would allow a focus on a smaller number of key outcomes rather than practices have to deliver lots of detailed outputs, whilst giving Practices more flexibility to decide how to achieve the outcomes, often needing to work with other practices in a locality.

There is also the opportunity for pharmacists to increase their contribution to general practice services especially if training is provided to enable them to extend their role as part of the general practice team.

Design Principles

- The General Practice – 1st point of contact for patients
- Whole practice, not just the GP, supporting **Better Health**

What does this mean for patients?

- Patients will be seen by the right professional, with the skills related to their need, whilst recognising for some patients continuity of care is crucial.
- Other primary care professionals (e.g. Practice Nurse; Pharmacist) are involved in the delivery of care where appropriate

What does this mean for general practice?

- Continuous professional development and opportunities to up-skill
- New roles developed in general practices.
- Reduced administrative burden and duplication
- More time spent with those patients that have complex and continuing needs

How will we measure success?

- No. of Career Start GPs/Nurses/HCAs appointed and retained
- GP workforce stabilised
- Survey of general practice staff in respect of career intentions, workload
- Number and range of skill based training and leadership courses available and accessed

OBJECTIVE 2: Improving patient access

Access is important for patients and is an area currently where there is variation across practices. Waiting times to access general practice services is important to patients and it is becoming increasingly important when managing system wide resilience. In addition, time is important when engaging with people in managing their care given complexity of needs. Longer face to face consultations are included in access. Greater use of technology could also be part of the solution to improved access.

We will evaluate the outcomes of the extended access locality pilots to inform how we best commission extended general practice outside of core hours as part of an Urgent Care strategy for the whole system.

As outlined under objective 1, delegated co-commissioning will help us to support improvement in this area, e.g. by adapting traditional funding and contracting approaches to support the development of a local solution.

Design Principles:

- Urgent and non-urgent access
- Agreed standards in relation to access
- Patient education regarding accessing NHS services
- Shared records/information

What does this mean for patients?

- Patients can book routine appointments in advance as well on the same day if they have an urgent clinical need
- Patients will be able to access general practice services within a locality
- Patients will understand how, when and who to access in primary care
- Patients will be confident that professionals who have access to their relevant information will comply with Information Governance statutory guidance

What does this mean for general practice?

- Clinicians and healthcare professionals may contribute to the provision of extended general practice within localities and/or as part of an urgent care system within Sunderland
- Medical records will be shared within a defined governance arrangement so that

clinicians and healthcare professionals have access to the right information

- Providers will have a safe, effective system to prioritise patients according to clinical need

How will we measure success?

- 80% of respondents in the annual GP patient survey are very or fairly satisfied with making an appointment with their general practice
- Patients with most complex needs report an improvement in access
- Reduction in attendances at A&E for primary care conditions

OBJECTIVE 3: Ensuring the central, co-ordinating role of general practice in delivering out of hospital care

General practice remains the key co-ordinator of care for the vast majority of patients. This objective recognises general practice's central role in the delivery of **out of hospital care.** In particular the importance of the registered list and the GP (and Nurse Practitioner) assessment and diagnostic skills and the skill set of Practice Nurses in managing people with long term conditions. These clinical and medical skills are key components in the 5 community integrated teams wrapped around practices and the city wider Recovery at Home service both providing person centred co-ordinated care for the most complex patients.

Further work needs to take place to transform the care of people with a long term condition who at not currently at high risk of admission, preventing and/or delaying further deterioration and supporting self- management. This is a key opportunity for Practices to co design how they can enhance the care offered to this group of patients (30,000) in the city.

Having mobilised 2 of the 3 work streams (Recovery at Home and Community Integrated Teams), we will proactively establish and share the learning from these programmes to inform how we improve patient care out of hospital delivered by general practice.
We will build on the on-going work in respect of sharing data across health and social care systems in the context of the Vanguard programme.

We will work with our practices to co-design the "Primary care 'plus'" model of care for people with long term conditions.

Design Principles:

- Reduced waste
- Shared governance, not just 'handover'

What does this mean for patients?

- Patients with long term conditions will have access to enhanced local health services to ensure their care remains within primary and community care wherever appropriate.
- Patients will, where clinically appropriate and evidenced, have the opportunity to self-care with support from professionals including via telehealth and telecare.
- Improved experience and outcomes from improved communication and support in relation to their health and care.

What does this mean for general practice?

- Where another organisation (e.g. acute hospital, mental health organisation, community services) is dealing with the patient's problem, the patient's GP practice will remain pro-actively involved, seeking information and assurance that the patient is receiving high quality care
- Practices proactively manage patients with LTCs which could include patient education programmes; medicines management advice and support; use of telecare and telehealth to aid self-monitoring
- Practices identify the most at risk patients who would benefit from co-ordinated care and proactively review them
- Proactive support from a multi-disciplinary team in their locality, and a city wide rapid response service, to manage the care needs, reducing the time needed from the GP following assessment and diagnosis.
- Sharing resources and skills across practices enabling better outcomes for patients and efficiencies for practices.

How will we measure success?

- Reduced emergency admissions for patients with long term conditions
- Reduced or delayed admissions to care homes
- Improved quality of patient experience of their care out of hospital
- Improved quality of life for people with LTCs
- Information sharing agreements with practices and partners in place
- More people able to stay at home longer following discharge from hospital

OBJECTIVE 4: Supporting better health through prevention and increasing patients' capacity for self-care

The majority of illnesses the NHS treats are caused by obesity, smoking or alcohol and many of these illnesses (such as heart disease or diabetes) are preventable. General practice has a role within the wider health and social care system in developing the health literacy of patients.

We will aim to start to shift the focus in general practice to well-being and prevention and empowering patients to take greater responsibility for their health and to make necessary changes in their lifestyle. Both clinicians and patients have a lot to gain from patients being informed and sharing in the decision making. Developing a new way of working together should improve care and could reduce workload.

New technologies, supported by an evidence base, would also offer opportunities to help patients to manage their own health and would be covered in this objective.

We have examples already within our localities where general practice, in partnership with the wider community, is supporting people to self-care. We will share and capitalise on the learning from such initiatives.

Design Principles:

- Compact between the patient and GP
- Technology
- Locality/community

What does this mean for patients?

- Patients will have information to prevent ill health and manage their condition
- Patients are asked about their wellbeing and their capacity and goals for improving health
- Patients will understand their own contribution to their health and use of health services

What does this mean for general practice?

- All clinicians and healthcare professionals in general practice will promote good health and prevention as part of every contact
- General practice will work with partners and public health in the community to develop assets and resources that will help people to remain healthy and

connected in their community.

How will we measure success?

- % patients who feel confident to self-care and manage their conditions

OBJECTIVE 5: Encouraging new working arrangements between practices

This objective embodies both the need to sustain general practice moving forward and support it to transform. However, we recognise that new ways of working between practices to survive in light of the pressures and transform to meet local and national challenges must be led by them; we do not prescribe or advocate one approach over another. The only design principles would be about locality delivery, whilst recognising city wide/at scale may often need to be the organising principle supporting locality delivery when resources are limited. Equally, that the personal and local nature of general practice is safeguarded.

We will support the federations to develop ways of working to improve health outcomes, address capacity and access issues.

Design Principles:

- Locality structure as a minimum

What does this mean for patients?

- Improved access
- Access to additional services
- Sustainable Sunderland general practices services

What does this mean for general practice?

- Opportunity to reduce pressure on the workforce
- Minimising duplication of processes
- Reduced cost
- Increased level of peer support and shared learning from each other
- Opportunity to reduce administrative burden
- Support and promote initiatives to share skills across practices
- Achieve primary care assurance and CQC standards

How will we measure success?

- Reduced variation across practices, e.g. access standards and delivery of enhanced services
- Support the development of new roles

- Increase in good/outstanding scores from CQC inspections and the Primary Care Assurance ratings

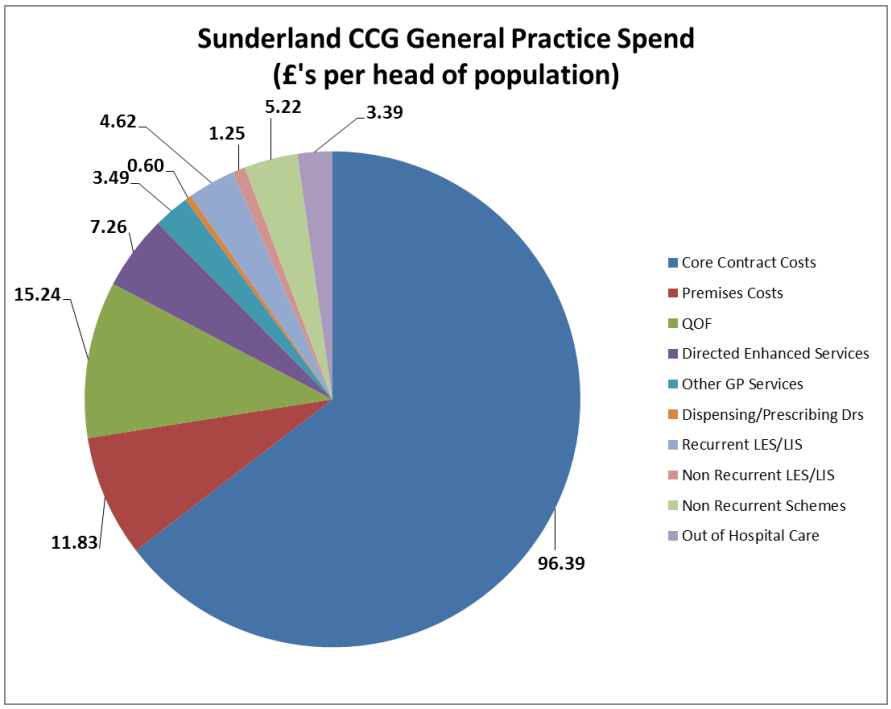
6.2 Enablers

To support change and delivery of our general practice strategy we have identified the following enablers.

6.2.1 Co-commissioning budgets

We now have delegated budgetary responsibility for general practice commissioning and we currently allocate 9% of our total expenditure on general practice services.

The current breakdown of expenditure on general practice services per head of population is outlined in the pie chart below. This incorporates the areas which compromise delegated budgets from NHS England which is core contract costs, premises costs, QOF, Directed Enhanced Services, other GP services and Dispensing / prescribing doctors. In addition we have put in place recurrent investment into out of hospital care, recurrent and non-recurrent funding into Local Enhanced Services and Local Incentives Services as well as non-recurrent investments in areas such as GP Career Start, Extended Hours Pilots and Locality Innovation Schemes.



It is anticipated that there will be significant efficiencies released from the PMS review which has taken place (circa £2m) over the next 5 financial years and the re-procurement of APMS contracts (circa £960k per year) over the next 5 financial years. We will ring fence these efficiencies for reinvestment into general practices services in line with allocation policies developed by NHS England.

Our aim will be to ensure the financial sustainability of general practice for the future. This will be as a minimum through effective commissioning of general practice, for example reviewing the approach to enhanced services, and where possible through additional investment subject to our overall strategic and financial plans for the next few years. These are due to be developed following the issuing of national planning guidance and financial allocations to the CCG early 2016.

6.2.2 Estates

We will ensure our future strategic estates plan (SEP), which is in development, is aligned to this strategy to enable and support delivery. The aim of the SEP is to get the right services in the right place and make best use of the estate over the next 5 years. However, this must support the delivery of our transformation programmes, including this strategy.

6.2.3 Informatics

We recognise the importance of information and information technology to improve: patient care; access to care; patient experience; delivery of clinical outcomes; and health record keeping.

The ability to share data across health and social care will be critical to the successful delivery of **out of hospital care**, of which general practice services are a key part. In conjunction with on-going work in relation to Community Integrated Teams and Recovery at Home and the extended access locality pilots, we will work with partners to develop and implement an informatics strategy to enable sharing of information, supported by robust governance processes, to support clinicians to provide high quality care.

6.2.4 CCG Support

We understand that we will need to:

- Be configured to take up the opportunities presented by co-commissioning;

- support the development of workforce planning;
- streamline practice provision of enhanced services to reduce bureaucracy;
- support practices to consider alternative approaches to working together;
- take on professional leadership for quality improvement in general practice through the development of a new quality framework as well as a contracting and funding model, alongside the existing GMS/PMS/APMS contracts, to commission differently, e.g. commission for outcome;
- continue to invest in the clinical education via the Time In and Time Out programme (currently £90k a year) which is highly valued by member practices; and
- promote and assist with healthcare research to improve the health of patients and engender a culture of quality improvement.

6.2.5 Organisational development

We recognise that to be sustainable practices need to work together and work differently but we accept that they are best placed, supported by federations, to determine how to do this ensuring individual practice identity is maintained wherever possible.

We will work with federations to consider a programme of organisational change support.

Section 7 – Taking the strategic direction forward

This section describes the next steps to making change happen – how we move from strategy to implementation.

7.1 Governance

To ensure that the CCG and its Board are delivering on its strategic objectives, a committee structure has been developed to provide assurance on the key aspects of plans under the Governing Body.

In line with our full delegated responsibility for general practice commissioning we have established a Primary Care Commissioning committee (PCCc) to maintain oversight of this function and demonstrate accountability that the CCG will be able to meet its delegated responsibilities. This committee is a formal sub-committee of the Governing Body and its purpose is to enable the members to make collective decisions on the review, planning and procurement of primary medical care services in Sunderland. The role of the committee is to carry out the functions relating to the commissioning of primary medical care services under section 83 of the NHS Act.

The development of the strategy has been overseen by SCCG's Governing Body and has been approved by this group prior to wider circulation. The Governing Body have agreed that the implementation of this strategy be overseen by the PCCc.

7.2 Implementation

Having engaged widely with our practices, patients, the general public, partners and practice representatives in the development of this strategy, the next phase is the delivery.

We will establish an Implementation Group to oversee the development of implementation plans for the 5 strategic objectives reporting to the PCCc. Although the membership and Terms of Reference are to be determined, it is anticipated that this group would comprise commissioners, representatives from the GP federations and HealthWatch.

A Workforce Steering Group and the General Practice Group (GPG), of the Vanguard Programme (responsible for developing enhanced primary care), already exist and the work programmes of these groups would need to be reviewed and informed by this strategy and the 5 priority areas of focus.

Appendix 1 Glossary

Acronym	Meaning
APMS	Alternative Provider Medical Services
BMA	British Medical Association
CCG	Clinical Commissioning Group
CNTW	Cumbria, Northumberland, Tyne & Wear
FTE	Full time equivalent
FYFV	Five Year Forward View
GMS	General medical services
GPG	General Practice Group
HC	Head Count
HEE	Health Education England
HENE	Health Education North East
LMC	Local Medical Committee
NHSE	NHS England
PCT	Primary Care Trust
PMS	Primary medical services
PCCc	Primary Care Commissioning Committee
RCGP	Royal College of General Practitioners
SCCG	Sunderland Clinical Commissioning Group
SEP	Strategic Estates Plan
SRG	System Resilience Group
TDA	Trust Development Authority