NHS
Sunderland
Clinical Commissioning Group

Commissioning Strategy for General Practice 2019-2024

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Section 1 – Executive summary of the General Practice strategy for Sunderland

This section summarises the strategy by setting out the aim of the strategy and the five objectives set to ensure delivery. Further detail is provided in section 4.

In 2016 we published our first General Practice Commissioning Strategy which explained our vision of **Better Health for Sunderland.** Our overall aim was 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.**

To do this we developed five objectives:

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.**

Since 2016 we have seen several changes within the NHS both locally and nationally which has led us to review and revise our strategy; this revised strategy explains where we have got to in delivering our vision, and what we still need to do. Our practices have told us that we need to concentrate on the following areas:

- **Workforce** – Practices have reported that they need more staff and a greater diversity of skill mix to meet patient demand. The importance of training and retention of staff has been highlighted. Workforce requirements include the need for specific roles to address gaps in current provision within general practice such as mental health support, social prescribing and further clinical pharmacist input;

- **Integrated working** – Practices have stated that they would like primary and community services to be available in a more integrated manner with robust collaboration between different healthcare organisations to ensure patients are cared for holistically. Removal of bureaucracy and duplication across the wider healthcare sector and further integrated working with social care have also been highlighted;

- **Premises and IT/digital** – Practices have stated that they need faster IT with greater interoperability alongside an estate which is fit for purpose, meets capacity needs and ensures the sustainability of general practice;

- **Prevention and Self-Care** – Practices have highlighted the importance of having access to tools/information that will support patients to take responsibility for their clinical conditions and a greater focus on the prevention agenda;

- **Communication** – Practices have stated that they need standardised information, templates and guidance which are clear, easy to use and support them in their daily work.

On reviewing the delivery of initiatives against our original objectives, along with changes to the local and national healthcare landscape, this revised strategy highlights that our objectives should remain the same. However, to support the implementation of our objectives we have identified a number of initiatives that we will implement as follows:

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 will develop or continue initiatives to support recruitment and retention of the general practice workforce to meet increasing demand and complexity.	We will support our general practices by aligning extended hours requirements with our Extended Access service.	We will continue to develop Community Integrated Teams, support MDT working and to further refine schemes such as 'Recovery at Home' and 'Care Home Alignment'.	We will work with the Local Authority and Community Voluntary Sector to support the development of self-care models.	We will provide support to our PCNs to ensure delivery of the seven national specifications introduced by NHS England.
We will develop and support emerging and existing leaders.	We will support the requirement and ability for NHS 111 to book patients directly into the right service.	We will work with Local Authority colleagues to develop public health links and social care input to our PCNs.	We will continue to progress with and implement digital technologies to support self-care for patients.	We will support PCNs to maximise funding opportunities.
We will source and support education and training of the general practice workforce.	We will develop initiatives to support increased capacity within our practices.	We will work with colleagues to develop mental health services that support our patients	We will strengthen mental health prevention to address factors that shape mental and physical health and wellbeing of patients.	We will ascertain, in line with Objective 2, the general practice and wider health care estate needed to support further collaboration via PCNs.

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 will support PCNs with the introduction of additional roles to general practice via the Network Directed Enhanced Service (DES).	We will implement the outcome of the national 'Improving Access to General Practice' review once published.	We will work with public health colleagues to determine how we can best ensure Health Visitors and Midwives are closely linked with our practices and that there are links between School Nurses and our practices.	We will continue to support the prevention agenda via local schemes.	We will continue to support practices who wish to merge or introduce new working arrangements.
We will continue to implement and work with our local practices to implement the initiatives within the GPFV.	We will continue to develop digital solutions to support better patient access to general practice services.	We will develop a safeguarding hub for the city to provide centralised support for the Safeguarding Adults and Children's agenda to ensure GPs meet their statutory responsibilities and improve outcomes for vulnerable adults and children.		We will continue to invest in our practices to sustain funding and reduce bureaucracy.
	We will support our practices to ensure there is sufficient premises capacity to deliver services to patients.			We will continue to develop a pipeline of general practice investment opportunities that could attract local and/or national funding and also be delivered at a regional level.

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				We will implement initiatives that support the interface between primary, community and secondary care.

Despite being aligned to one of the five objectives, several of the initiatives will contribute to the delivery of more than one objective. The order in which these initiatives will be implemented will be influenced by our organisational Operational Plan and our transformational change programmes for 2019/20 onward.

Expected benefits

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

- Recruitment and retention of the general practice workforce and support for a different skill mix of staff working within general practice;
- Developing a workforce strategy that supports ongoing development of the various staff roles;
- Increased capacity within our general practice teams by introducing new ways of working and a holistic model of care delivery across community care;
- Improved integrated working with areas such as Mental Health, Public Health and Health Visiting;
- Developed and mature Primary Care Networks that deliver population-based care;
- Improved patient access to routine and urgent appointments within general practice;
- Increased capacity and additional staff roles, providing the platform for longer consultation time (to support a holistic and pro-active approach to care);

- Patients are engaged in making decisions about their health and are confident to care for themselves;
- Through reduced administrative burden on GPs and nurses, this will 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 developed and 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.

Section 2 Introduction

This section introduces the history of the original strategy and discusses the context and purpose of the revised strategy.

2.1 General Practice Strategy 2016-2021

In 2016 NHS Sunderland Clinical Commissioning Group published the 'Commissioning Strategy for General Practice 2016-2021' (the strategy), which set out our ambition to support and sustain general practice and its workforce within Sunderland, to improve access to services and to support better outcomes for patients.

The strategy was developed following a series of consultation events with Sunderland practices and other stakeholders, and outlined five objectives to be delivered; these objectives were designed to support the overall vision of **Better health for Sunderland** with the aim to **sustain and transform general practice to ensure the provision of high quality primary medical care and delivering improved health outcomes for local people, now and in the future.**[1]

2.1.1 Strategy Objectives

As part of the engagement with practices and stakeholders to inform the previous strategy, feedback received highlighted key initiatives that were analysed and grouped thematically into the following work streams:

- Workforce;
- Ways of working;
- IT infrastructure;
- Prevention and self-care;
- Premises;
- Contractual/Financial Arrangements.

We also engaged with the public about what was important to them. From the collective feedback, five objectives were identified as shown in figure 1.

Figure 1

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**
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[1] Commissioning Strategy for General Practice 2016-2021

Responsibility for the implementation of the strategy was assigned to our Primary Care Commissioning Committee (PCCC) – this is the committee established to make collective decisions on the review, planning and procurement of primary medical care services in Sunderland, under delegated authority from NHS England.

To support and oversee delivery of the strategy, the Committee approved the development of an oversight group called the General Practice Strategy Implementation Group (GPSIG) which includes personnel from within the CCG and from partner organisations. A sub-group of the GPSIG, the Workforce Steering Group, was also initiated to specifically oversee the development and implementation of workforce initiatives.

There has been significant progress against the delivery of the objectives since the publication of the original strategy; these include initiatives to address clinical workforce shortages, the development of services to improve access to primary medical care services and the implementation of Community Integrated Teams and other schemes to deliver care to patients outside of the hospital setting. **These, alongside the implementation of some of the national schemes are discussed in Appendix 1.**

2.2 Current Baseline Position

Since publication of the original strategy there have been significant changes to the general practice landscape, both locally and nationally. These changes are discussed further in section 3 and have resulted in the need to review and revise the original strategy for general practice within Sunderland to ensure we not only respond to the ambitious national expectations but also to determine what new initiatives are required to be implemented.

This revised strategy therefore builds on the previous strategy and its deliverables. In developing this document we have held events with all GP practices within Sunderland, liaised with CCG personnel, members of our Governing Body and Executive Committee, Primary Care Commissioning Committee and other key stakeholders to ensure we collate a view from commissioners and providers alike. A list of all key partners and stakeholders is shown in Appendix 2.

2.2.1 GP Practice Numbers and Contract Types

As mentioned above there have been changes to the general practice landscape both locally and nationally since April 2015; in Sunderland we have seen a significant reduction in practice numbers as shown in figure 2. This reduction is a result of different factors including practices agreeing to merge to form larger practices, practices terminating their contracts and those contracts not being re-commissioned or contracts being reviewed at the point of expiry and then being commissioned differently. As a result of there being less practices, the average list size of a practice has increased.

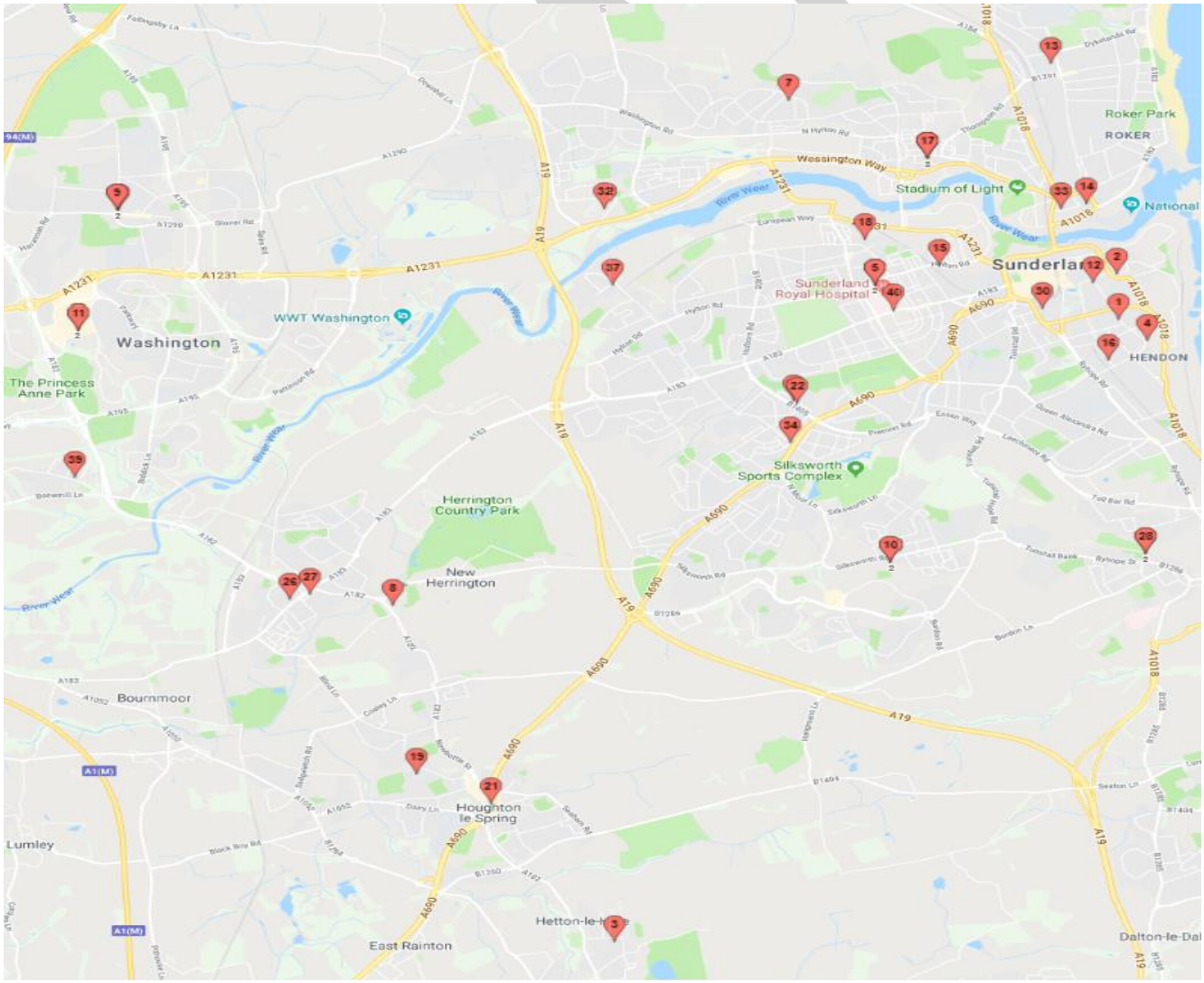
Figure 2

	2015		2019	
Number of GP Practices	51		40	
Number of Patients	283,434		284,295	
Average Practice List Size	5,456		6,769	
Number of Single-handed Practices*	10		9 (reducing to 7 by October 2019)	
Contract types[2]	GMS	14	GMS	36
	PMS	34	PMS	2
	APMS	3	APMS	2

*Single-handed practices are practices with only one individual holding the contract and placing its sustainability at risk.

A map of our current practices is shown in figure 3 - a key to the map is provided in appendix 3.

Figure 3



[2] There are three contract types. GMS is a nationally agreed contract negotiated between NHS Employers and the General Practitioners Committee on an annual basis. PMS agreement is a locally negotiated contract but the funding paid to the practice per patient is in line with GMS. APMS is a contract that is procured and is tailored specifically to commissioner requirements and its funding is locally decided – all GP contracts procured are now of this type

2.2.2 Development of City-Wide GP Federation

In 2015, Sunderland practices formed a federation, Sunderland GP Alliance (SGPA) which is currently owned by 36 out of the 40 GP practices in Sunderland. SGPA is a not-for-profit limited liability organisation designed to support its member practices with city-wide initiatives and to enable closer collaboration between GP ractices and GPs within the city[3].

Sunderland GPA has been commissioned to provide the following services to support practices:

- Community Integrated Team facilitation;
- Care Home Alignment support;
- Extended Access Scheme;
- Career Start GPs;
- Career Start for Practice Nurses and Healthcare Assistants;
- Ambulatory ECG;
- NHS England Clinical Pharmacy Scheme;
- Leading on Clinical Pathway development;
- GP input to Recovery at Home.

They also hold 2 APMS contracts for GP services within Sunderland. GPs from their member practices are elected to their Board on a cyclical basis to ensure adequate representation of their practices' interests.

2.2.3 GP Practice Workforce

In terms of workforce, practices nationally and locally were facing and continue to face significant workforce pressures; a comparison of workforce figures in 2015 and 2018 (taken from general practice workforce figures for Sunderland (September 2018))[4] are highlighted in figure 4 and show that we now have fewer GPs than we had in 2015 but, in contrast, we have more nurses overall. Whilst the GP workforce numbers have reduced, the increase in the number of nurses is predominantly due to the increase in Advanced Nurse Practitioner roles. Practice Nurse numbers have reduced gradually with over 50% of the Practice Nurses above the age of 55. However, in order to support the long-term condition management agenda over the coming years we require more nursing roles and greater diversity of the workforce to bring a different skill-mix. The development of a range of clinical roles is a key priority for our workforce plan. Analysis of the non-clinical workforce highlights that there are 19 Practice Managers and 64 receptionists/Medical Secretaries are aged 55 and over, highlighting that we also need to support the development of the wider general practice workforce to ensure sustainability.

[3] http://www.sunderlandgpalliance.co.uk/
[4] National Workforce Reporting System https://www.nwrs.nhs.uk

Figure 4

	2015	2018
Number of GPs (headcount)	190	186
Number of GPs per FTE*	186	150
Number of GPs aged 55 and over	51	38
Number of Nurses** headcount	113	128
Number of Nurses per FTE*	84	96
Number of Nurses aged 55 and over	Not published	45

*FTE equates to 37.5 hours per week

**Mixture of Practice Nurses and Advanced Nurse Practitioners

Figure 5 shows the age profile of general practice staff in Sunderland (as at September 2018) and figure 6 shows the trend in GP numbers.

Figure 5

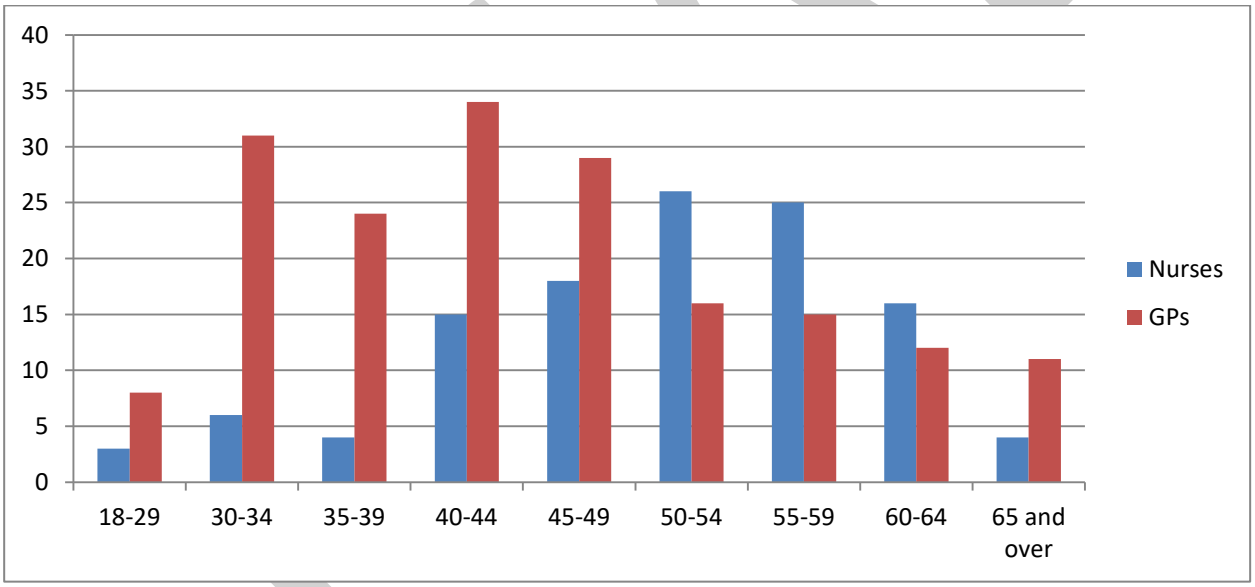
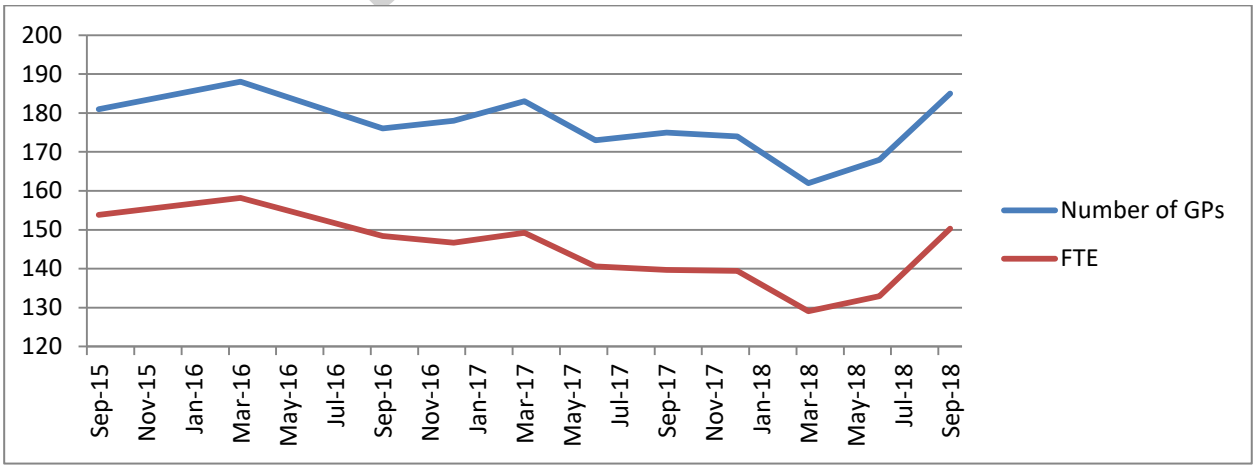


Figure 6



2.2.4 GP Practice Funding

Following agreement to delegate primary care commissioning to the CCG, we have received a specific allocation for commissioning core GP services. This funding was £38.152 million in 2015/16 and has increased year on year in line with announced allocation growth increases as shown in figure 7. In addition, we have committed additional resources to support general practice from its programme allocation which is also shown in figure 7.

Figure 7

	2016/17 (£000s)	2017/18 (£000s)	2018/19 (£000s)
Delegated GP Allocation	39,284	40,469	40,644
CCG monies invested (non-delegated):			
Recurrent Funding (GP QP)	656	656	656
Extended Access (£6 per head)	1,278	1,704	1,804
Non Recurrent Funding	1,240	1,803	3,591*

*Note that 2018/19 non recurrent funding included significant one off investment into medical record scanning across practices to support release of estate for clinical use.

2.2.5 GP Practice Premises

In 2017/18 NHSPS in conjunction with the Department of Health and NHS England published a Consolidated Charging Policy[5] which outlined how GPs (amongst others) occupying NHSPS buildings without formal lease agreements, would be charged on a market rent basis. This has affected 20 of the practices in Sunderland. Whilst some charges (including rent, rates and clinical waste) are reimbursable by commissioners, others such as facilities management and service charges are not. NHS Sunderland CCG has supported practices to secure historical subsidy funding from NHS England and put in place additional capacity in the CCG to support practices in understanding their debt position.

[5] https://www.property.nhs.uk/about-us/policies/charging-policy/

Section 3 Changes to the Healthcare Landscape

This section focuses on the changes to the healthcare landscape over recent years which have impacted on general practice in Sunderland.

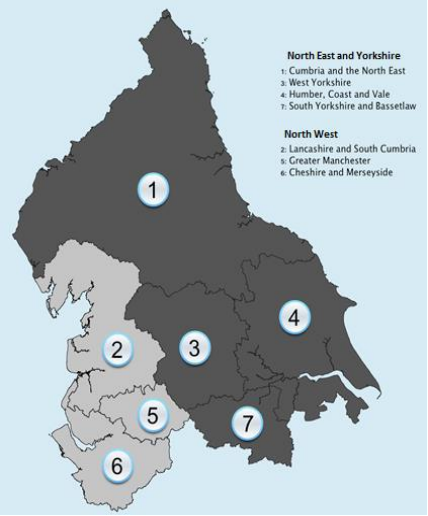
3.1 General Practice Forward View

The publication of the General Practice Forward View (GPFV)[6] in April 2016 committed an extra £2.4 billion per annum nationally (up to and including 2020/21), with the expectation that this extra funding would improve patient access but also support general practice to introduce new ways of working in order to ensure its sustainability. The GPFV introduced many initiatives to be implemented; implementation of these initiatives within Sunderland is highlighted in appendix 1.

3.2 Integrated Care Systems and Partnerships

In 2016, 44 Sustainability and Transformation Partnerships were formed throughout the country; these partnerships brought together NHS organisations and local councils to set out proposals for planning and commissioning care to improve the health and care for their local population and provide system leadership[7]. These partnerships have in some areas evolved and continue to evolve into Integrated Care Systems (ICSs) of which there are two emerging in the North region as shown in figure 8.

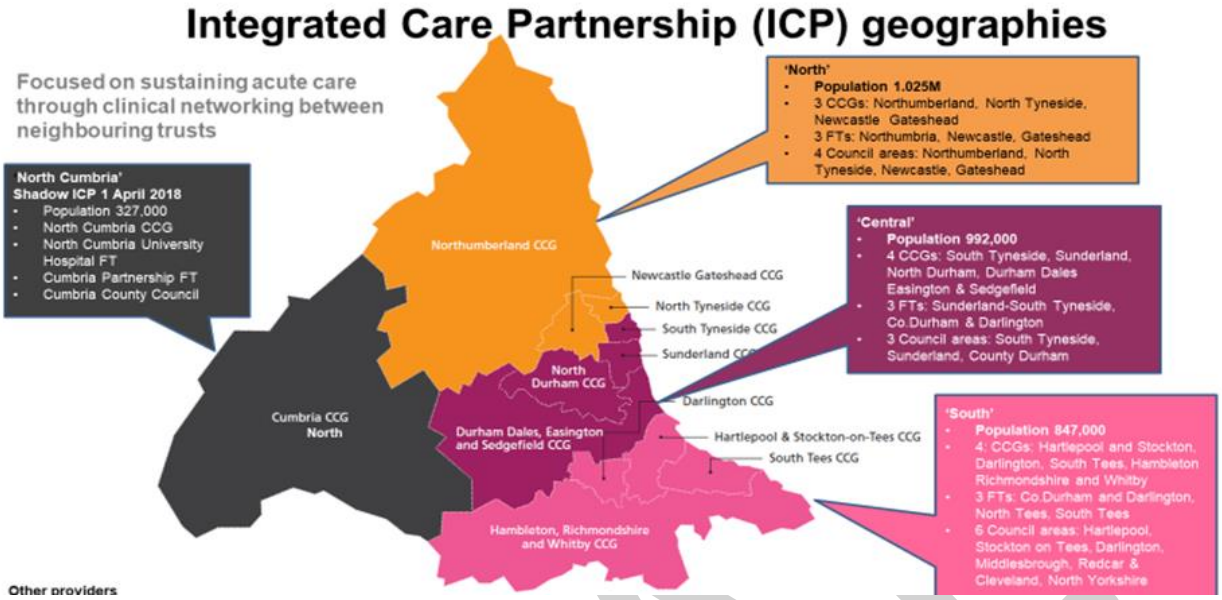
Figure 8



Within an ICS there are smaller Integrated Care Partnerships (ICPs); there are four in this area (figure 9). Sunderland is part of the Central ICP alongside NHS South Tyneside CCG, NHS North Durham CCG and NHS Durham Dales, Easington and Sedgefield CCG, covering a population of 992,000 people. The work of the ICS and the ICP has yet to have an impact on general practice. General practice will have a role to play in the future in the success of the ICP/ICS.

[6] https://www.england.nhs.uk/gp/gpfv/
[7] https://www.england.nhs.uk/integratedcare/integrated-care-systems/

Figure 9



3.3 The NHS Long Term Plan

In June 2018, a new five-year funding settlement was announced for the NHS, equating to a 3.4% average real-terms annual increase in funding. In response to this, NHS England published The NHS Long Term Plan (LTP)[8] in January 2019. The LTP outlines the key ambitions for the NHS over the next 10 years and how it will utilise the funding increase by setting out fundamental changes to the healthcare system to:

- Break down the barriers between primary and secondary care;
- Increase the focus on prevention and tackling health inequalities;
- Continue the focus on chronic conditions;
- Boost services for children and young people;
- Support further digital enhancements and;
- Confront plans to tackle the diminishing NHS workforce.

The LTP contains seven chapters focussing on a new service delivery model, prevention and health inequalities, long-term conditions and services for children and young people, workforce (recruitment, training and retention), digital platforms to transform care delivery, investment and, finally, mechanisms for implementation of the LTP.

Whilst all chapters of the LTP are relevant to General Practice, it is chapter 1 – '*A new service model for the 21st century*', which will have the most impact on how General Practice will function. It commits a ring-fenced primary care fund of an additional £4.5 billion per annum by 2023/24 to fund demand, workforce expansion and service redesign. The historical divide between primary and community care will be dissolved by boosting out-of-hospital care:

[8] https://www.longtermplan.nhs.uk/

- Through redesign there will be reduction in pressure on emergency hospital services;
- There will be greater emphasis on personalised care with people getting more control over their own health;
- Mainstream changes across the NHS for digitally-enabled primary and outpatient care;
- There will be an increased focus on population health.

To further support the implementation of the LTP within general practice, NHS England in conjunction with the British Medical Association published changes to the GP contract to take effect from 01 April 2019; these changes introduce the requirement to implement **Primary Care Networks**[9] (PCNs) which are designed to ensure general medical services are part of an integrated approach to health and social care delivery over the next few years.

This is one of the key changes affecting general practice over the next 5 years; PCNs are to be led by general practice working closely with community teams and the primary care sector to create a fully integrated community-based health care team.

PCNs are to be implemented via a Directed Enhanced Service (DES)[10] and will be accountable to the CCG and NHS England as co-commissioners.

3.4 Primary Care Networks

PCNs are geographically based teams, led by GP practices in the PCN area, delivering services to their registered population of between 30,000 and 50,000 patients. The PCN must have a Clinical Director providing strategic leadership and oversight of service delivery of the PCN and representing the PCN as part of the wider health and social care system.

In Sunderland we have been working as geographical localities for a number of years. Our PCNs represent the current localities with the exception of Sunderland West, which have agreed to split into two PCNs due to the size of the locality.

PCNs and their mandated services have been developed following the learning from the vanguard programme. The vanguard programmes were national programmes designed to test new models of care. Sunderland was a trailblazer due to the existing relationships and the vanguard programme which has allowed practices, working within the wider out-of-hospital system, to be ready to implement mandated services at an accelerated pace. Some of the areas are highlighted in figure 10.

Over the next five years, PCNs are expected to deliver seven specifications as shown below; whilst the specifications are still being developed by NHS England, figure 10 shows the equivalent schemes which have already been implemented within Sunderland.

[9] https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-des-specification-2019-20/
[10] A DES is options for practices to sign up to and are for services which are over and above what is delivered via their core contract.

Figure 10

Delivery Year	Mandated Service	What Do We Already Have In Place?
2019	Extended Hours Access (2019)	This service will be delivered alongside Extended Access scheme from 2019
2020	Stuctured Medication Reviews and Optimisation	Quality premium initiatives including specific medicines optimisation schemes
2020	Enhanced Health in Care Homes	Care home alignment, care home nursing support and regular MDTs
2020	Anticipatory Care	Community integrated teams, care home alignment, care home nursing support and regular MDTs and end of life pathway
2020	Personalised Care	Social prescribing model such as piloting the PAM
2020	Supporting Early Cancer Diagnosis	Part of the Cancer Alliance, Early Diagnosis Awareness worker, lung cancer case finding, FIT testing for colorectal cancer, quality premium initatives, cancer screening programmes
2021	CVD Prevention and Diagnosis	Quality premium, QOF management, NHS Health Checks, Steps for Health, stop-smoking services
2021	Tackling Neighbourhood Inequalities	No information at present

To support the delivery of services, each PCN is entitled, under the DES, to reimbursement (up to a maximum threshold) of some or all of the salary of 5 key additional roles which will come into force over the next 5 years. These roles and the year in which they can be reimbursed by NHS England are shown in figure 11.

Figure 11

Year	Role
2019/20	**Clinical Pharmacist**
2019/20	**Social Prescribing Link Worker**
2020/21	**Advanced Practice Physiotherapist**
2020/21	**Physician Associate**
2021/22	**Advanced Paramedic Practitioner**

Whilst initially the PCN may start with GP practices, the PCN is designed to be a '*foundation of all Integrated Care Systems; and every Integrated Care System will have a critical role in ensuring that PCNs work in an integrated way with other community staff*

such as community nurses, community geriatricians, dementia workers and podiatrists/chiropodists'.[11]

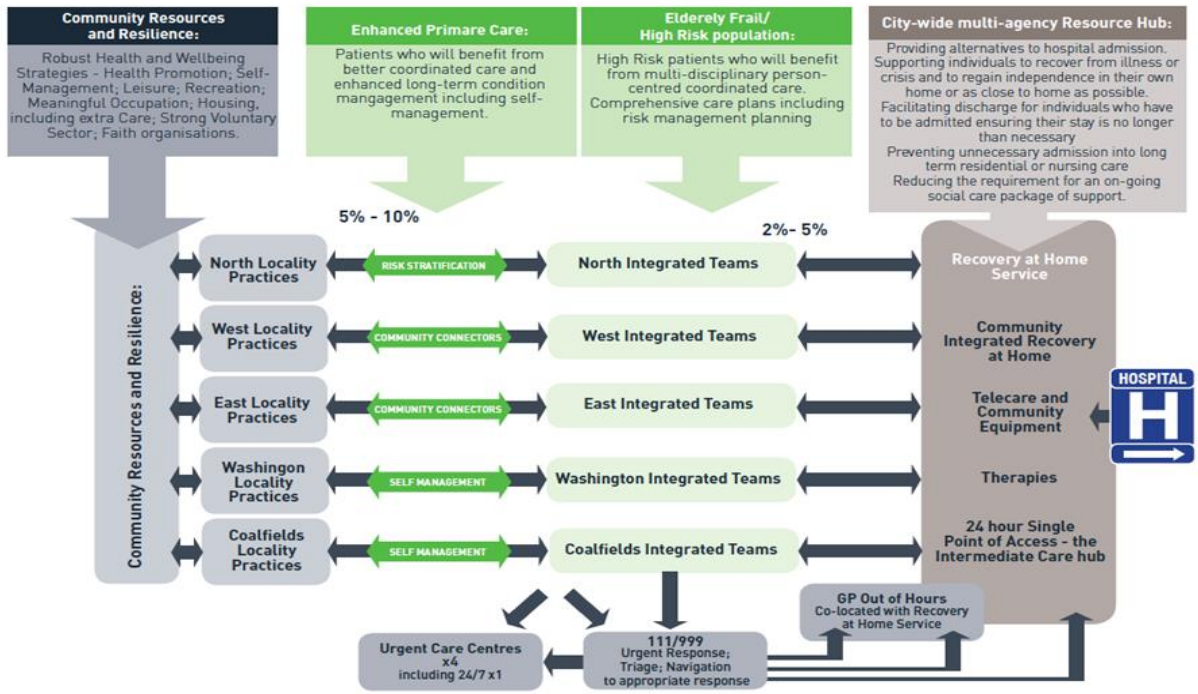
It is expected that the PCN will be a key player and delivery vehicle for the Sunderland out-of-hospital ATB model.

3.5 All Together Better

In October 2014 a new care model known as the Multispecialty Community Provider (MCP) model was introduced as part of the vanguard programmes highlighted in the Five Year Forward View[12]. Sunderland became one of the vanguard sites utilising the MCP programme which was designed to integrate out-of-hospital care via a population based health and social care model. In Sunderland this is now known as All Together Better (ATB)[13] which has been working towards delivering a vision for the future of out-of-hospital care with the aim of promoting health and wellbeing, delivering quality care for patients and carers and ensuring sustainability of the system.

Since March 2018 commissioners and providers have worked collaboratively to develop the alliance approach for Sunderland. It is agreed that ATB will focus on; '*person centred, proactive and coordinated care, which will support appropriate use of health and care services, will improve patient and carer experience and outcomes, ensuring people will live longer with better quality of life'*[14]. The revised model is depicted in figure 12, and will be revised further in light of the implementation of PCNs.

Figure 12

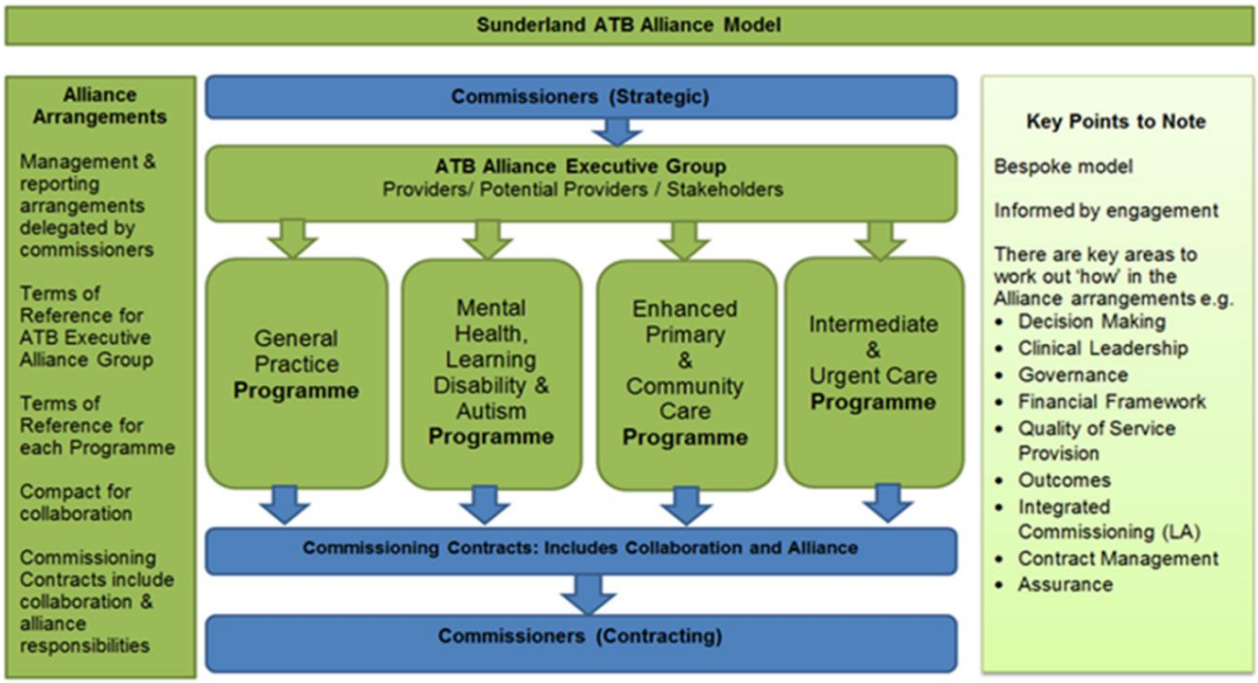


[11] Page 30-31 'Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan – https://www.england.nhs.uk/publication/gp-contract-five-year-framework/
[12] https://www.england.nhs.uk/new-care-models/about/
[13] http://www.atbsunderland.org.uk/
[14] ATB Programme 1 Terms of Reference

The scope of services (all out-of-hospital services) has been organised into four programmes acting as the implementation and delivery mechanism for ATB. The programmes are shown in figure 13 with Programme 1 being dedicated to general practice; this programme has been established to undertake and be responsible for overall integrated delivery, performance, outcomes and system-wide overview of general practice and pharmacy services. The overall expectation is that the priorities identified within this strategy, as well as supporting the delivery of PCNs, will be the key focus for Programme 1.

PCN Clinical Directors will also support the work of the ATB and will be able to influence the out-of-hospital system by working closely with the ATB programmes.

Figure 13



3.6 CCG Priorities

The CCG priorities are to support the development of the ICS, implement the LTP and the priority areas summarised in the operational plan as shown in figure 14.

As shown in figure 14, general practice is one of the key transformation programmes with an overall objective to develop PCNs, increase the workforce and support digital transformation.

Figure 14

Sunderland CCG Plan on a Page 2019/20

SUSTAINABILITY - Finance, Workforce & Quality & Safety

Our Vision:	Better Health for Sunderland							
Delivered by:	Prevention		Transforming Community Care		Transforming In Hospital Care			
Measured by:	CCG Improvement & Assessment Framework, All Together Better Alliance Outcomes							
Underpinned by our values:	Inclusive	Patient centred	Responsive	Innovative	Empowering	Integrity	Open and Honest	

	Transformation Programmes	Objective
Prevention	Maternal Health & Wellbeing	Ensure safe and sustainable services for improved outcomes in maternity and ensure the best start in life.
	Child Health & Wellbeing	Improve child health; mental, physical and emotional wellbeing and reduce avoidable illness in later life.
	Cancer	Improve cancer outcomes, reducing smoking, increase screening uptake, early diagnosis and improve patient cancer pathway experience including survivorship and end of life care.
	Respiratory	Improve health outcomes and optimise the length and quality of life for people with and at risk of respiratory disease including care at end of life.
	Cardiovascular Disease (incl. Diabetes)	Optimise the length and quality of life for patients with, and at risk of CVD, through robust primary and secondary prevention, streamlined pathways and integrated services that meet national standards .
Community Care	**Transformation Programmes**	**Objective**
	General Practice	Further Development of Primary Care Networks, increasing workforce and digital transformation
	Mental Health, Learning Disabilities and Autism	Working with partners to ensure the successful implementation of system wide Mental Health, Learning Disabilities and Autism programmes
	Enhanced Primary and Community Care	Deliver integrated and patient centred care through the transformation of enhanced primary and community services.
	Intermediate and Urgent care	Ensure patients benefit from treatment, in the right place, at the right time, by the right professional through the provision of a simple seamless pathway across Intermediate and Urgent Care.
In hospital	**Transformation Programmes**	**Objective**
	Path 2 Excellence	Ensure a safe and sustainable model for acute services by delivering a single clinical operating model across the local health economy

Enabled by:					
	Integrated commissioning	Digital & Technology	Training & Leadership	Medicines Optimisation	Locality Networks
	Engagement	Patient & Carer Empowerment	Population Health Analytics	Collaboration	Research Evidence & Innovation

ICP ICS

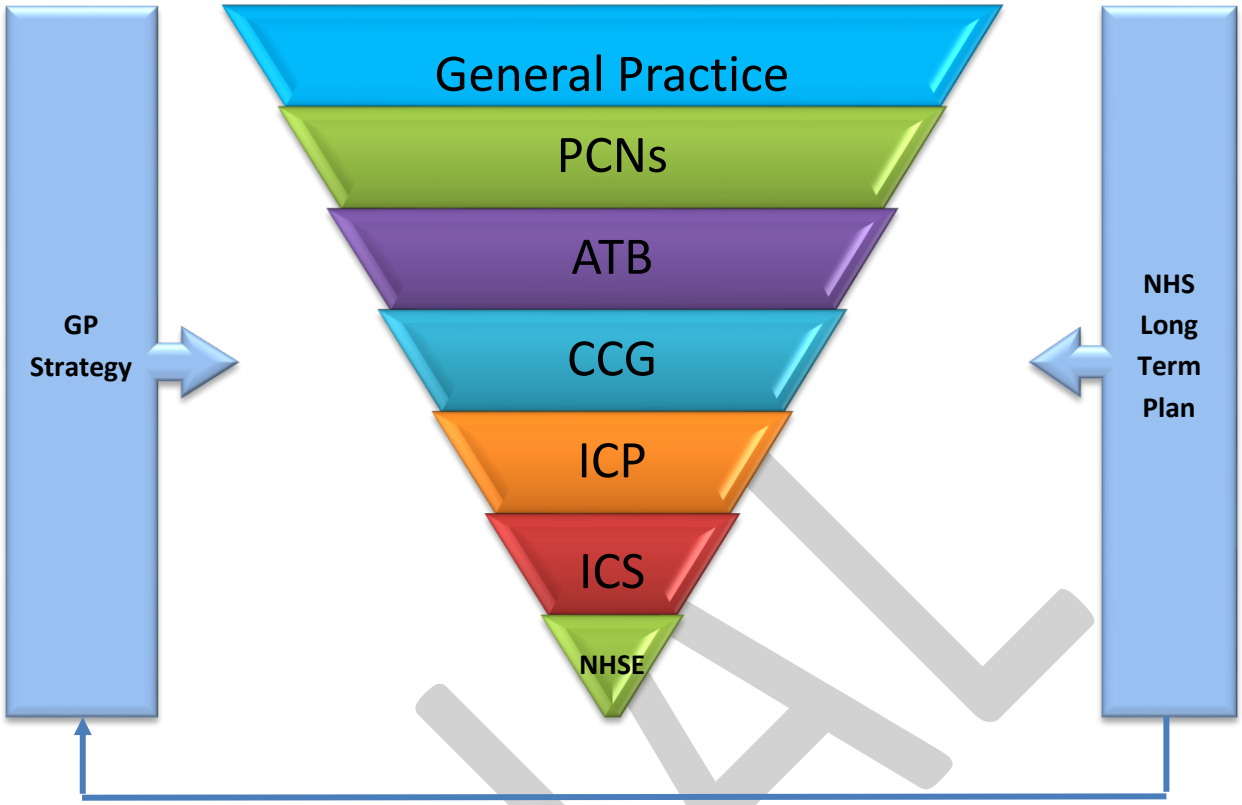
3.7 How does it all fit together?

The NHS LTP states how health and social care should be delivered now and in the future, with seamless care delivered by integrated primary, secondary and community teams in accordance with the needs of the population.

There are many organisations involved in healthcare commissioning, all with similar priorities; however in terms of the general practice landscape the key interdependencies and associated hierarchy are depicted in figure 15. This diagram aims to show how all organisations are responsible for delivery of the LTP. It also aims to show that delivery of the objectives of this strategy are the collective responsibility of the CCG, ATB, PCNs and practices alike and that the priorities identified by those organisations have influenced the deliverables of this revised strategy.

It is worth noting that currently it is the CCG and NHSE that has statutory responsibility for healthcare commissioning. Integrated Care Systems and Integrated Care Partnerships remain an evolving virtual part of the system.

Figure 15



Section 4 Vision and Objectives

This section discusses the agreed strategic objectives and priorities which will be implemented by 2025. These strategic objectives have been developed as a result of engagement with our practices and other key stakeholders.

4.1 Vision

The overall CCG vision of **better health for Sunderland** remains the same, as does the vision 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.**

To do this we will need to:

- Ensure our practices have the right workforce in terms of numbers and skill mix to support a holistic model of health and social care delivery, both now and in the future;
- Implement initiatives to improve efficiency in order to create capacity within general practice to care for patients through longer appointment times and different ways of accessing services;
- Develop the physical infrastructure.

We will need to work with our delivery partners and our PCNs in order to achieve our collective goals and the expectations stipulated in the LTP.

4.2 Objectives and Priorities

In order to determine the objectives and deliverables within this revised strategy, facilitated engagement events were held in each locality with practice personnel. Clinical and Managerial leads for the CCG outlined the purpose of the engagement event as being:

- To refresh the current general practice strategy;
- To listen to practice views and give them the chance to shape the future of general practice through the strategy;
- To get practices' ideas and ensure the strategy makes those ideas and visions a reality;
- To consider the wider strategic developments of:
    - ATB;
    - Long Term Plan;
    - Previous general practice strategy achievements.

A presentation highlighted the key elements of the LTP and working groups were held to consider the following questions:

1. What do you like in the current strategy?
2. What do you need to improve general practice?

3. What do you need more / less of?
4. What would you want the future to look like?

Each group was also asked to feed back their top three priorities.

The collated results from each of the events were thematically analysed and the results are shown in appendix 4.

In summary they focus on the following key areas:

- **Workforce** – Practices need more staff and a greater diversity of skill mix to meet patient demand. The importance of training and retention of staff was highlighted. Workforce requirements included the need for specific roles to address gaps in current provision within general practice such as mental health support, social prescribing and further clinical pharmacist input;

- **Integrated working** – Practices want primary and community services to be available in a more integrated manner with robust collaboration between different healthcare organisations to ensure patients are cared for holistically. Removal of bureaucracy and duplication across the wider healthcare sector and further integrated working with social care were also highlighted;

- **Premises and IT/digital** – Practices need faster IT with greater interoperability alongside an estate which is fit for purpose, meets capacity needs and ensures the sustainability of general practice;

- **Prevention and Self-Care** – Practices need access to tools/information that will support patients to take responsibility for their clinical conditions and a greater focus on the prevention agenda;

- **Communication** – Practices want standardised information, templates and guidance which are clear, easy to use and support them in their daily work.

From feedback provided by practices and other key stakeholders, it is clear that the current objectives are still relevant and therefore should remain (figure 16).

Figure 16

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.

Feedback has also been utilised to analyse the current strengths, weaknesses, opportunities and threats (SWOT) to establish where we need to focus our attention (figure 17).

Figure 17

Strengths	Weaknesses
• Sunderland GP Alliance; • Local University Medical, Nursing and Pharmacy Schools; • Established locality working; • Established recruitment initiatives; • Stability in majority of practices; • Established ATB; • Established Extended Access service; • Recurrent funding streams.	• 9 single-handed practices; • Shared care arrangements; • Mental health support into practices; • Health visitor and midwifery liaison with practices; • Retention of general practice staff.
Opportunities	**Threats**
• Closer collaboration via Primary Care Networks; • Additional roles – Clinical Pharmacist and Social Prescriber models; • Initiatives to recruit, train and retain general practice staff; • IT initiatives to support greater interoperability; • Digital work streams to support capacity building; • Further funding to support implementation of PCNs; • Mergers to support smaller practices.	• Premises (space utilisation and state of repair), and uncertainty (practices in NHSPS buildings); • Ageing workforce (clinical and non-clinical) – loss of experienced clinicians and managers; • Reducing number of GPs; • Changes to NHS Pension • Increased demand on general practice.

As a result of engagement and SWOT, we have been able to highlight a number of initiatives to be implemented which include general practice and partner organisations, where appropriate for this strategy. The delivery of the objectives and the associated initiatives is a collective responsibility of the CCG, ATB, PCNs and practices.

4.2.1 Objective 1 Supporting General Practice to increase capacity and build the workforce

The initiatives that have been implemented since 2016 to develop our workforce have supported an increase in overall nursing staff. However our GP and Practice Nurse

numbers continue to reduce; this would have been significantly worse had we not implemented recruitment initiatives such as Career Start and Golden Hello programmes. However with a significant proportion of the workforce coming up to retirement age, there is more to do to ensure our workforce meets the challenges of modern general practice.

This may be addressed to some extent via the introduction of the PCN additional roles that are designed to provide a different skill mix focussing on specific tasks that would usually be undertaken by GPs and nurses. In turn this would not only ensure patients are seeing the appropriate healthcare professional but would also ensure GP and nurse time is used effectively to manage appropriate clinical tasks.

The workforce challenges may also be addressed by the review and appropriate continuation of existing workforce initiatives, and the introduction of new initiatives within Sunderland and indeed the region, to boost workforce recruitment and retention over the coming years as follows:

Our commitment	How will we achieve this?
We will develop or continue initiatives to support recruitment and retention of the general practice workforce to meet increasing demand and complexity.	• Reviewing current contracts for Career Start GP, Career Start Practice Nurse and Career Start Healthcare Assistants; • Working with NHS England to implement the GP Retention Scheme; • Working with local universities (Nursing, Medical and Pharmacy schools) to scope the development of a training academy to support the availability of multi-professional clinical placements and education/training delivery within Sunderland; • Identifying a specific funding source and agree processes for allocation and access to CCG and other local/national schemes i.e. CCG, Apprenticeship Levy; • Ensuring the regional ICS Primary Care Workforce Strategy objectives and our workforce plan are aligned; • Creating opportunities to be involved in design, delivery and deployment of research and evidence gathering activities to support recruitment and retention of the general practice workforce and improve quality for patients, as identified in the Cumbria and North East Primary Care Research Strategy[15].
We will develop and support emerging and existing leaders.	• Setting up leadership development sessions by identifying new GPs to the city via Career Start; • Continuing to support CCG Executive Clinical Leads and other non-clinical staff to develop leadership skills; • Supporting Primary Care Network Clinical Directors on the National Leadership Development Programme; • Increasing the number of training practices and GP

[15] Cumbria and North East Primary Care Research Strategy (July 2018) - North of England Commissioning Support in partnership with NHS National Institute for Health Research Local Clinical Research Network North East and Cumbria

	Trainers across Sunderland.
We will source and support education and training of the general practice workforce.	• Scoping the current state by assessing skills and interests in general practice for general practice clinical and non-clinical staff; • Identifying training needs for existing Practice Nurses and Healthcare Assistants; • Identifying training opportunities and education programmes for the general practice workforce; • Developing a training and education plan to reflect needs and opportunities identified; • Scoping all relevant career pathways for nurses and Practice Manager role development; • Supporting the wider health economy in the development of a regional training hub; • Continuing to support attendance at Time-In-Time-Out (TITO) education events; • Scoping specialist interest roles for clinicians with a view to supporting the development of services that will assist the out-of-hospital agenda to meet demand for services (i.e. Clinicians with specialist interest in Dermatology); • Scoping the development of appraisal and clinical supervision support for all staff; • Developing a training plan for Administration staff and Practice Managers with a skills escalator to enable succession planning.
We will support PCNs with the introduction of additional roles to general practice via the Network Directed Enhanced Service (DES).	• Supporting the emerging workforce groups highlighted in the Network DES; • Develop a social prescribing model working with Practices, the ATB, the Local Authority and the voluntary sector • Developing a Social Prescriber Link Worker job description and model to be utilised by PCNs; • Supporting ATB to develop a clinical pharmacy model for Sunderland to support PCNs; • Identify funding for those PCNs who sign up to a Network Plus agreement, to recruit the additional roles faster than identified within the DES.
We will continue to implement and work with our local practices to implement the initiatives within the GPFV.	• Reviewing implementation of each GPFV initiative to date and assessing any gaps; • Developing a work-plan to support the further implementation of each initiative, including any associated funding support; • Supporting resilience within general practice through a local resilience fund which can be accessed by those practices most in need as identified via a Resilience and Sustainability Dashboard.

4.2.2 Objective 2 Improving patient access

Despite the introduction of the Extended Access service and different ways of accessing clinical consultations via digital solutions, more needs to be done to ensure patients are aware of the different ways to access services at their GP practice and in the community. This will reduce waiting times, effectively manage patient demand and expectations and give an overall better patient experience.

The following initiatives have therefore been identified:

Our commitment	How will we achieve this?
We will support our general practices by aligning extended hours requirements with our Extended Access service.	• Contract negotiation with the current Extended Access provider; • Support to the PCNs to achieve extended hours contractual requirements via the development of formal sub-contracting arrangements; • Consider a city-wide triage interface for general practice to support consistent messages to patients accessing same-day services across the system; • Support to advertise extended access services thereby increasing patient awareness of the service.
We will support the requirement and ability for NHS 111 to book patients directly into the right service.	• Working with our regional colleagues to ascertain gaps in provision so that gaps can be addressed.
We will develop initiatives to support increased capacity within our practices.	• Support the development of a capacity planning tool; • Pilot and evaluate (with a view to continue) initiatives that will support increased capacity within practices and thereby reduce demand on other services.
We will implement the outcome of the national 'Improving Access to General Practice' review once published.	• Gap analysis of the review outcome versus current delivery; • Supporting the necessary contract changes (extended access and PCN Network Agreements) including contract variation and funding requirements to ensure implementation.
We will continue to develop digital solutions to support better patient access to general practice services.	• Continuing to deploy the technology that underpins and enables the range of new digital channels into general practice for patients. • Allowing other channels, such as video conferencing between patient and practice, advanced telephony, patient messaging and patient access to mature within our digital exemplar practices and increase coverage across the city;

	• Review new capabilities from NHS Digital such as the NHS App.
We will support our practices to ensure there is sufficient premises capacity to deliver services to patients.	• Undertaking formal baseline assessments of the current general practice and wider healthcare estate; • Developing a cohesive estates plan to explore ways in which we can support the delivery of services within practices and PCN areas; • Supporting the primary care estate to be environmentally sustainable; • Working with Local Authority spatial planners to determine the impact of future planning applications on the general practice estate. • Continuing to support practices to bid for capital expenditure to improve or develop the general practice estate; • Committing to provide those practices that occupy NHS Property Services premises with a subsidy for non-reimbursable service and facilities management costs; • Providing practical support to practices to help them understand and validate their bills from NHSPS; • Supporting PCNs to ensure they have the required estate to deliver mandated and additional services; • Considering funding support for the conversion of records rooms into clinical rooms, where demonstrably required, released as a result of the digitising of patient records.

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

The out-of-hospital model in Sunderland, determined by the ATB will continue to be developed and supported via the following initiatives:

Our commitment	How will we achieve this?
We will continue to develop Community Integrated Teams, support MDT working and to further refine schemes such as 'Recovery at Home' and 'Care Home Alignment'.	• Continuous improvement of GP-led multidisciplinary Community Integrated Teams managing frailty and multi-morbidity; • A central GP role in advanced care planning for complex patients (utilising deciding right documents such as EHCP); • Continuing to review and improve the Care Home Alignment Scheme, working closely with the older people nursing teams and care home staff, improving advanced care planning, providing an enhanced service of medication reviews and end of life planning;

	• Exploring the integration of mental health professionals into Community Integrated Teams as part of the multi-disciplinary approach; • Working closely with 'Recovery at Home' to improve access and enhance GP leadership within the 'Recovery at Home' programme; • Supporting further developments in end of life care to those not within care homes, ensuring patients and families are supported and have access to the right care when required; • Improving prescribing outcomes via the minimising of harm due to excessive prescribing and reducing waste.
We will work with Local Authority colleagues to develop public health links and social care input to our PCNs.	• Meeting with Local Authority Public Health Services to understand capacity within the public health teams.
We will work with colleagues to develop mental health services that support our patients (including IAPT, CPN, Dementia workers).	• Working with ATB Programme 2 to understand current service provision; • Mapping current service provision to current need (known and unknown) to develop a model for delivery; • Supporting the alignment of mental health workers to PCNs, starting with IAPT LTC staff, who will be co-located in primary care; • Developing closer alignment between practices and CPNs to improve relationships, improve visibility of secondary care mental health services with the aim of improving patient journeys, outcomes and experiences; • Further develop and promote initiatives such as telephone access to a Mental Health Consultant by practices to manage patient queries, promotion of 'Silver Cloud' to prevent progression of mental health symptoms and increase number of SMI Physical Health Checks.
We will work with public health colleagues to determine how we can best ensure Health Visitors and Midwives are closely linked with our practices and that there are links between School Nurses and our practices.	• Working with public health teams within the Local Authority to understand current service commissioning and provision; • Mapping current service provision to current need (known and unknown) to develop a model for delivery; • Supporting the alignment of Health Visitors and Midwives to PCNs and encourage greater links between School Nursing and our practices.
We will develop a	• Utilising the skills and expertise of the existing CCG

safeguarding hub for the city to provide centralised support for the Safeguarding Adults and Children's agenda to ensure GPs meet their statutory responsibilities and improve outcomes for vulnerable adults and children.	Named and Designated Professionals to enhance the competencies of GP Safeguarding Leads and other general practice staff in accordance with the Royal Colleges' Intercollegiate Guidance; • Evaluating the 'Child Protection Report Writer' pilot and consider extension of the role to cover the city; • Working with strategic safeguarding partners to continually improve information sharing with GPs; • Providing strategic leadership to develop a hub and spoke model which provides resources that enable centralised support to review policies, improve training and support ongoing quality improvement initiatives; • Ensure key staff have access to robust safeguarding supervision from the CCG Designated Professionals.

4.2.4 Objective 4 Supporting better health through prevention and increasing patients' capacity for self-care

Delivery against this objective is a key priority not only of this strategy but is a key focus of the LTP which will be supported via the implementation of the following initiatives:

Our commitment	How will we achieve this?
We will work with the Local Authority and Community Voluntary Sector to support the development of self-care models.	• Applying for and utilising Voluntary Sector Grant Funding to develop initiatives within PCNs; • Working with ATB colleagues and Local Authority to develop the social prescriber model with a view to promoting access to prevention and self-care programmes and services across the city.
We will continue to progress with and implement digital technologies to support self-care for patients.	• Continuing to develop the content of our digital platforms to align to the national 111 on-line guidance and the forthcoming NHS App. • Continuing to progress with our investment made through the NHS Technology Tariff and will increase the use of the MyCOPD app as part of annual reviews; will further explore similar capabilities that support other long term conditions. • Working with the ICS digital community to develop a strategy for the application of the Health Call[16] platform within the ATB model. • Supporting our Local Authority partners in the mobilisation of their National Test Bed project to develop the Assistive Technology Strategy

[16] https://www.healthcall.com/

	which will see connected 'Internet of Things (IoT)' devices piloted within 120 homes across to support health and care needs initially focusing on: • Moving around the home; • Nutrition and hydration; • Monitoring mood; • Managing medication use.
We will strengthen mental health prevention to address factors that shape mental and physical health and wellbeing of patients.	• Enabling local integrated care teams to draw on and incorporate mental health expertise to support people with low level to complex care needs; • Working with mental health providers and the ATB to increase the visibility and availability of mental health services.
We will continue to support the prevention agenda via local schemes.	• Support the delivery of national and local programmes such as screening, smoking dependency, and achieving a healthy weight; • Explore better use of Making Every Contact Count specifically in respect of supporting brief interventions relating to smoking and alcohol; • Raising awareness of the harms of smoking in pregnancy with patients and supporting midwifery teams to reduce levels of smoking in pregnant women in Sunderland; • Support the delivery of a healthier environment within primary care for patients and for those working in primary care; • Ensuring our Quality Premium continues to include indicators relating to the early diagnosis and treatment for identified clinical conditions.

4.2.5 Objective 5 Encouraging new working arrangements between practices

We have continually supported new working arrangements between practices and the development of locality working; the emerging PCNs will ensure that these working arrangements continue and improve. A key focus for the CCG and ATB is to ensure our PCNs are supported. We will therefore support our PCNs to go further, faster and encourage innovative approaches which will ensure services provided are of high quality, high performance and are sustainable.

To support delivery of this objective we will implement the following initiatives:

Our commitment	How will we achieve this?
We will provide support to our PCNs to ensure delivery of the	• Providing business intelligence support to analyse and monitor data for use by the PCN;

seven national specifications introduced by NHS England.	• Providing CCG Locality Commissioning Manager links to the PCN; • Supporting the attendance of practices via dedicated time to attend specified PCN meetings.
We will support PCNs to maximise funding opportunities.	• Alignment of a CCG Finance Manager to advise PCNs of availability of funding streams; • Development of an annual 'Network Plus' agreement to support additional services and innovation; • Supporting our PCNs to ensure optimum access to the Investment and Impact Fund.
We will ascertain, in line with Objective 2, the general practice and wider health care estate needed to support further collaboration via PCNs.	• This will be achieved by the priorities identified under objective 2.
We will continue to support practices who wish to merge or introduce new working arrangements.	• Policy and contractual advice; • Locality Commissioning Manager support to oversee the process; • Funding support for HR, legal and communications advice.
We will continue to invest in our practices to sustain funding and reduce bureaucracy.	• Continuing to develop and implement the Quality Premium on an annual basis, ensuring it links with our CCG and ATB priorities; • Liaising with NHS England to identify funding and mechanisms for applying and developing bids with and on behalf of practices; • Working with practices to develop 'off the shelf' schemes that can be utilised to access non-recurrent slippage monies at short notice; • Providing funding support to our practices in NHS Property Services buildings.
We will continue to develop a pipeline of general practice investment opportunities that could attract local and/or national funding and also be delivered at a regional level.	• Developing the Clinical Digital Resource Collaborative (CDRC) which will develop tools to support standardisation of data capture and coding to enable information to flow easily for direct patient care and also to be aggregated for population health management; • Refresh the technical infrastructure supporting the delivery of GPIT services; • Migration to the national Health and Social Care Network (HSCN) which will deliver additional resilience, improved capacity and support for practices;

	• Starting the process of digitising Lloyd George paper records within general practice.

We will implement initiatives that support the interface between primary, community and secondary care.	• Implementing plans to widen the scope of our existing information sharing capabilities;
	• Increasing the range of services using the functionality to share information between general practice and our community provider;
	• Continue to work with colleagues throughout the region as part of the development of the Great North Care Record (GNCR);
	• Supporting Local Authority partners with the requirements of connectivity to NHS infrastructure and preparation for connectivity to the HIE to support;
	  • Outpatients remodelling;
	  • Non-value-added diagnostics and tests.

Section 5 Implementation

This section provides details of the implementation of the revised strategy, including the funding available and the governance arrangements in place to support its implementation.

5.1 Governance

In line with our delegated responsibility for the commissioning of general practice services, our established Primary Care Commissioning Committee, which reports directly into our Governing Body, will maintain the responsibility for overseeing the implementation of this revised strategy. Six-monthly updates on the implementation of the actions identified in section 4 will be provided to the committee and will be subject to internal audit in line with our audit cycle.

5.2 Funding

NHS England has now published primary care allocations for the five year period from 2019/20 to 2023/24 with the first three financial years being firm allocations and the subsequent two financial years being indicative at this stage. The announced allocations for this period are outlined in figure 18.

Figure 18

	2019/20 (£000s)	2020/21 (£000s)	2021/22 (£000s)	2022/23 (£000's)	2023/24 (£000's)
Delegated GP Allocation	42,058	43,805	45,675	47,742	50,053

The growth in primary care allocations is required to fund inflation pressures such as increases in global sum payments and premises reimbursements to practices as well as elements of contractual investments required into primary care networks such as workforce reimbursements.

In addition to the primary care allocations for the five year period, we will continue to separately receive and invest funding in relation to extended access (£6 per head) services which will support the improvements in patient access outlined within the strategy. We will also continue to ring fence the funding currently invested in the Quality Premium from our programme allocations for general practice.

We will explore the appropriate investments which could be made from our programme funding or drawdown funding to form an offer which could be made to primary care networks to assist increasing capacity in general practice and the management of demand pressures within the health and care system.

5.3 Operational Delivery

To implement the previous strategy the Primary Care Commissioning Committee established the GP Strategy Implementation Group and a Workforce Steering Group.

These groups will continue to oversee the implementation of our key priorities. However, the role of both groups will be reviewed to determine how they link with ATB Programme 1 - General Practice Group, which, in time is expected to be the group to oversee the implementation of this revised strategy.

Appendix 1 – Objectives and Priorities Delivered to Date

To support delivery of the last strategy key priorities were developed for the years 2016/17, 2017/18 and 2018/19; these priorities were aligned to the objectives – delivery of the key initiatives that have been implemented are as follows:

Objective 1 Supporting general practice to increase capacity and build the workforce

GP Career Start

This scheme attracts newly qualified GPs to general practice, giving them the opportunity to work in a practice for two years which not only gives them valuable experience as a GP but also allows them to spend two sessions per week on a specialised area of their choice. Our experience shows that Career Start GPs are more likely to stay in the city when they finish their 2 year programme. Since April 2015 we have had 19 GPs on this scheme (8 of whom are still on the scheme) with an 80% retention rate in the city.

Practice Nurse and Health Care Assistant Career Start

Practice nursing is very similar to GP recruitment and there is an identified need for more nurses in general practice. Equally, skilled Practice Nurse time can be freed up when supported by Healthcare Assistants undertaking particular tasks. To enable this, we have commissioned two programmes; a Career Start Practice Nurse Programme which enables trained nurses to consider a career in practice nursing, giving them experience in general practice and access to specialist training; and the second is the Career Start Healthcare Assistant Programme, designed to attract candidates into healthcare who may have little or no experience. The programme provides candidates with academic and general practice training which enables them to become Healthcare Assistants and/or access nurse training. To date 14 nurses and 11 Healthcare Assistants have been recruited via these schemes. We have also been a key partner in the development of the Nursing School within the University of Sunderland; this has given us the opportunity to support placements in general practice for pre-registration students, as well as mentorship for students, which ultimately provides student nurses with an insight into general practice with the aim that this may be a career pathway. Alongside this we have supported Practice Nurses to attend clinical skills training at university and supported them to become Advanced Nurse Practitioners.

Golden Hello Scheme

This is a recruitment and retention scheme which incentivises GPs to come and work in Sunderland, including those who may have been Career Start GPs. GPs must stay for a minimum of 3 years and are incentivised with a £20k pro rata payment. To date we have had 34 GPs on this scheme since 2017.

GP Trainers Bursary

This is a financial incentive to support GPs wishing to become GP Trainers. In the longer term this will encourage newly qualified GPs to stay in Sunderland as they are often

attracted to training practices where they can get extra support. We currently have 18 GP Trainers and 6 GP Educators and have 13 training practices.

Non-Clinical Workforce Schemes

As well as the clinical workforce schemes developed we have also implemented specific elements of the GP Forward View to increase capacity in general practice and we have also implemented the following schemes for administration staff and Practice Managers:

Administration Staff

- Awareness sessions on working with patients who may need more support i.e. patients who are sensory impaired, and what services are available locally to signpost patients to;
- Managing pressure at work and quality improvement activity which included what is looked for in a CQC inspection e.g. clinical audit.

Practice Managers

We have supported Practice Managers to undertake the North East Leadership Academy Practice Management Leadership Programme.

30 Practice Managers have also attended a development day, giving managers the opportunity to network and share ideas both in localities and in city wide groups. The session included:

- Stress, personal resilience and five ways to wellbeing;
- New roles and apprenticeship training programmes in general practice;
- Collaborative working in localities.

Deputy Manager/Office Managers/Team Leaders also attended a series of workshops which included:

- Delivering service excellence;
- HR – the basics;
- Promoting quality and handling complaints.

We have also been involved in the development of the new Medical School at the University of Sunderland with our Chair being a member of the Partnership Board set up to establish and mobilise the school – the school is GP focused and, by being so it is hoped it will not only attract trainers and educators to the city but will also attract medical students who will want to stay within the city as GPs in the longer term.

The GPFV also highlighted a number of programmes to boost the workforce, of which many have been implemented as follows:

GP Retention Scheme

The GP Retention Scheme provides financial and educational support to GPs and practices to help retain GPs who are seriously considering leaving, or have left, general practice. The scheme provides funding for the GP for up to four clinical sessions per week for a period of up to five years.

NHS Sunderland CCG does not have any GPs on the GP Retention Scheme; however the CCG has implemented a number of initiatives to increase and retain GPs in the area.

International Recruitment

Sunderland is part of the North East and Cumbria-wide scheme designed to source qualified GPs from abroad to work in England. There is a robust process to recruit and support the GPs so that they are able to work within the NHS, including 3 months where they observe general practice locally in a host practice, as well as a period of induction and refresher training in a host practice before they undertake any direct patient activity. At least four local practices have expressed an interest in being a host, however the scheme has not proven to be as successful as hoped and there are currently only two international recruits in the North East and Cumbria, none of which are in Sunderland.

Clinical Pharmacist in General Practice Programme

This programme was initially a pilot which was first introduced in 2015 as a means to secure 250 clinical pharmacists to work in general practice throughout England, with the expectation that the programme would support those practices in areas of greatest need due to the high number of GP vacancies. It was recognised that the Clinical Pharmacist has a role in streamlining practice prescription processes, medicines optimisation, minor ailments and long term conditions management and has a key part to play within general practice.

The evaluation of the pilot, undertaken nationally, led to further investment committed within the GPFV of an additional £112 million to secure 1,500 pharmacists working in general practice.

NHS Sunderland CCG managed to secure 6 Clinical Pharmacists as part of the initial pilot scheme.

Objective 2 Improving patient access

Extended and Improved Access

The GPFV first introduced the Extended Access initiative which is designed to provide improved access to GP services. The initiative also forms part of the NHS Operational Planning and Contracting Guidance 2017-19[17] and the Refreshed Planning Guidance

[17] https://www.england.nhs.uk/operational-planning-and-contracting/

published in February 2018[18]. CCGs across England have the responsibility of commissioning an Extended Access service which has specific key requirements as follows:

- Commission pre-bookable and same day appointments for general practice services after 18:30 and until 20:00 Monday to Friday; these appointments should be a mix of nursing and GP appointments;
- Commission pre-bookable and same day nurse/GP appointments on both Saturdays and Sundays to meet local population needs;
- Number of appointments to commission equate to 30 minutes of consultation time per 1000 population (weighted[19]).

We commissioned this service in 2016 and it is currently being delivered by Sunderland GP Alliance, utilising the current general practice workforce. The service delivers GP and Nurse Practitioner urgent and pre-bookable appointments on weekday evenings and on weekends from five hubs within the City. Appointments can be booked via the GP practice reception or by calling 111. Utilisation rates vary across the localities with an average of 78%.

In terms of general access to GP services, at the time the original strategy was produced, 73% of patients surveyed via the national GP patient survey stated that their experience of making an appointment was 'good' and 86% of patients described their experience of their GP practice was 'good' or 'very good'. The latest GP patient survey shows that there has been a slight deterioration in the results compared to 2016 despite the many initiatives that have been implemented to improve patient access. Sunderland is still however above the national average for these results. Figure 19 highlights the results of the key questions from the GP patient survey.[20]

Figure 19

	Q - Generally, how easy is it to get through to someone at your GP Practice on the phone? A - Easy or Very Easy	Q - Overall, how would you describe your experience of making an appointment? A - Good or Very Good	Q - How satisfied are you with the General Practice appointment times that are available to you? A – Satisfied or Very Satisfied	Q - Overall, how would you describe your experience of your GP Practice? – A – Good or Very Good
Sunderland Average 2018*	77%	70%	68%	85%
National Average 2018*	70%	69%	66%	84%
Sunderland Average 2016**	76%	73%	No comparable data	86%

*last published data Jan to March 2018 **Published July 2016

[18] https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

[19] Weighted population is where a weighting factor is applied to the actual number of patients registered at a practice. The weighting factor takes into account rurality, patients in a care home, age and deprivation factors and practice funding for core services is based on weighted population – the weighting factor is designed to support practices financially for the additional workload required by specific population groups

[20] National GP Patient Survey https://www.england.nhs.uk/statistics/statistical-work-areas/gp-patient-survey/

A different mechanism for measuring how satisfied a patient is with their practice is the Friends and Family Test (FFT) which asks patients if they would recommend their practice to their friends and family. 91.3% of patients in Sunderland who participate in the FFT are reporting that they would recommend their GP practice to a friend or family member, indicating that patients are satisfied overall with the service they are receiving from their GP practice.[21]

One of the initiatives introduced via the GPFV is to redesign appointment systems in order to reduce the number of patients not attending for their booked appointment (DNAs). Reducing DNAs help to improve access for those patients who have not been able to get an appointment at a convenient time. We have implemented bi-directional text messaging to remind patients of their appointments and have introduced advanced telephony in 31 of our 40 practices to make it easier for patients to cancel appointments.

We have also implemented 'active signposting' which provides patients with a first point of contact within general practice who can direct them to the most appropriate source of help; called Care Navigators, they utilise web and app-based portals to provide self-help and management resources, as well as signposting patients to the most appropriate professional. In Sunderland we have 19 practices with staff trained in active signposting and 15 practices that have implemented the e-consult system which gives patients self-help and self-management resources.

Premises

We have supported our practices to submit bids to NHS England for improvement grants to improve their premises as well as bids against the Estates and Technology Transformation Fund (ETTF). The ETTF is a multi-million pound fund designed to invest in modernising and transforming premises and technology within general practice to improve services for patients.

In total, eight practices have been successful in obtaining funding 2016 and 2019 equating to £136,014.

IT and Digital

We have implemented many digital schemes to support patient access as part of the GPFV and other initiatives as follows:

- The migration of practices onto EMIS Web as the primary GP clinical system in use across the city;
- We have invested heavily to support the digitising of Lloyd George paper records to deliver a more efficient retrieval process for clinicians and support administrative processes for subject access requests; furthermore capacity within practice may be increased through the release of estate as storage and possible conversion into clinical rooms;

[21] Business Intelligence Analysis of Friends and Family Data April 2019

- EMIS to EMIS record sharing enabled between general practice and community services across all practices;
- Widescreen monitors deployed across all practices to support the use of decision support tools (Map of Medicine);
- Patient Wi-Fi / Guest Wi-Fi deployed across all practices ahead of the national deployment also enabling social care access;
- Docman advanced workflow deployed to 36 practices (later removed after Docman 10 upgrade leaving 7 practices);
- The Medical Interoperability Gateway (MIG) deployed across all practices along with a specialised EPaCCS dataset;
- EMIS data sharing extended to cover GP Extended Access Service
- EMIS Anywhere devices deployed to all practices enabling remote access to clinical systems and supporting business continuity
- Refreshing of all label printers supporting electronic ordering and specimen management across all practices underway
- Integrated Devices - All practices in Sunderland have access to a set of integrated clinical devices (BP machine, ECG and Spirometry) that integrate into the clinical system.
- Infrastructure for video consultations - This project looked at ensuring that the infrastructure was in place to allow practices to carry out video consultations. All 40 GP practices have screens in clinical rooms with integrated web cameras and headsets to allow video consultations to take place. The five practices that are part of the new consultation types work stream are currently testing out the software required for video consultations;
- New Consultation Types – this introduces new communication methods that can be utilised for consultations, such as telephone consultation and e-consultation. We currently have five practices that are testing new software to allow video consultations. Using funding from the GPFV we have also led a regional procurement exercise to secure a provider of online consultations. 'E-consult' were procured to deliver this service and, to date, there are 15 practices in Sunderland live with the service; in quarter 4 of 2018/19 there were 1575 unique visits to the software generating 345 e-consults for the practices; a third of these consultations were looking for administrative support.

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

We have made a firm commitment to support the integration of services and GP leadership in the out-of-hospital system as part of our ATB programme. After extensive consultation, a set of design principles were developed for ATB.

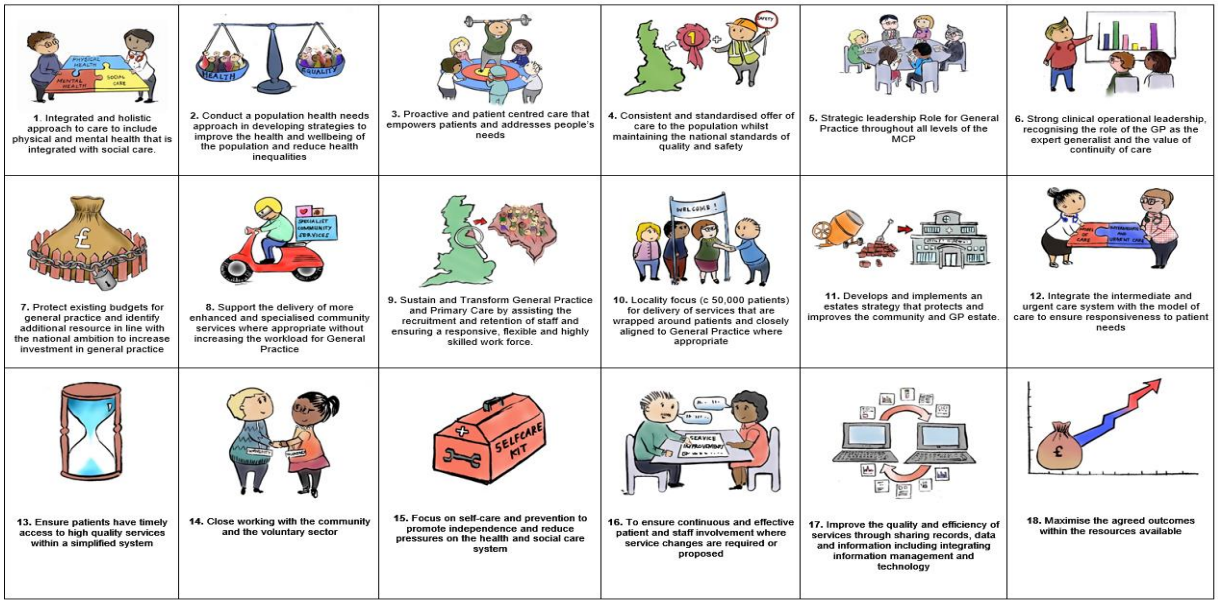
To ensure strong GP leadership and to maintain a central role for general practice in the delivery of community services the following design principles have been agreed:

- Strategic leadership role for general practice throughout all levels of the MCP;

- Strong clinical operational leadership, recognising the role of the GP as the expert generalist and the value of continuity of care;
- Protect existing budgets for general practice and identify additional resource in line with the national ambition to increase investment in general practice;
- Sustain and transform general practice and primary care by assisting the recruitment and retention of staff and ensuring a responsive, flexible and highly skilled work force;
- Locality focus (c 50,000 patients) for delivery of services that are wrapped around patients and closely aligned to general practice where appropriate
- Develops and implements an estates strategy that protects and improves the community and GP estate.

These design principles were co-developed with practices and wider stakeholders in 2017 and are the guiding principles for the development of ATB and future integrated care providers. Those design principles are increasingly relevant with the emergence of Primary Care Networks which are expected to have a locality focus (c50,000 patients) with strong GP and clinical leadership, and investment in workforce and premises. The full design principles are depicted in figure 20.

Figure 20



As part of our integration agenda we have implemented the following initiatives to support the delivery of our objective to ensure general practice has a co-ordinating role in out-of-hospital care:

Community Integrated Teams

In 2015 we developed Community Integrated Teams (CIT) as part of our extensive design and planning phase of the vanguard programme; this reflected the strong requirement for better integrated care from general practice. CIT enables a more

collaborative way of working, bringing together multidisciplinary teams (MDT) to manage complex, frail and vulnerable patients in a proactive and patient centred way.

As a result of this programme, community staff such as District Nursing, Community Matrons and Social Workers are now co-located in each locality to enable better working relationships. This also allows further understanding and sharing of roles of responsibilities. New roles such as MDT Co-ordinators, Living Well Link Workers and Carers Centre Locality Leads have been developed and attend weekly MDT meetings and support the teams in managing people's needs.

Multidisciplinary meetings are held in and led by each practice to review risk stratified patients to improve outcomes and experiences with a focus on prevention and supporting people to managed at home or closer to home with the aim of reducing admissions and Emergency Department attendances. General practice takes a lead role in these meetings.

Feedback from staff and patients has been overwhelmingly positive regarding the approach and the new way of working. CIT are co-terminous with the CCG and Local Authority localities and are the platform on which Primary Care Networks have been developed.

Care Home Alignment and Older People Nursing Support

Funding has been allocated to practices to enable the streamlining and alignment of care homes to practices and the advanced care planning initiative.

We have also increased the specialised Nursing support into the care homes by commissioning the Older People Care Home Nursing Team who support the care home MDT and delivery of clinical services. This has impacted significantly on both patient outcomes and GP experience of delivery of care by increasing efficiency as a result of the reduction in multiple care homes to visit.

We have also implemented the Medicines Optimisation in Care Homes scheme as part of the Pharmacy Integration Fund which involves pharmacists and pharmacy technicians working with their health and social care colleagues and care homes staff, patients and their families to provide a number of benefits for care homes and their residents.

Recovery at Home

The Sunderland Recovery at Home Service is a multi-disciplinary integrated 24/7 rapid response service to address an individual's immediate needs, to be patient centred, advocate proactive care management and ensure patients can be cared for at home until proven otherwise. It promotes minimal clinical handovers, so that patients deal with as few faces as possible and, fundamentally it is a hospital discharge and re-admission prevention service focused on maximising peoples' independence and recovery. The service now includes 24/7 GP support, allowing further enhancement and sustainability of the service.

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

There are many initiatives that we have implemented to ensure patients are given the opportunity to increase their capacity to self-manage their clinical conditions. In Sunderland, we support the Sunderland Information Point[22] and Wellbeinginfo.org[23] both of which include a plethora of information for patients and carers to utilise. We also continue to promote the childhood app[24] for use by parents and formed part of a Digital Roadshow held in Bridges, Galleries and Hetton Centre.

As part of the vanguard programme we promoted the use of a tool called Patient Activation Measure (PAM)[25]. The Patient Activation Measure (PAM) is a validated, commercially licensed tool and has been extensively tested with reviewed findings from a large number of studies. It helps to measure the spectrum of skills, knowledge and confidence in patients and captures the extent to which people feel engaged and confident in taking care of their condition.

In terms of other initiatives we have implemented, patients with Diabetes have benefitted from the implementation of the following:

- DESMOND[26] – this is a structured education programme specifically for Diabetics. We have worked with our practices and community services to promote and encourage uptake. We also have trained some Practice Nurses to deliver DESMOND, and have a further cohort due to begin their educator training in June 2019, with the aim of increasing patient choice and access;
- HeLP Diabetes[27] - this has been implemented across all practices in Sunderland and we are currently working with the Implementation Advisory Group to share our learning, with a view to becoming an early adopter site for the new tool once ready;
- Diabetes UK Information Prescriptions[28] – this has been implemented across all of our practices. Implementation was supported by individual practice visits to ensure prescriptions are available live in EMIS. All practices now have food models to enhance discussions around diet with patients during consultations;
- National Diabetes Prevention Programme[29] – to date there have been 990 referrals made into the programme. We have worked with our practices to embed the referral process as part of practice processes for future patients meeting the criteria.

We have supported practices to empower patients to self-care by providing patient information and commissioning a campaign on self-management of minor and self-

[22] https://www.sunderlandinformationpoint.co.uk/kb5/sunderland/directory/home.page
[23] https://wellbeinginfo.org/
[24] https://www.sunderlandccg.nhs.uk/campaigns/childhood-illnesses-app/
[25] https://www.england.nhs.uk/ourwork/patient-participation/self-care/patient-activation/pa-faqs/#11
[26] https://www.desmond-project.org.uk/
[27] https://www.help-diabetes.org.uk/
[28] https://www.diabetes.org.uk/Guide-to-diabetes/Managing-your-diabetes/information-prescriptions
[29] https://www.england.nhs.uk/diabetes/diabetes-prevention/

limiting illnesses. We have worked with practices and Community Pharmacy to move all patients capable of doing so, to self-manage the ordering of their own prescriptions. This not only supports improved patient engagement with their medicines but also reduces medicines waste and free-up valuable time within the practice.

We have supported practices with the rolling out MyCOPD[30], a self-care system for patients with COPD. Currently 20 practices have active patients. We also extended the use of the platform to include a small group of heart patients. Five practices have 11 patients using this for a variety of heart conditions.

Further self-care is being supported with the roll out of help sheets obtained from a number of recognised websites. The practices are also able to promote public health apps including change4health[31].

We have implemented Step2Health, which is a self-care and rehabilitation service aiming to enable those people at high risk, and who are diagnosed with long term conditions, to live better quality, independent and healthier lives for longer. It also is designed to reduce the preventable dependency and demand on public sector services amongst people living with long term conditions. The programme provides the following elements:

- A single route into a menu based service;
- Triage of all referrals to determine the most appropriate route for the patient, right care, right time, right place, first time;
- Assessment through guided conversations, goal setting and action planning to work with the patient to develop a tailored programme menu to support achievement of goals;
- A menu of interventions to include education, disease self-management, physical exercise with opportunities to sustain active lifestyle;
- Behavioural management to support ongoing engagement, anxiety and mood management, with a focus on the importance of social integration;
- Social navigation to a broad range of community resources and support in line with the pathways developed by the service;
- Robust exit strategies to ensure flow through the service.

Objective 5 Encouraging new working arrangements between practices

To support the delivery of this objective, the CCG has dedicated recurrent funding to support practices who wish to merge; the funding is also utilised to support practices to register patients when a neighbouring practice closes. The CCG follows recently-developed NHS England local policies to manage mergers and contract termination but provides additional support via the Locality Commissioning Manager, NECS' Communications and Engagement Team and NECS' IT team to manage a safe transition for practices and patients. We also have a local Sunderland policy to provide specific support to practices that see a significant increase in patients when a nearby practice

[30] https://www.nhs.uk/apps-library/mycopd/
[31] https://www.nhs.uk/change4life/about-change4life

closes. Since 2016 we have managed seven practices to merge, 2 APMS contract procurements and 2 contract terminations.

We have also developed a 'Localities Working Together' programme, with Locality Practice Managers and Locality Practice Nurses working collaboratively with us to support new initiatives and act as a key link back into practices.

Other Initiatives and Support

Quality and Performance

The CCG has responsibility, as a delegated commissioner of general practice services, for quality assurance; to hold GP practices (as indeed all providers) to account for delivery of contractual obligations and quality standards. As a strategic commissioner we also take responsibility for working closely with and supporting GP practices to ensure service delivery continually improves and that they have in place processes to drive this continual improvement, including the adoption and sharing of innovation[32].

We work closely with NHS England and the Care Quality Commission (CQC) to be assured that the quality of our general practice services continue to improve and, to oversee practices we have a Local Quality in Primary Care Group which utilises a Primary Care Quality Dashboard to identify practices that may need support or guidance. The group is accountable to the Primary Care Commissioning Committee which has responsibility for the commissioning of general practice services.

The dashboard, developed over the last two years, contains key contractual and statutory compliance data about each practice; this way we can gain a holistic picture about current performance. However, data is only one part of the picture. We also consider softer intelligence gained through engagement with our practices to determine if there are any circumstances which explain highlighted performance, such as staff shortages or specific demographic explanations.

We also provide specific support to our practices following unfavourable CQC inspections and have supported all of our practices rated as 'Inadequate' to be taken out of special measures with the CQC – furthermore we have held specific training events with practices to assist them in the requirements and expectations of the CQC, which has proven successful in reducing the number of practices requiring additional support. We now have one practice that is rated 'Outstanding', 38 practices that are rated as 'Good' and one practice that is rated as 'Requires Improvement'.

Resilience

The GP Resilience Programme was amongst the first programmes implemented by NHS England in 2016/17 as part of the GPFV; it was designed to support practices to be more resilient thereby ensuring sustainability. The programme, which is still ongoing, invites practices to bid for funding to allow them to access from a menu of support; this menu ranges from helping to stabilise practices at risk of closure through to more

[32] NHS Sunderland CCG's Quality Strategy 2018-2021

transformational support, including, if appropriate, helping practices to explore new models of care, including:

- Diagnostic services to quickly identify areas for improvement support;
- Specialist advice and guidance e.g. human resources, IT;
- Coaching/supervision/mentorship;
- Practice Management capacity support;
- Rapid intervention and management support for practices at risk of closure;
- Co-ordinated support to help practices struggling with workforce issues;
- Change management and improvement support to individual practices or group of practices.

Within Sunderland we have had three practices in 2016/17, two practices and a city-wide bid in 2017/18 and three practices in 2018/19 that have successfully requested and been granted support since the programme's commencement.

To provide further support, we implemented a local resilience fund to support those practices that were not successful in obtaining funds via the national programme; this has resulted in further investment in 13 practices since the local fund was introduced in 2017/18.

Productive Workflows

This initiative was introduced as part of the GPFV and introduces new ways of working to enable staff to work more effectively, including document management systems. We have implemented patient check-in screens in all 40 practices which allow patients to check in when they attend the GP practice; it can also collect information to support friends and family test (FFT) responses and Quality and Outcomes Framework indicators (QOF). Sunderland has also implemented GPTeamnet across all 40 practices which allows practices to share information both within their practice and across both localities and the CCG as a whole.

There are also five practices in Sunderland which have access to Surgery Pods; these allow patients to take height, weight and BP in the waiting area and the information feeds back into the clinical system.

We have implemented a Correspondence Management initiative within 31 practices which aims to reduce the volume of paperwork dealt with directly by GPs by ensuring actions from incoming correspondence are dealt with by the most appropriate person in the practice. This is facilitated by providing funding for additional training for clerical staff, and relevant protocols, in order for them to support GPs in clinical administration tasks. All incoming correspondence about patients from hospitals is processed by a member of the clerical team by following protocols developed in-house and refined through continuous improvement.

The Quality Premium

We first introduced the Quality Premium (QP) in 2017/18 as a result of merging the funding realised from the PMS review[33], Directed Enhanced Services[34] and Local Enhanced Services/Incentive Schemes[35]. The funding was utilised to develop one scheme to incorporate key indicators that could be delivered in general practice with the aim that it increased capacity and saved some practice staff time as well as giving certainty to what had been historically annual funding and contracts. This thereby reduced bureaucracy associated with claiming different sources of funding, whilst also rewarding practices for achieving key clinical priorities. The QP is split into 3 areas:

- 70% indicators - these are indicators that are a 'must-do' for participating in the scheme and are not performance monitored;
- 30% indicators - these are indicators which are monitored and funding is based on performance against key targets;
- QP+ - these are areas that are activity based.

The scheme utilises recurrent funding and is assessed on an annual basis to determine which indicators are to be included, amended or resigned. All practices signed up to participate in the QP in 2017/18 and in 2018/19.

Medicines Optimisation – Support for Practices

Since 2015, practices have realised the benefit of a CCG-based Medicines Optimisation Team whose aim it has been to improve patient care and safety and improve the cost effective use of medicines in Sunderland.

We have worked with stakeholders across the Sunderland health care economy to develop a joint formulary of medicines and therapeutic guidelines for use across primary and secondary care, with the aim of standardising treatment and reducing variation. We have also implemented a safety review and taken actions to ensure shared care drug monitoring is adequate. We have committed to reviewing and implementing a safer system of managing shared care drugs going forward. We are currently working with partners in NHS South Tyneside CCG to develop a formulary and harmonise guidelines across both CCGs.

The formulary is published on a website and implemented primarily through OptimiseRx[36] which delivers messages to prescribers at the point of prescribing. It will also be populated within EMISweb. Formulary compliance is monitored and practices receive reports to support safe and cost-effective prescribing.

Treatment guidelines that have been developed to date include Type II Diabetes, Asthma and COPD, Atrial Fibrillation and Headache. Cost-effective prescribing guidelines for

[33] A review by NHS England of the contract and funding mechanism of ractices with PMS agreements
[34] Services commissioned by NHS England, over and above core contracted services which every Practice is eligible to deliver for extra funding
[35] Services commissioned by the CCG, over and above core contracted and Directed Enhanced Services which every Practice in Sunderland is eligible to deliver for extra funding
[36] https://medicines.necsu.nhs.uk/optimise-rx-support-information/

emollients, treatment of dry eyes and stoma appliances and accessories have also been developed.

A key priority over the last four years has been to improve antimicrobial stewardship within Sunderland. Through a range of measures, we have supported Sunderland prescribers to reduce inappropriate antibiotic prescribing and have achieved significant reductions with around 28,000 fewer prescriptions for antibiotics written in the twelve months to Feb 2019, than in the twelve months to Feb 15. These measures include:

- The development and promotion of antimicrobial prescribing guidelines;
- Provision of self-care and safety netting materials;
- The commissioning of campaigns to promote behaviour change in patients
- Providing access to funded point of care C-Reactive Protein testing for upper respiratory tract infections.

During the same period the percentage of higher risk broad spectrum antibiotics has also reduced from 10.6% to 9.2%. This led to the achievement of the National Antibiotic Guardian Award in 2018 for the work on point of care testing.

We also commission Medicines Optimisation Support Teams to ensure practices are supported to implement medicines optimisation initiatives. In addition to Practice support, medicines optimisation support to care homes has also been commissioned; this is an initiative which is now being rolled out by NHS England. The service provides holistic medication reviews to complex patients in care homes and also those patients who are identified as being vulnerable housebound patients.

We commission a number of other specialists to support medicines optimisation in general practice. This includes a Community Diabetes Nurse to review and optimise treatment of patients with Type II Diabetes, a Care Home Dietitian service to improve nutrition and quality of life for patients in care homes and a Community Stoma Review service.

To reduce unnecessary waste and ease pressure in general practice associated with the prescribing of wound dressings, we have worked with our tissue viability colleagues in community services to introduce on-line ordering. We will investigate this method for obtaining other non-drug items that are traditionally supplied on prescription over the coming months.

We have implemented a wide range of additional productivity initiatives to ensure best value for money for the NHS, providing support for practices via the Practice Pharmacist teams and encouraging engagement by offering practices a share of efficiency savings to reinvest in patient care. In the last financial year, prescribing costs were £3 million less than in 2015.

We engage with practices through regular prescribing reports, allowing benchmarking and monitoring of progress and we have recently started to offer practice visits to discuss

prescribing. We also produce a monthly newsletter, ‘Medicines Safety Net’, to highlight new guidelines, evidence and patient safety issues.

Appendix 2 - List of Key Stakeholders

All GP practices in Sunderland
CCG personnel
Sunderland Local Medical Committee
All Together Better Executive
Sunderland City Council
South Tyneside and Sunderland NHS Foundation Trust
Sunderland GP Alliance

Appendix 3 - Key to practices

Marker	Name
1	DEERNESS PARK MEDICAL GROUP
2	DR BHATE SURGERY
3	HETTON GROUP PRACTICE
4	VILLETTE SURGERY
5	WEARSIDE MEDICAL PRACTICE - PALLION
6	PALLION FAMILY PRACTICE
7	RED HOUSE MEDICAL CENTRE
8	HERRINGTON MEDICAL CENTRE
9	DR STEPHENSON & PARTNERS
10	JOSHI NA
11	GALLERIES MEDICAL PRACTICE
12	THE NEW CITY MEDICAL GROUP
13	FULWELL MEDICAL CENTRE,
14	ST BEDE MEDICAL CENTRE
15	MILLFIELD MEDICAL GROUP
16	ASHBURN MEDICAL CENTRE
17	BRIDGE VIEW MEDICAL GROUP
18	THE OLD FORGE SURGERY
19	KEPIER MEDICAL PRACTICE
20	CONCORD MEDICAL PRACTICE
21	HOUGHTON MEDICAL GROUP,
22	THE BROADWAY MEDICAL PRACTICE
23	SUNDERLAND GP ALLIANCE MEDICAL PRACTICE
24	NEW WASHINGTON MEDICAL GROUP
25	SPRINGWELL MEDICAL GROUP
26	GRANGEWOOD SURGERY
27	WESTBOURNE MEDICAL GROUP
28	HYLTON MEDICAL GROUP
29	NEW SILKSWORTH MEDICAL PRACTICE
30	PARK LANE PRACTICE
31	SOUTHLANDS MEDICAL GROUP
32	CASTLETOWN MEDICAL CENTRE
33	MONKWEARMOUTH HEALTH CENTRE
34	HAPPY HOUSE SURGERY
35	DR. R. OBONNA
36	DR WEATHERHEAD & ASSOCIATES
37	SOUTH HYLTON SURGERY
38	RICKLETON MEDICAL CENTRE
39	I J HEALTHCARE
40	CHESTER SURGERY

Appendix 4 – Feedback from practices

What do you like in the current strategy?

Key Themes	Specific Areas
Workforce	• Career Start Scheme • Clinical Pharmacists in practice • Golden Hello Scheme • Healthcare Assistant Scheme • Community Matron input into MDT • Nurse training • TITO training and development sessions
Ways of Working	• Community Integrated Teams • Multi-disciplinary teams • Integration • MCP/ATB way of working • Recovery at Home • Care home alignment • Extended access • Out-of-hospital care
IT/digital and estates infrastructure	• EMIS community • Data sharing • Health pathways
Contractual/financial arrangements	• Resilience funding • Quality Premium
Prevention and Self-care	• Self-care programmes • Age UK

What do you need to improve General Practice?

Key Themes	Specific Areas

Workforce	• Training of the workforce, including IT training
	• Training hubs
	• Training practices and GP Trainers
	• Workforce including diversity of skill mix
	  ○ Clinical pharmacists
	  ○ Health visitors
	  ○ Care co-ordinators in practice
	  ○ CPN/Mental Health Practitioners in practice
	  ○ Paramedics
	  ○ School nurses
	  ○ Safeguarding co-ordinators
	• Succession planning

Key Themes	Specific Areas
	• Practice development • Links with University of Sunderland • Workforce strategy • Retention of retiring GPs
Ways of Working	• Specialist hubs • Community services • Responsive support • Spirometry hub • Sharing staff in a hub setting • Collaboration between teams • Networks of staff
IT/digital and estates infrastructure	• Estates funding to be clarified • Resolution of NHSPS lease cost disputes • Faster and robust IT • Interoperability • IT sharing across secondary and primary care • Digitalisation
Contractual/financial arrangements	• Decrease costs of primary care • Winter pressures funding recurrently • Local Authority contracts to be improved
Prevention and Self-care	• Social prescribing • Focus on Prevention • Patient education • Improved self-care arrangements • Navigators to support benefits appeals • Health promotion services
Communication	• Consistent messages • Reduced bureaucracy • Improved relationships with primary care • Extended Access standard protocols • Secondary care protocols
Specific Clinical Areas	• Access to IAPT • Better Mental Health provision in community • Prescribing issues resolution • Pharmacy dispensing of hospital scripts • Treatment rooms • Working with Out of Hours • Care home reviews • Recovery at home prescribing • Cognitive Behaviour Therapy in schools • Shared care across boundaries • Allied Health Professionals to make referrals

Key Themes	Specific Areas
	• Support for complex care home patients

What do you need more / less of?

MORE	
Key Themes	**Specific Areas**

Workforce	• Training of the workforce, including IT training, contraception training and issue resolution training
	• Training hubs
	• Formal links to training
	• GP Trainers
	• Workforce including diversity of skill mix
	  ○ Nurses and Nurse Associates
	  ○ Clinical Pharmacists
	  ○ Mental Health Practitioners
	  ○ Paramedics
	  ○ Medical Assistants
	  ○ Consultant based in primary care
	• GP Choices
	• Support bank for all staff
	• Group appraisal

Ways of working	• Hub working and networks • Public health links • Social care input • Remote working for some staff • Capacity • Child protection reports centrally written
IT/digital and estates infrastructure	• Robust IT/local IT technician • Shared IT systems • GP Team net expansion • Estates strategy to be developed and implemented
Contractual/financial arrangements	• Recurrent investment rather than non-recurrent spend • Winter schemes to be recurrent to support increased demand
Prevention and Self-care	• Self-care programmes • Prevention programmes • Patient education

MORE	
Key Themes	**Specific Areas**
Communication	• Standard policies and templates • Advice and guidance/helpline • Communication and engagement • Improved correspondence from hospital • Newsletter • Clearer info about pilots/initiatives • 111 protocols
Specific Clinical Areas	• Mental health services • Treatment rooms • Extended access • Medication review • Over The Counter scheme • Opioid/CBT • Easier patient pathway
LESS	
	• Bureaucracy

What would you want the future to look like?

Key Themes	Specific Areas

Workforce	• More staff
	  ○ Health Visitors
	  ○ Personal trainers
	  ○ Nurses and Nurse Associates
	  ○ Clinical Pharmacists
	  ○ Mental Health Practitioners
	  ○ Paramedics
	  ○ Medical Assistants
	  ○ Consultant based in primary care
	• More time for staff to do tasks
	• Workforce strategy
	• More training practices
	• Training hubs and access to training
	• Collaboration with University of Sunderland
	• Career Start for GPs

Key Themes	Specific Areas
Ways of working	• Central hub to access support • Collaboration • Integration with the community • Links with Public Health and Social Workers • Pharmacist in care homes • Mental Health Hub / Practitioner • Shared resources i.e back office functions • Mobile workforce • Working across multiple sites • Health and social care complimenting each other • Sure start programme • Social prescribing drop in service • Young people's services • Safeguarding network
IT/digital and estates infrastructure	• Better and faster IT/interoperability • Better use of E-consult • Evaluation of Steps to Health • Data sharing • Central telephone triage • Patient records to be viewed • Localised apps • Use of IT • More room
Prevention and Self-care	• Self-care promotion and practitioners • Self-care in schools
Communication	• Manage patient expectation • Responsibility for information • Effective signposting
Specific Clinical Areas	• Minor Injuries Unit in Washington • Planning support for CQC inspections • Improved pathways • GP on the day/access • Appropriate transfer from secondary to primary care • 15 minute appointments • Appropriate 111 referrals • Self-referral service to physiotherapy • Mental health, alcohol and SMS patient treatment advice service

What do you think are the top 3 priorities?

Key Themes	Specific Areas

Workforce	• Training and education
	• Workforce
	  ○ Nurses and Nurse Associates
	  ○ Clinical Pharmacists
	  ○ Mental Health Practitioners
	  ○ Paramedics
	  ○ Medical Assistants/ PA
	  ○ Consultant based in primary care
	  ○ Social Prescribers
	  ○ Health Champions
	• Career Start GP and Practice Nurse Schemes

Ways of working	• Further Integration/Community Integrated Teams • Recovery at Home Roll Out and development • Improved links with public health • Community hub development • Self-referral to physiotherapy • Mental health links in practices • Improved Shared care arrangements/support • GP Practice not first port of call
IT/digital and estates infrastructure	• Estates • IT services • DOS for all services
Contractual/financial arrangements	• Out-of-hospital care to come with appropriate funding • Recurrent funding and less non-recurrent
Prevention and Self-care	• Self-care promotion and prevention • Self-care in schools
Communication	• Signposting for administrative staff
Specific Clinical Areas	• Improve existing services • Patient access • Social prescribing • Standardised policies to support with CQC