

Transforming Primary Care in Essex

The Heart of Patient Care

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NHS England

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Issue date: 20 June 2014. Version 2.0

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Executive Summary

1. Our Starting Point

Essex has over a thousand primary care practices, with GP services organised into seven Clinical Commissioning Groups. The four professions: general practice, pharmacy, dental and optometry are not integrated. The current model is not sustainable in the face of increasing life expectancy, a rise in long-term conditions, increasing availability of technology and rising patient expectations.

2. The National Perspective

The Essex strategy takes into account nationally agreed principles and ambitions. The *NHS Mandate*, the *NHS Outcomes Framework*, and *Everyone Counts: Planning for Patients 2014/15 to 2018/19* set out national criteria for primary care. NHS England has seven key ambitions and the NHS Constitution sets out what patients can expect from the NHS and the NHS for patients, while the GP Contract sets out requirements for General Practice.

3. What Primary Care is and what it should be

Although people often use 'Primary Care' to mean General Practice, the term includes dental practices, pharmacies and opticians. In our strategy, the primary care hub will bring these together alongside a rich diversity of other professionals.

4. The Patient Perspective

Patients regularly give us feedback on how services should operate, with integration and clarity of communication being key.

5. Why is Change Needed?

The situation is not sustainable because currently services are not integrated, no new money is available, and the General Practice workforce is already overloaded. Further, our premises are of variable quality and are not used to their full capacity, quality of interventions is variable and we are sometimes failing the most vulnerable. All this is set against a background of a rising population with increased long-term conditions.

6. Public Health Perspective

Primary care has an ongoing role to play in reducing the impact of major diseases in Essex, especially in stroke and heart attack, through promoting smoking cessation, and, raising awareness of early signs of cancer and screening, and on early diagnosis and treatment of COPD.

7. Morale of General Practice

The GP workforce must be supported through the period of transformation, as increasing pressures and rising expectations have left many without appetite for change.

8. Releasing the Potential

Integrating optometry, dentistry and pharmacy within General Practice hubs and engaging patients in their own health, alongside improvements in information sharing, use of technology for consultations, changes in medicine and developing the workforce will enable us to meet the challenges.

9. Our Commitment

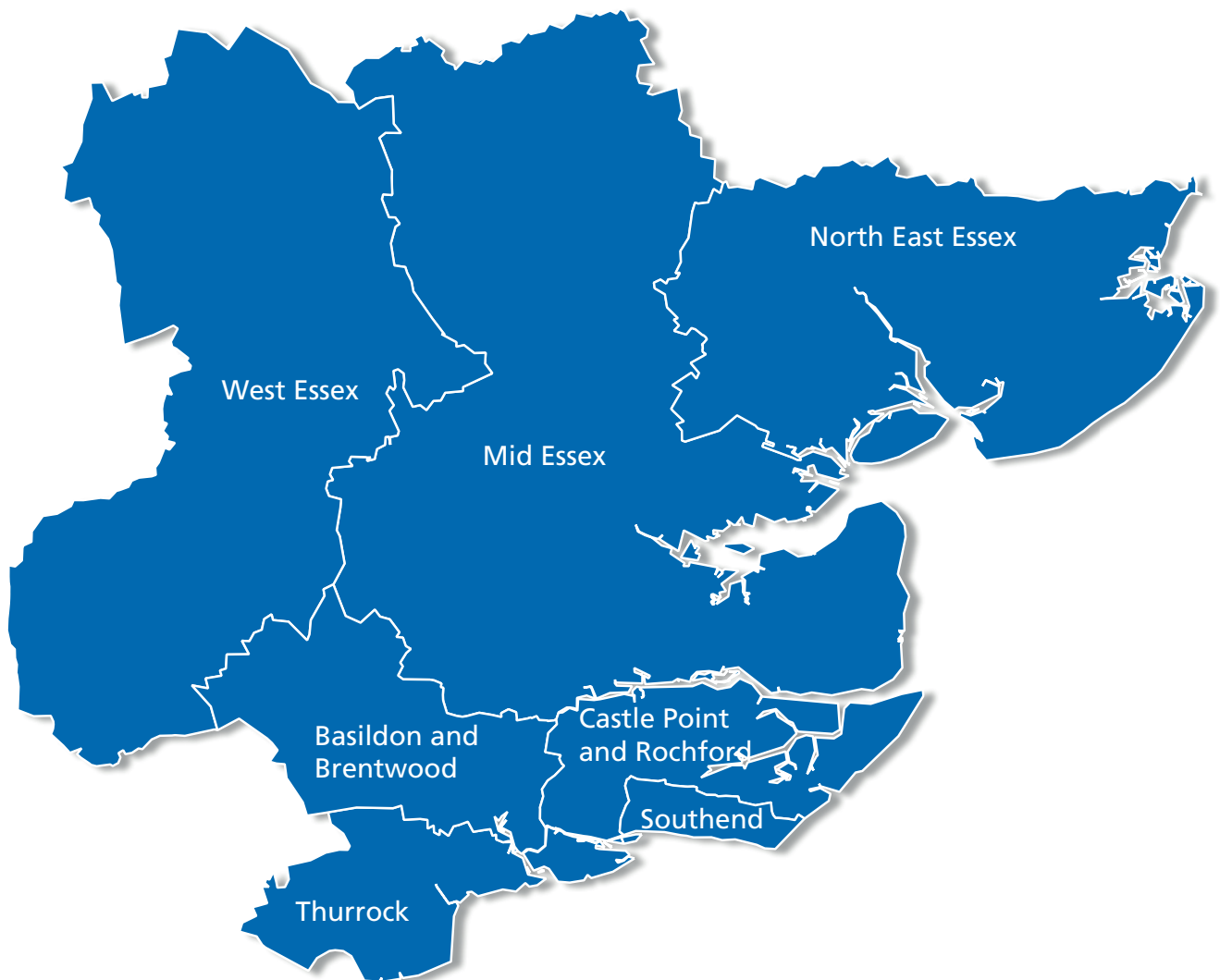
As the NHS in Essex, we commit to a service which is consistent, high quality, responsive and accessible, integrated, sustainable and preventative.

10. What we need from you

We will need patients to take responsibility for their own health and to use the services appropriately.

11. What will the new model of primary care look like?

Primary Care will work as 'hubs' covering a suggested minimum population of 20,000 patients. Each hub will deliver integrated services, reducing the need for patients to attend A & E inappropriately. There will be a significant shift in resource from the acute sector into primary care. GPs will still retain personal lists but will care for the vulnerable and at-risk groups in new ways, making best use of the expertise that exists within the defined 'hub'. We will implement new ways of delivering services for those not able to engage with the traditional model of primary care. Nursing will evolve to establish a new role of General Nurse Practitioner to take on additional functions from GPs. Pharmacists and Optometrists will play a significant role in the community from the High Street. Local primary care networks will be established within each locality to facilitate integrated working.

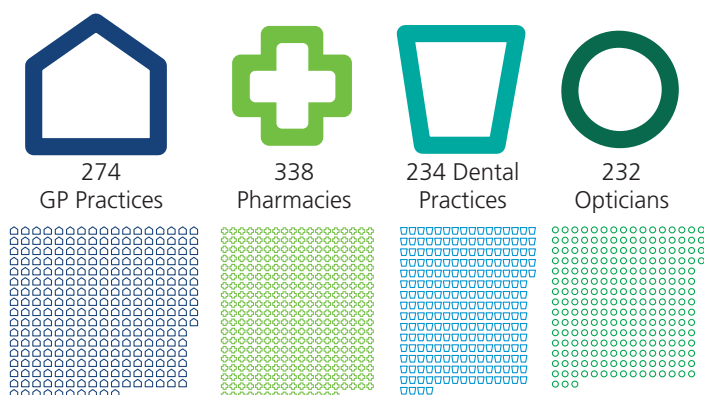


The 274 GP Practices in Essex are in seven localities, with one Clinical Commissioning Group for each locality.

The Seven Localities of Essex

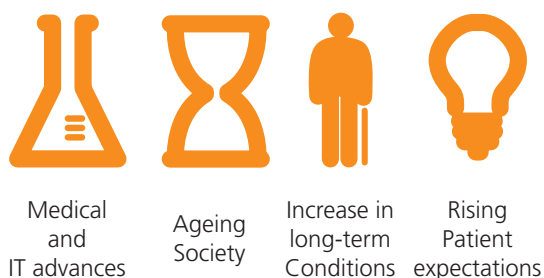
1. Our Starting Point

There are 1,078 primary care providers in Essex — 274 GP Practices, 338 Pharmacies, 234 Dental Practices and 232 Opticians. Over many years, these have delivered excellent care for local people.



The current model of primary care is four different kinds of service — GP Practices, Pharmacies, Dental Practices and Opticians — all working independently of each other, both professionally and geographically.

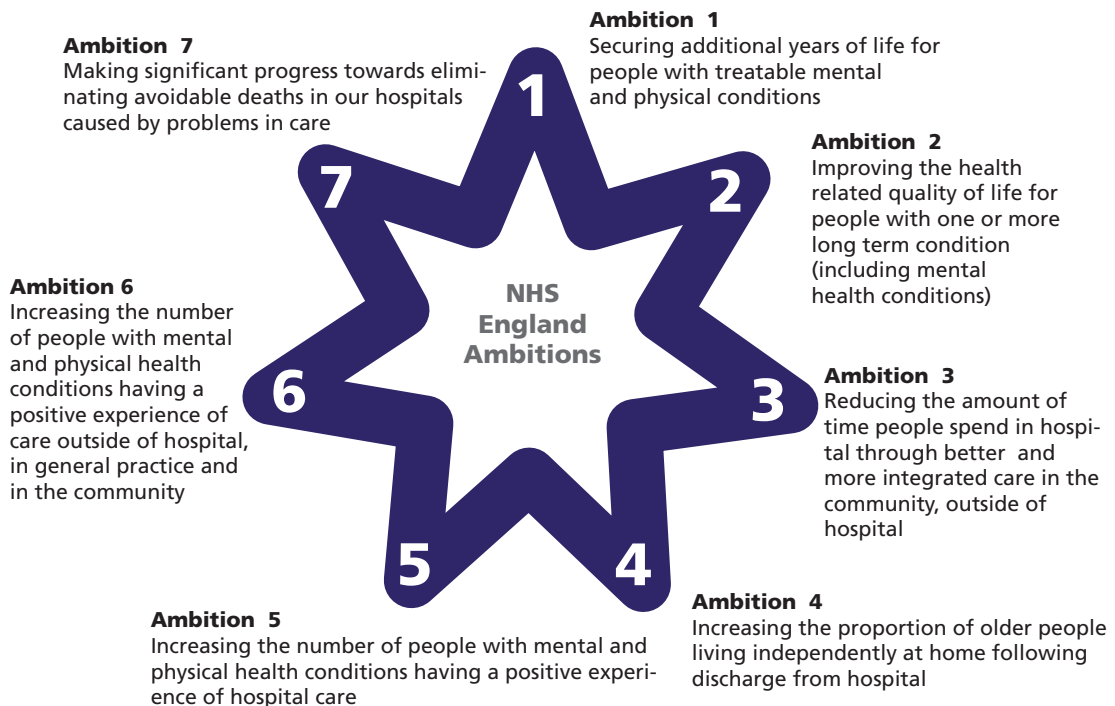
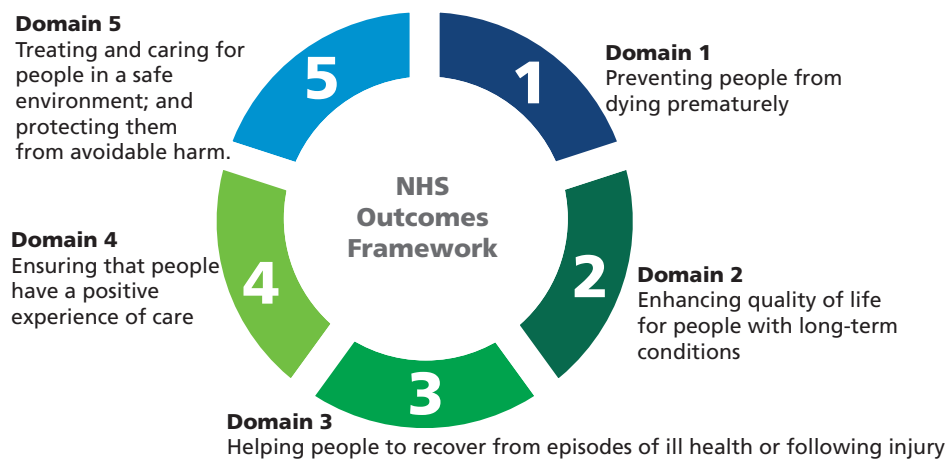
The way in which we live our lives has changed and continues to change, affecting our healthcare needs and expectations. We are living longer and our opportunities to lead fulfilling lives into old age have grown. Medical advance has meant more interventions are possible, and many of these can now be provided in a primary care setting. However, the quality of diagnosis and interventions varies.



As a result, the traditional model of how primary care is delivered is not sustainable. We see this in the following:

- The quality of primary care is variable and early diagnosis/interventions differ
- Because they are not integrated, primary care services do not provide a seamless experience for patients
- Demands on health services are increasing but no new investment is available
- The GP workforce is overloaded
- The primary care estate is variable, lacks flexibility and is not being fully utilised
- The current model is not flexible enough to adapt services for the most vulnerable in our community
- The demographics of the population are changing.

This strategy sets out why things have to change and evolve in order to address the needs of our patient population in the next 25 years and beyond. Already new models of delivering primary care are beginning to emerge across the country and Essex aspires to be a leader in the delivery of these innovative new models, accepting that there will be slightly different approaches and speed of change in the seven localities within Essex.



2. The National Perspective

The NHS Mandate

The Mandate renews the focus on improving patient outcomes and reducing health inequalities.

The NHS Outcomes Framework

The indicators in the NHS Outcomes Framework are grouped around five domains:

- Domain 1 Preventing people from dying prematurely;
- Domain 2 Enhancing quality of life for people with long-term conditions;
- Domain 3 Helping people to recover from episodes of ill health or following injury;
- Domain 4 Ensuring that people have a positive experience of care; and
- Domain 5 Treating and caring for people in a safe environment; and protecting them from avoidable harm.

For each domain, there are a small number of over-arching indicators followed by a number of improvement areas.

Everyone Counts: Planning for Patients 2014/15 to 2018/19

The five offers as set out in NHS England's planning framework 'Everyone Counts: Planning for Patients 2013/14' remain central in 2014/15 to 2018/19. They are:

- Offer 1 NHS Services, Seven Days a Week;
- Offer 2 More Transparency, More Choice;
- Offer 3 Listening to Patients and Increasing their Participation;
- Offer 4 Better Data, Informed Commissioning, Driving Improved Outcomes; and
- Offer 5 Higher Standards, Safer Care.

NHS England has seven key ambitions

- Ambition 1 Securing additional years of life for people with treatable mental and physical conditions
- Ambition 2 Improving the health related quality of life for people with one or more long-term condition (including mental health conditions)
- Ambition 3 Reducing the amount of time people spend in hospital through better and more integrated care in the community, outside of hospital
- Ambition 4 Increasing the proportion of older people living independently at home following discharge from hospital
- Ambition 5 Increasing the number of people with mental and physical health conditions having a positive experience of hospital care
- Ambition 6 Increasing the number of people with mental and physical health conditions having a positive experience of care outside of hospital, in general practice and in the community
- Ambition 7 Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

We will also:

- Improve health in conjunction with partner agencies
- Reduce health inequalities
- Ensure our focus is on patients' mental health needs as well as their physical needs.

The NHS Constitution

The NHS constitution sets out principles for what patients can expect from the NHS and what the NHS can expect from patients.

The GP Contract

Changes to the current GP contract will be implemented over the lifespan of this strategy. Any change or increased flexibility should be fully utilised to help bring about the strategic change that is needed.

The Essex strategy takes into account a number of nationally agreed principles and ambitions (see opposite page).

3. What Primary Care is and what it should be

Although people often use 'Primary Care' to mean General Practice, the term includes dental practices, pharmacies and opticians.

Primary Care is the heart of the wider health and social care system. Our vision for primary care in Essex is that it should provide the same high quality service seven days a week wherever people visit it.

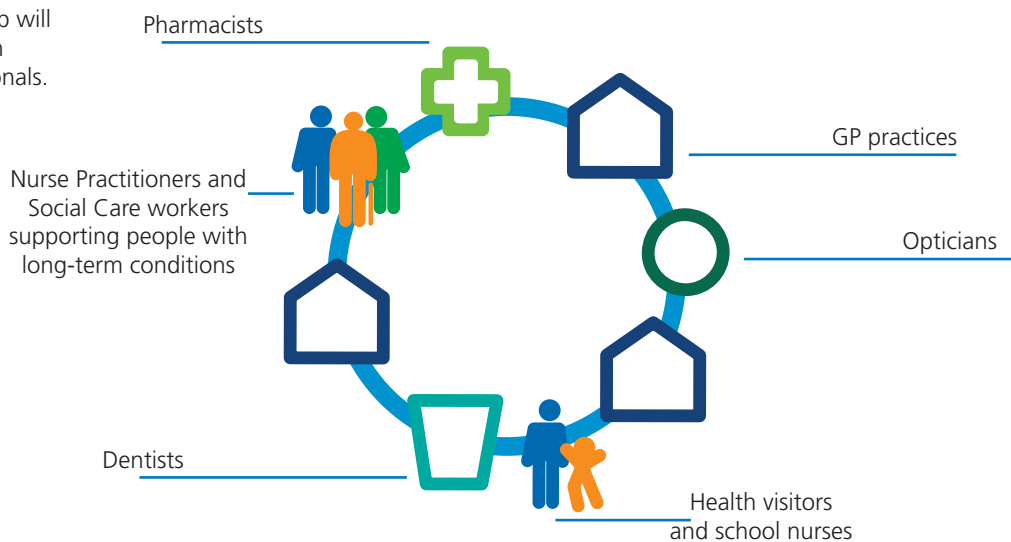
Primary care is people's entry point for the prevention and treatment of illness. It already includes a rich diversity of professionals ranging from GPs, Nurse Practitioners, Nurses, Opticians and Pharmacists through to allied health professionals and social care workers.

Advances in technology and changing demographics mean that, with the right premises and the correct skill mix, more care can be delivered in a primary care setting. People who have historically gone to hospitals to receive their care will no longer need to.

In the future, the Primary Care Hub will integrate district nurses, therapists, mental health nurses, health care assistants, palliative care nurses and health visitors, and offer new, innovative ways of providing care.

This will not necessarily mean that practices will have to relocate into a new centre (although this may be a solution in some areas). Rather, it is about how primary care providers in our community work together collaboratively to deliver the high quality, consistent services patients require.

The primary care hub will bring together a rich diversity of professionals.



4. The Patient Perspective

The following is a summary of the ten requirements most often heard by primary care clinicians in Essex when they discuss improving primary care with patients.

- 1 "Make it simple for me and my family or carers to access and receive primary care services and advice."
- 2 "Help me and my family or carers be aware of how to care for ourselves and detect health issues early."
- 3 "Support me to manage my acute or long-term physical and mental conditions."
- 4 "If my need is urgent, provide me with guaranteed same-day access to my primary care team."
- 5 "Ensure that I am in contact with a senior clinical professional early on to improve my care, experience and outcome"
- 6 "Wherever appropriate, manage me where I seek help, including at home and over the telephone."
- 7 "If it's not appropriate to treat me where I seek help (including at home and over the telephone), direct me to a place of treatment within a safe amount of time."
- 8 "Make sure the information that is critical for my care is available to everyone who treats me."
- 9 "Whenever I need wider support for my mental, physical and social needs, ensure it is available and easy to access."
- 10 "Make sure I can be confident that the quality of my care is good and I am protected from harm."

In Essex, 87% of patients are happy with their GP practice¹.

¹ Department of Health Annual Report and Accounts 2013

I want to feel listened to and be treated as an equal.

We have tested this outline strategy with patients across Essex who have supported the direction of travel and have endorsed the need to bring together services in a more cohesive way. Patients have welcomed the ten principles listed above.

I should be able to be able to go to my GP surgery, pharmacy, dentist or optician and have my needs met quickly and efficiently by a professional who knows what they are doing.

The seven day a week is an excellent suggestion — getting a number of practices to share the load and provide late opening hours and weekend cover is welcomed. (PPG group)

Patients should be able to make an appointment on a date of their choice in the future and not just on the day.

I realise that my needs may not be met the first time I seek help, but I do need to understand the care I am receiving and know what to expect next.

I value having a GP who knows me as a person and understands fully my condition.

5. Why is Change Needed?

Why don't health services talk to social care?

I would like services that talk to each other so that every time I speak to someone new I do not have to go through everything over again.

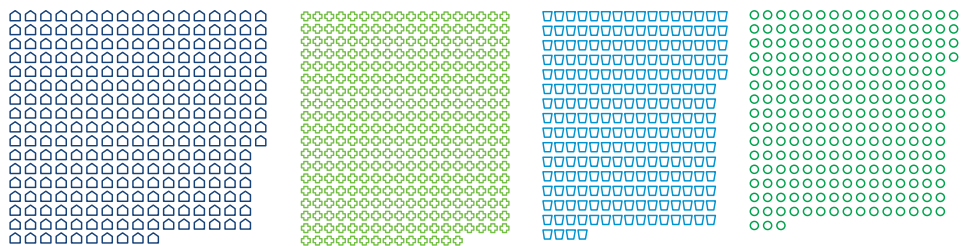
I did not realise it cost the NHS £120 if I go to A&E. I would have taken a GP appointment instead, if one was available.

Services are not integrated

In Essex there are over 1,000 independent contractors delivering primary care services as well as five community trusts, five acute trusts and two mental health trusts. Although there are some excellent examples of integrated care being implemented, people are still too often treated as a new patient every time they see a different health or social care professional (medical records are not routinely shared between the different arms of the NHS). Links with social care are developing but much greater integration is needed. This also applies to the vital role played by the voluntary sector.



5 acute trusts, 5 community trusts, 2 mental health trusts and 1,078 primary care practices



No New Money Available

We know that there will be very limited new resource for the NHS and other public authorities in the next five years. As well as the increased health demands on our system we will see a growth in population of approximately 160,000 residents over the next ten years in Essex.

For historical reasons, primary care providers receive different payments for delivering primary care services. We need to ensure that — within the resource available — there is a more even distribution of funding. This will mean some practices see their funding reduce whilst others see it increase.

The funding system treats hospitals and primary care differently by rewarding hospitals for each item of service, known as 'payment by results', while primary care is funded based on how many patients are registered with the practice. These two systems should be equalised so that primary care provides more services in the community.

64% of our spend takes place in the acute setting with only 20% in primary care and 16% in community settings. In addition, there is the unpaid care that is provided in the community through the third sector and carers.

We have to see a shift in resources from the hospital-provided services into appropriately configured primary care services in order for transformation to happen.

We aspire to see a shift of resources from hospital providers into primary care. It will be up to each CCG area to determine the scale of this shift. Details of CCG approaches are contained in the second section of this strategy.



The current financial planning assumptions to enable the transformation within primary care over the medium term are as follows:

- Growth in funding allocation assumptions are limited to 1.7%-1.8% year on year, except 2015/16 where growth funding is 2.37% in recognition of underfunding in Essex. This underfunding is based on the current national formula for allocating primary care resources and results in higher growth funding for Essex in 2014/15 and 2015/16.
- Financial plans assume that previous year's surplus will be carried forward as part of the following year's allocation.
- Price inflation is estimated at 1.5% year on year.
- Each planning year maintains the nationally required control surplus and reserves including 0.5% contingency.
- 2% non-recurrent headroom requirement is met via QIPP ambition and non-recurrent investments each year.
- Over seven years the PMS premium is released to fund reinvestments within primary care as PMS contracts transfer to GMS contracts.
- The demographic growth impact has been recognised at approximately 1% year on year over planning period.
- The revenue impact of primary care premises developments are funded as per the capital pipeline investment strategy and then an estimated revenue impact of £500k per annum for future years outside of the pipeline period.
- Funding to be released within CCG allocations to invest in primary care rather than secondary.

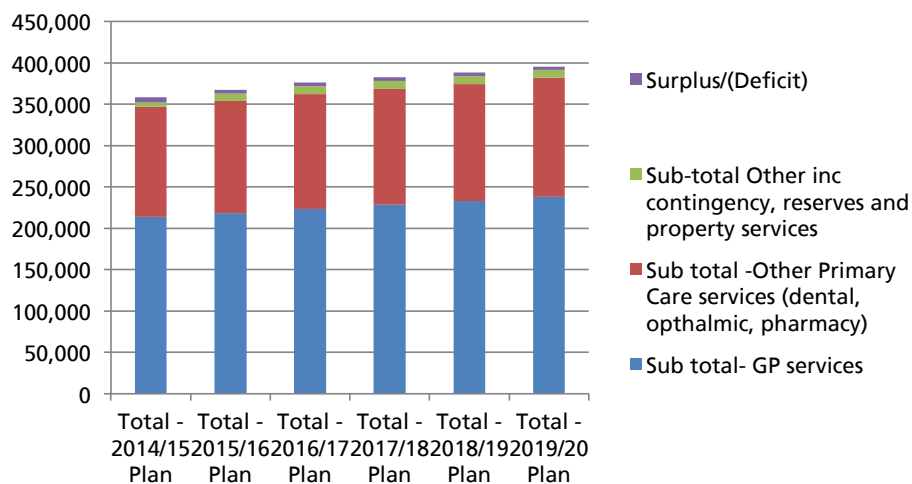


Chart: High level overview of the current financial planning assumptions.

An overloaded General Practice Workforce

General Practice has absorbed more and more work over the past ten years. GP consultation rates increased by 40% in the period 2005/08 and are predicted to continue to rise by a further 33% by 2035, compared with 2008 levels. This may be as a result of an increased diagnosis of long-term conditions as well as an increased reliance on patients accessing surgeries for minor ailments.

The average member of the public now sees a GP almost six times every year – twice as often as a decade ago.

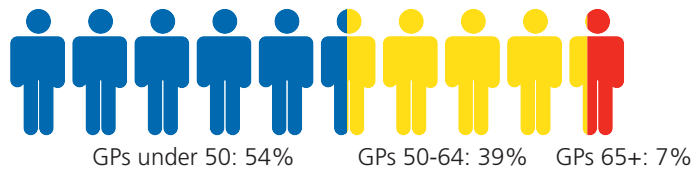
The average time a GP spends with each patient is now just under 12 minutes compared with just over eight minutes in 1993. This highlights the complexity of managing the long-term conditions that patients are increasingly living with.

As the number of people with long-term conditions rises, so too will demand on GPs. Although patients with long-term conditions account for around 29% of the population, they make up 50% of all GP appointments.

We cannot ignore the issue of clinical capacity in general practice. One GP in fourteen is aged over 65 and two-fifths are in the 50-64 age bracket.

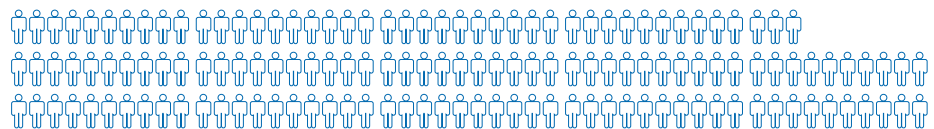
I don't understand why I have to go to the hospital for a simple diagnostic procedure.

46% of GPs are due to retire within the next fifteen years.



Essex already has one of the lowest concentrations of GPs per resident in the country. In order to reach the England average, Essex needs to attract and retain another 143 full-time GPs.

143 additional full-time GPs are needed to reach the England average.



A recent mystery shopper survey carried out by NHS England Essex revealed that patients within a quarter of the practices across Essex are waiting more than two weeks for a routine appointment to see a GP.

One quarter of patients are waiting two weeks for a routine GP appointment



If dissatisfied with their wait for a primary care appointment, patients are more likely to go to Accident and Emergency or another out-of-hours service.

Only 22% of our practices are designated as training practices. More training practices are needed to attract new GPs to the county.

Nationally, one in five of current practice nurses is over the age of 55. Local figures are not available, but it is likely that the Essex position is similar.

We do not make best use of other primary care professionals. For example, pharmacists are the third largest health profession after medicine and nursing. Pharmacists are highly trained, yet their skills are not fully utilised. The role of the community pharmacist must be developed to provide a greater input into patient care

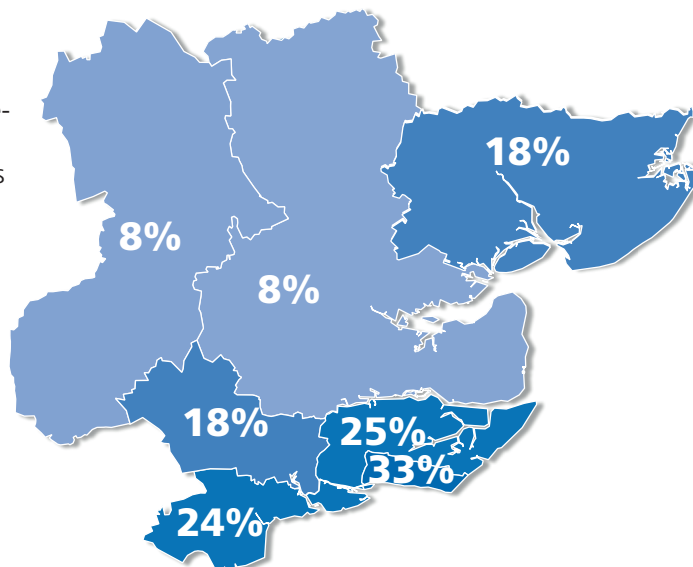
Almost a quarter of our GP practices have just one GP. These single-handed practices face particular difficulties when we look at a future where care is provided seven days a week. New models must be developed to enable small practices and their patients to benefit from strong networks.

I struggle to get an appointment to see my GP.

I am encouraged to only speak to my GP about one problem per appointment as my GP does not have time and is already running late.

Clinical Commissioning Group	Number of GP Contracts	Number of Single Hander Contracts	% Single Hander Contracts
BBW	45	8	18%
CP&R	28	7	25%
MID	48	4	8%
NEE	44	8	18%
Southend	36	12	33%
Thurrock	34	8	24%
West	39	3	8%
Essex	274	51	18%

Percentage of single-handed practices in each of the localities



I want to pop into my GP practice over lunchtime to make an appointment or speak to a receptionist but my practice is closed.

“A new approach to the design and operation of the estates and new partnerships with other parts of the public, private and voluntary sector are now required to release money and creativity and allow the development of some very different models.”

*NHS Building Obstacles or Opportunities?
The King's Fund, July 2013*

I'd like to be able to make an appointment at my GP practice at the weekend.

I have difficulty in getting upstairs to see the nurse in her clinic and am aware that special arrangements have to be made for me to be seen downstairs.

A Mixed Primary Care Estate

Essex has a wide range of premises where General Practice and Dental services are delivered. These range from purpose-built primary care centres to converted terraces. At evenings and weekends, these premises are largely unused.

The traditional way of organising premises has provided some stability to the NHS, but it has also led to inertia. Many other health services are now delivered peripatetically or from 'hot desks' in various locations, but general practice is still largely delivered from consulting rooms in long established buildings. Restrictions on established premises or from landlords can sometimes hamper attempts to deliver more integrated services.

As services continue to change, so too will the locations from which they are provided as health professionals look at ways to improve access to services.

Many services are already provided in shopping centres, schools, football grounds and workplaces as well as virtual consultations being provided by telephone or Skype.

Changes in service models brought about by greater use of technology will also lead to changes in the way that premises are used in the future. Eventually, patients are likely to have more contacts with the service digitally than they do face-to-face.

In order to shift activity into the primary care sector, we need to do three things:

- 1 Make the most of how existing primary care buildings are used.
- 2 Minimise or eliminate empty space and "void" costs, and close premises that are not up to standard.
- 3 Work with health and wider partners to better use all publically owned or leased estate.

The NHS reimburses the rent and rates for all general practices. The space we have paid for is only used Monday to Friday and the majority sits unused over the weekend.

Inconsistent Quality and Interventions

Primary care has provided a range of services over a long period of time, and the quality is not always consistent. A patient with the same condition may undergo a different programme of treatment if they go to one provider rather than another. This is not acceptable: all patients should be treated to the highest quality standards.

The NHS England primary care assurance framework will be utilised to drive up the quality of primary care.

A high priority for Essex is the need to improve cancer services in primary care. We know timely primary care interventions can improve the proportion of cancer patients still alive one year on from their first diagnosis.

The link between alcohol misuse and domestic violence is a significant issue and it is essential that all primary care providers are able to identify alcohol problems and provide appropriate early intervention.

Failing the most vulnerable

Those most vulnerable in our community are often those groups who do not, or cannot engage with the traditional delivery of primary care.

The elderly, those with mental health conditions, and those with physical or learning disabilities should receive the same high-quality primary care as all residents.

Identifying those most vulnerable is a challenge. Progress is being made to identify those patients most at risk on GP lists. However the mechanisms to proactively intervene for those patients who have a range of long term conditions, those with mild to moderate mental health needs, and those who care for family and friends, does not exist.

In 2012/13 only 65% of practices signed up to deliver health checks for adult patients with learning disabilities. Even those who signed up did not deliver a check to all their patients on their list. Practices should ensure they make their service accessible to vulnerable groups. All practices which commit to deliver this service will provide checks for all their learning disabled patients. If a practice cannot sign up to this, alternative provision will be commissioned from other local providers.

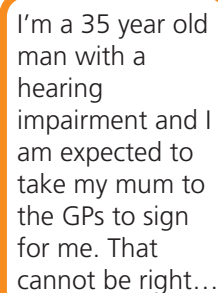
Children's oral health is essential and often parents and carers do not appreciate that good oral health begins before birth. Too many children have dental decay by the age of 5. We will need to ensure that the services commissioned for vulnerable groups take into account the differing levels of need across the communities of Essex.

The Demographics of the Population are changing

The health needs of the population are changing. In England, more than 15 million people have a long-term condition - a health problem that can't be cured but can be controlled by medication or other therapies. This figure is set to increase over the next 10 years, particularly those people with 3 or more conditions at once.

The population will be growing. In the next ten years across Essex, there are 107,000 new dwellings planned. This translates to an additional 165,000 residents moving into the area, each needing health services.

Within Essex, the impact of this will differ by CCG area. For example, the highest number of new homes being built is in Thurrock and Colchester.¹



I'm a 35 year old man with a hearing impairment and I am expected to take my mum to the GPs to sign for me. That cannot be right...

¹ Housing Growth and Evidence for Local Authorities within Essex – August 2013

6. Public Health Perspective

Could do better?

How primary care could reduce the impact of major diseases in Essex

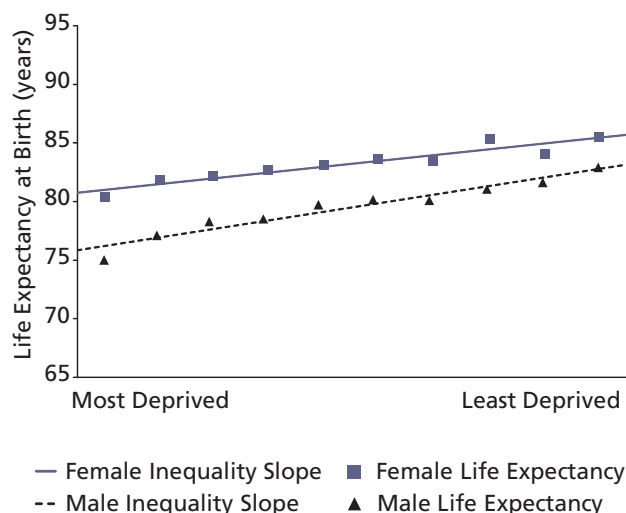
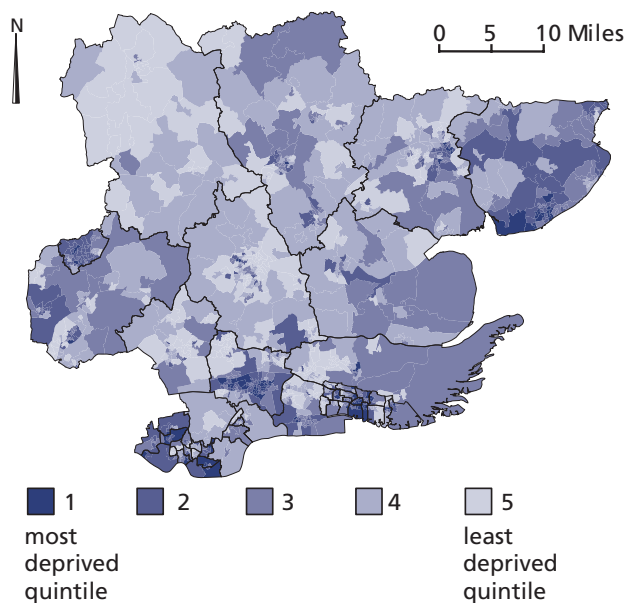
Primary care in Essex has played a major role in preventing and treating some of our biggest health problems over the last decade. Heart disease, stroke, cancer, diabetes and chronic lung disease (COPD) are our main causes of premature death and disability and have all benefited from improvements in primary care. But public health reports show that in some areas of Essex and among some disadvantaged groups significantly more people suffer from these illnesses and receive poorer standards of care than in other areas. In north east and west Essex, for example, the death rates from cancer in the under 75s are much worse than the national average, while Thurrock and north east Essex suffer with much higher premature mortality from heart disease. In Southend significantly more people die early of lung disease than the national average. Across the whole county, people with long term conditions feel less well supported to manage their condition than the England average.

Below, left.
This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2010 by Lower Super Output Area). The darkest coloured areas are the most deprived.

Below, right.
The lines on this chart represent the Slope Index of Inequality, which is a modelled estimate of the range in life expectancy at birth across the whole population of this area from most to least deprived. Based on death rates in 2006-2010, this range is 7.3 years for males and 4.9 years for females. The points on this chart show the average life expectancy in each tenth of the population of this area.

- Primary care could help reduce the number of people having strokes and heart attacks further by improving blood pressure and cholesterol control of people in these groups and improving the care of people with diabetes. This would also reduce the higher than average levels of diabetes complications such as amputations that exist in parts of the county.
- Services to promote and support smoking cessation could be focussed on disadvantaged groups with higher than average levels of smoking and disease to bring them below the national average. This would reduce the number of people who develop these major diseases.
- Community initiatives to raise awareness of the early signs of cancer and improve uptake of breast screening would improve outcomes in cancer. Better training of GPs to improve early diagnosis could also help reduce the inequalities in cancer outcomes experienced by the people of Essex.
- Earlier diagnosis and better treatment of COPD (Chronic Obstructive Pulmonary Disease) could slow progression of the disease and avoid unnecessary hospital admissions.

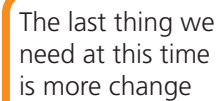
These improvements in care would help reduce premature mortality and improve quality of life for people with long-term conditions and help deliver Domains 1 and 2 of the NHS Outcomes Framework.



7. The Morale of General Practitioners

Another significant factor in delivering a transformed primary care service is how to improve the morale of the GP workforce. With a shortage of GPs, increased patient expectations and many practices seeing a fall in their core funding as a result of GP contract changes, many of our GPs do not have an appetite for change.

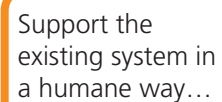
The system needs to support professionals through this period of transformation. Doing nothing is not an option and we have to find a way to support clinicians as well as to harness and encourage those who have a vision for a joined-up primary care service for Essex.



The last thing we need at this time is more change

8. Releasing the Potential

In spite of the challenges we face, we have a lot of potential in the health care provision already in Essex. We have health professionals ready to take on the challenge and become part of a transformed primary care system.



Support the existing system in a humane way...

Optometry

Optometry in Essex has for many years been active in promoting patient care in the community and has some geographical areas of excellence in service. Optometry as a profession is well equipped, well trained, geographically evenly spread and much underused, particularly when its wide skill set is taken into account.

The future strategy for eye care needs to be built to cascade current community-based services of excellence to all parts of Essex; develop attainable eye health promotion and care and move towards electronic referral across the county.

All patients who can be appropriately and effectively seen by skilled community optometrists should be able to do so. There should be well-defined pathways to enable this, backed by robust and efficient technology. We need to improve people's knowledge about how to access eye care, especially for child eye care, for adults with learning disabilities, and for hard-to-reach groups. We must particularly ensure access for the elderly with failing eyesight, and publicise this across a range of organisations they are involved with.

Dentistry

The provision of dental care has never been joined up between high street dentists, community dental services and hospital services. Our intention is that this will now happen and patients will experience a seamless service. Dentists will take on a greater role in the community and deliver services closer to where patients live.

A dental system that is prevention-led is the most effective and efficient way forward in improving the health of the population. Dentists are able to provide patients with advice and information to encourage them to develop more healthy lifestyles leading to a reduction in disease risk through self-care in patients and carers. This reduction not only has an influence on patients' dental health but their general medical health as well.

In Essex, there has been a historical challenge to provide complex restorative care to patients, as this has normally entailed referring patients into London teaching hospitals. It is envisaged that a specialist-led facility could be set up in the county to perform the functions of second and third tier dental care provision. This facility could

also provide training within the area for *Dentists with Enhanced Skills* to meet these considerable needs, along with assisting in the training of other Dental Clinical Practitioners that will be required.

Pharmacy

The public use pharmacies as a regular source of healthcare advice, for maintaining good health and to self-treat simple conditions without needing to see their doctor or practice nurse. Pharmacies routinely offer a range of services including Stop Smoking, sexual health and flu vaccinations. These services have proven popular with the public who like the ability to access the services without an appointment.

Pharmacy services could be extended to enable greater choice for patients instead of having to attend the GP practice. One example is routine monitoring for medicines treatment, such as that required for anti-coagulant therapy.

Community pharmacy should become the first point of call for the public, able to triage, treat, refer or signpost as appropriate to help patients access the right service at the right time, reducing duplication of effort and pressure on GPs, out of hours services and A&E departments.

There are already pharmacist prescribers in the community, but this valuable resource is rarely used and should be developed further.

Full engagement

People who become fully engaged with their own health are much better able to manage their conditions, thereby reducing demand on services.

Tackling obesity, children's diet, stopping smoking, regular exercise, good nutrition and reducing alcohol intake can have an effect in extending years of healthy life. It should be the aspiration of all to help bring this about.

Through work in local neighbourhoods, with voluntary groups and other public services, the true potential of primary care services will be unlocked. It is recognised that innovation reaches its full potential when the whole community is engaged in developing solutions.

Information

Nationally, there have been a number of well-publicised cases where failure to share information between health and social care contributed to unacceptable breaches in people's care or safety. Through the correct use of information with appropriate controls, patient care will improve.

We should be using information sharing technology amongst the general population to share public health messages and enable patients to find their way around the health system. This may ultimately lead to new ways of consulting with health professionals.

Technology

New technology has enormous potential to improve systems and communications.

It is likely that patient contacts conducted through a digital health environment will exceed face-to-face contacts in the future. Across Essex, only a small proportion of practices are currently using technologies which enable patients to access their records, book appointments, or order repeat prescriptions on-line.

The use of shared data, with consistent IT systems that can talk to each other, is an essential part of unleashing the potential for better integrated care. Key to this is the need to share medical records between providers of primary care services (for example ensuring there is a shared medical record between General Practice and their Out of

Hours provider.

Electronic Prescription Service (EPS) is being introduced across the country. All GPs and pharmacies are encouraged to make full use of the Electronic Prescribing System which will improve services for patients. For example, patients stabilised on long-term medications should find it much easier to obtain their repeat medications without having to order prescriptions from their GP.

Changes in Medicine

The National Institute for Health and Care Excellence (NICE) makes recommendations based on the best available evidence of the most effective care. In Essex, we will use NICE guidance to revise pathways of care for patients, ensuring they benefit from the most up to date expert recommendations within available resources.

Workforce Development

There is a need to fully utilise and develop our primary care workforce. As well as giving a strong commitment for additional training facilities within Essex for all professionals (including healthcare assistants), there is also a need to develop new career pathways and support for staff. The role of the prescribing pharmacist and Independent Prescribing Optometrists should be developed and fully utilised. Support will be needed from all professionals to ensure this happens.

A training hub for Essex is will be established to drive forward a new wave of professionals who are flexible and adaptable to the new models of primary care that will be developed. With this in place, Essex will become a county which attracts and retains staff.

Financial Impact

The medium term financial plan prepares for reduced growth funding by relying on existing resources being used as efficiently and effectively as possible across the whole of Essex. Existing and new QIPP schemes will be required throughout the medium term financial planning period to enable this approach. These schemes will incorporate the best use of information, communication and technology, partnership working, tendering services where appropriate, and staffing skill-mix.

Alongside QIPP schemes, releasing the PMS premium will aid the financial impact of investment in transformation. It is estimated based on current responses from PMS practices that £855k can be released each year (for the next seven years) for reinvested. This level of funding is released by PMS contracts transferring to GMS contracts and will be reinvested in primary care.

The Area Team will work with CCGs to an agreed prioritisation framework for the use of transformational funds across Essex to ensure that the maximum impact is made across the widest population.

Collaboration

It is imperative that NHS England and the CCGs work together collaboratively to deliver the best possible outcome for patients. Key to this is the need to align outcomes for general practice with community services and to incentivise new ways of delivering services.

9. Our Commitment

This section outlines our commitment to Essex residents which we intend to fulfil through this strategy.

'All patients should receive high quality care without unnecessary delay.'

NHS Constitution

'You have the right to choose your GP practice, and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons.'

NHS constitution

'The NHS commits to make the transition as smooth as possible when you are referred between services, and to put you, your family and carers at the centre of decisions that affect you or them.'

NHS Constitution

C Consistent

Wherever you live in Essex, you can expect to have easy access, on-line or in person, to information, advice and support. This will be through national programmes such as 111 and local services.

You will be confident that the advice and care provided by your primary care professional is consistent with best practice.

Variation in the delivery of primary care will be identified through national data and the commissioners (NHS England and the CCG) will work together to support practices to provide core standards of care. Any practice unable to deliver this after thus support will be decommissioned.

H High Quality

You will be seen and treated by highly trained healthcare professionals who are committed to delivering the best quality care to the patient.

You will be treated as an individual by professionals and respected at all times.

R Responsive and Accessible

The way you are able to access information and be directed to appropriate services will be transformed through the use of new technology and social media.

You will be able to access primary care services over the weekends at access points not currently available although this may not necessarily mean seeing a GP or nurse in the traditional way.

You will be able to have access to a primary care professional within 24 hours whenever you feel your primary care need is urgent.

You will not have to wait more than five days for a routine appointment with a GP.

By giving you access to high level quality indicators for General Practice, you will be able to make an informed choice of GP practice, and you will be able to change practice easily if you wish.

I Integrated

You will find that services are working seamlessly together with you to co-ordinate your care and deliver the support you need to manage your condition. Holistic care will be delivered that addresses people's physical, mental health and social care needs together and not separately. There will be no duplication.

The voluntary sector, pharmacists, nurses and social care will be more involved in providing your care.

The way health services and local authorities work will change radically. Services will align more closely, which will mean that primary care and social care deliver a seamless service.

We expect to see a range of initiatives that unite health and social care such as respite prescriptions for carers.

S Sustainable

You can be confident that the primary care service you are receiving today will be there for you over the next 25 years.

P Preventative

Primary Care Professionals will act as Community Health Leaders.

You will be actively involved in the management of your own health and care.

You will receive more information on maintaining your health.

Underpinning this is the need for services to be innovative and continuously evolve and learn.

10. What we need from you

The NHS constitution sets out clearly what patients, the public and staff can expect from the NHS and what the NHS expects from patients in return:

- To recognise that you can make a significant contribution to your own, and your family's, good health and wellbeing, and take personal responsibility for it
- To treat NHS staff and other patients with respect
- To keep appointments, or cancel within reasonable time
- To participate in important public health programmes such as vaccination.

Every missed appointment costs the same as a filled appointment and it also means that someone else will have to wait longer to be seen.

There needs to be an understanding that when you access primary care you may be treated by any member of the primary care team, not just the GP.

You will be actively involved in the management of your own health and care. You will receive more information on maintaining your health and will have access to your own 'hand held/electronic records' to assist you manage your health more effectively.

Underpinning this is the need for services to be innovative and continuously evolve and learn.

11. What will the new model of primary care look like?

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

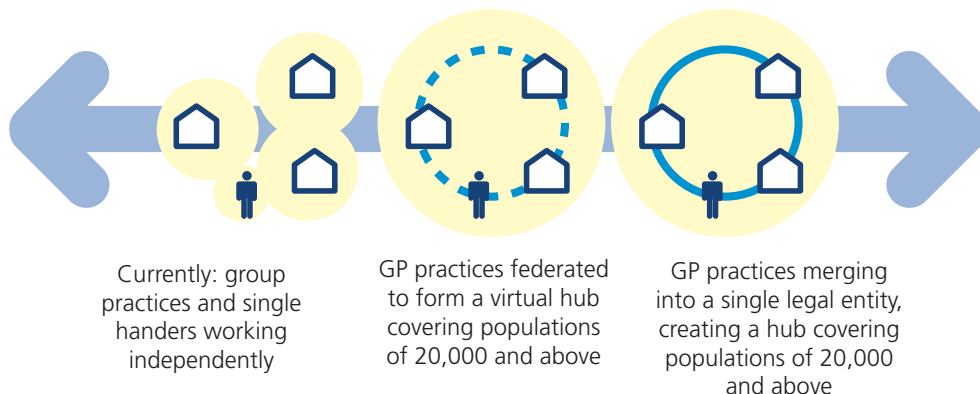
- Primary care providers will work at a larger scale within 'primary care hubs' reducing the need to go to hospital but ensuring personalised care for patients is maintained
- Primary care hubs will be integrated with community services and aligned with social care
- The demand on urgent hospital care will reduce once primary care is reshaped
- There will be a general shift of resources and work from acute hospitals to primary care
- Some hospital sites in Essex will become primary care-led sites offering a full range of diagnostic and other non-acute services
- Although offering a cradle-to-grave service, the way primary care is provided will be different for different groups of patients. A new way of delivering primary care to patients with long-term conditions will be implemented
- Pharmacists, dentists and optometrists will become a fundamental part of the primary care team within the primary care hub
- Primary care facilities will be fully utilised, seven days a week, within a primary care hub
- The primary care workforce will change with a greater role for nurses, pharmacists and health care assistants. There will be new and innovative opportunities for staff development within each hub
- All service providers will have access to patient records to ensure a more integrated and effective response to urgent care needs
- Patient voice will be strengthened within each primary care hub, building on the further development of patient participation groups.

We will explore all avenues to identify resources to incentivise the transformation of primary care and help bring about new ways of delivering services as set out in this strategy. We will utilise the flexibilities that different forms of GP contracts offer as vehicles for change with an emphasis on establishing a range of newly configured PMS/APMS contracts with clearly defined outcomes for patients.

CCGs and NHS England will work with the providers to implement these in ways which are suitable for the local situation. The schematics which follow represent the range from less integrated at the left to more integrated at the right.

Primary Care will work as 'hubs' covering a suggested population of 20,000 patients

How this will be modelled and the ultimate size of hubs will be for CCGs to agree as part of their overall health plans.



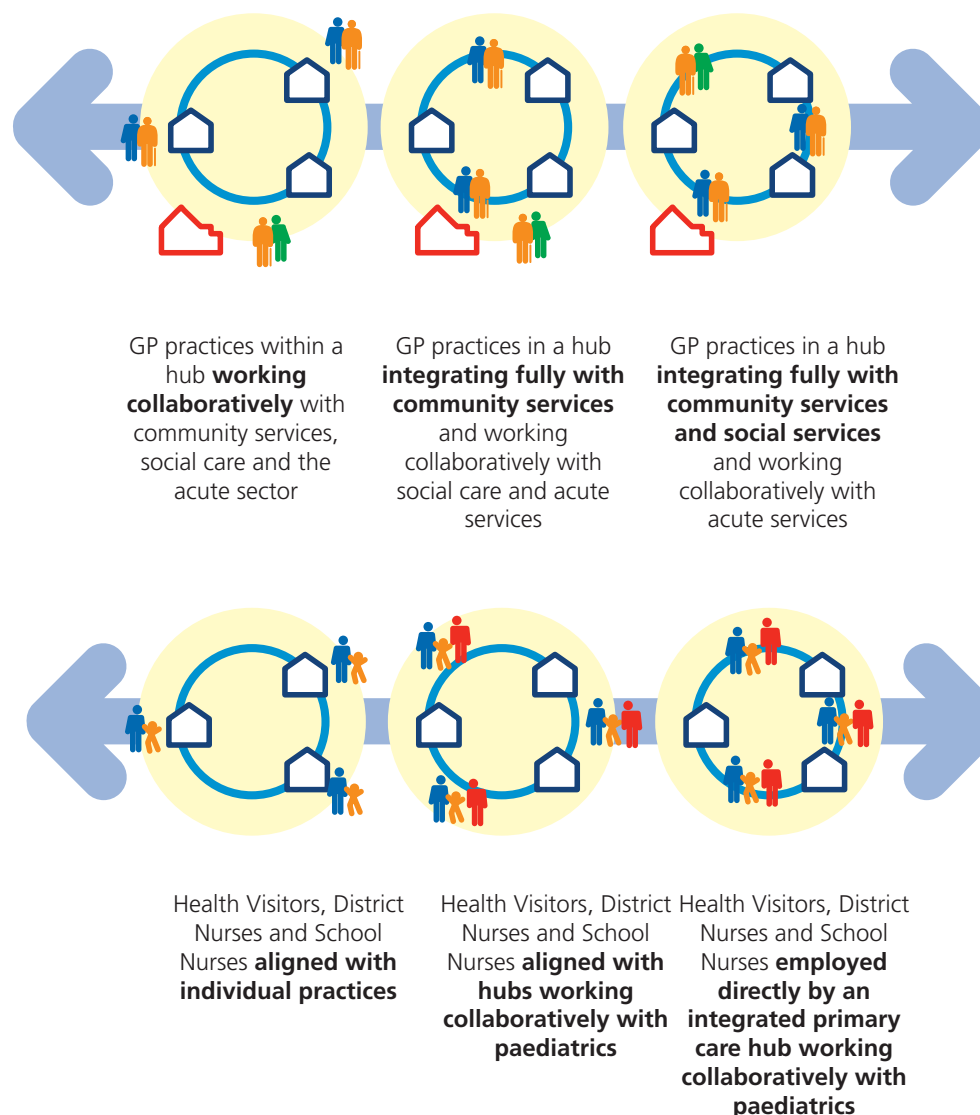
Currently: group practices and single handers working independently

GP practices federated to form a virtual hub covering populations of 20,000 and above

GP practices merging into a single legal entity, creating a hub covering populations of 20,000 and above

Each hub will deliver integrated services, reducing the need for patients to attend A & E inappropriately

How this integration will take place will depend on CCG strength of vision and their decision to integrate fully across the community.



GP practices within a hub **working collaboratively** with community services, social care and the acute sector

GP practices in a hub **integrating fully with community services** and working collaboratively with social care and acute services

GP practices in a hub **integrating fully with community services and social services** and working collaboratively with acute services

Health Visitors, District Nurses and School Nurses **aligned with individual practices**

Health Visitors, District Nurses and School Nurses **aligned with hubs working collaboratively with paediatrics**

Health Visitors, District Nurses and School Nurses **employed directly by an integrated primary care hub working collaboratively with paediatrics**

There will be a significant shift in resource from the acute sector into primary care

The level of shift will be in line with CCG plans.



GPs will still retain personal lists but will care for the vulnerable and at-risk groups in new ways, making best use of the expertise that exists within the defined 'hub'

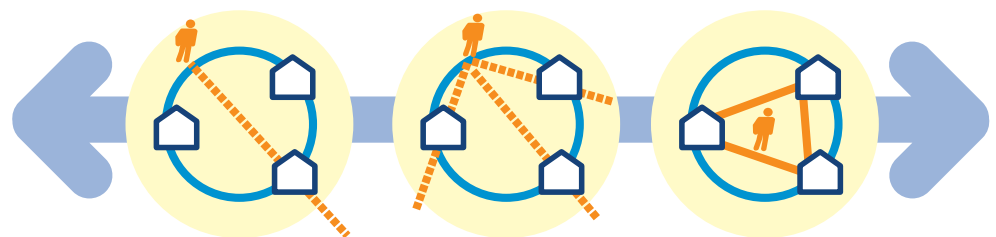


Patients with multiple long-term conditions will have a **named clinician** who will personally oversee their care.

Patients with multiple long-term conditions will have their care managed by a **specialist team within a hub**.

A hub will create a **specialist practice for patients with multiple long-term conditions**.

We will implement new ways of delivering services for those not able to engage with the traditional model of primary care



Commuter clinics provided by GP practices

Network of commuter clinics delivered across a hub open to all patients within the hub

New model of primary care provision commissioned with **hub delivering clinics in evenings and at weekends**.

Nursing will evolve to establish a new role of General Nurse Practitioner to take on additional functions from GPs



Nurse Practitioner taking on **increased roles** and operating from every hub

Nurse Practitioner **managing lists of patients** with GP support

General Nurse practitioners operating from within the hub

Pharmacists will play a significant new role in the community from the High Street as well as becoming integrated within General Practice providing a wider choice of access to healthcare for patients



Triage, diagnose and treat minor illness in the pharmacy. Have access to direct referral to some social care services

Write prescriptions for a limited list of medications.
Have an increasing role in **screening and prevention**

Fully integrated into the primary care team delivering **consultations, prescribing, immunisations**

Pharmacists will foster greater patient involvement in decisions about how they choose to use medicines as part of their overall treatment, in addition to enabling easier supply of repeat medicines and improved safety



Pharmacists take on a greater role in **managing supplies of repeat medicines** enabled by batch prescribing and electronic prescriptions.

Pharmacists will request or carry out appropriate **routine monitoring** e.g blood tests and be able to re-authorise repeat medicines. This will be integrated with **face to face discussions** with the patient about their medicines

A **holistic patient-centred medicines service** focussed on patient wellbeing, enablement and joint decision making, working closely with the patient's GP.

Pharmacists can help patients manage long-term conditions, once diagnosis has been made and a treatment plan initiated, offering a convenient alternative to a GP appointment for patients and freeing up GP and practice nurse time for patients with complex needs



Managing straightforward conditions such as allergic rhinitis, hayfever, dry and itchy skin.

Management of **long-term conditions** such as asthma or chronic pain, in the pharmacy, linked to, and supported by, GP hubs

Specialist pharmacists will be employed within hubs to be part of **specialist teams caring for patients with long-term conditions**

Optometrists will play a significant role in the community from the High Street



Effective referral management of patients with eye conditions

Refine referrals, diagnose, manage and treat where appropriate.

Prescribe from a limited list of medications as part of the primary care team in general practice

Optometrists will play a significant new role in the community from the High Street and within primary care teams helping patients manage long-term conditions, once diagnosis has been made and a treatment plan initiated, offering a convenient alternative to secondary care based appointments for patients.

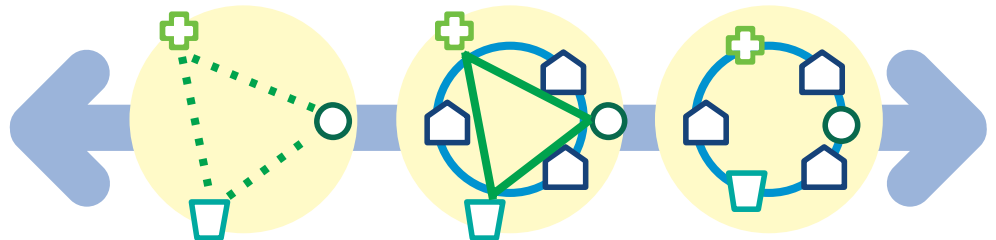


Managing long-term conditions such as dry eye, stable glaucoma, macular degeneration, diabetic eye disease

Management of long-term conditions with **full information sharing** to all stakeholder clinicians, led by GP hubs

Management of long-term conditions with full information sharing to all stakeholder clinicians, led by **specialist team hubs**

Local primary care networks will be established within each locality to facilitate integrated working



Virtual network of primary care professionals established within CCG area.

Actual network of primary care professionals established **mirroring hubs**.

Actual network of primary care professionals established **reporting to hubs**.

To facilitate the establishment of hubs and the delivery of consistent high quality primary care services, the following changes will take place:

- Make full use of NHS-funded premises. Unless a building is delivering NHS services (wider than just core GP services) for 75% of its contracted service it will be reviewed through the primary care strategy and, if appropriate, decommissioned. All new developments requiring investment from NHS England will be made available 7 days a week to primary and community care providers.
- The Area Team will work with local practices to establish contracts that have at least two signatories to the contract with robust partnership agreements. This will ensure we have a more stable and sustainable service for the future. The aim is to ensure peer review and support, provide choice of GP to registered patients, ensure continuity and subsequently make general practice a more attractive place to work.
- The number of GPs working in Essex will increase through the establishment of more training practices and enhanced roles within hubs that attract professionals into Essex.
- Practices will not close during their core contracted hours of operation (8:00am to 6:30 Monday to Friday) ensuring patients have access to their surgery during these hours.
- Patients will be able to access their practice at all times throughout the contracted hours of operation (8:00am to 6:30 Monday to Friday).
- All practices will reflect on their cancer practice profile and invite, on a regular basis, a MacMillan GP to visit the practice on early diagnosis of cancer, put in safety net measures whilst seeing patients with symptoms relating to cancer and fully utilise risk assessment tools in cancer diagnosis.
- The number of nurses working in Essex will increase through the enhancement of nurse practitioner training and enhanced roles within hubs.
- Practices which are unable to demonstrate that they are delivering high quality care will be supported to improve in the first instance but ultimately decommissioned if there is insufficient improvement.
- A new role of General Nurse Practitioner will be established with 100 new posts established by 2019 across Essex.
- A new role of General Practice Clinical Pharmacist will be established with 20 new posts across Essex by 2019, broadening the skill mix within General Practice. This new role will support medicines reconciliation by secondary care clinical pharmacists, reducing risks around transfer between care settings, and utilising the new Medicines Service and medicines use reviews provided by community pharmacists.
- The role of the dental nurse will evolve further to see the establishment of the dental nurse practitioners.
- Essex taking on a wider role in delivering dental care for patients.

CCG Section

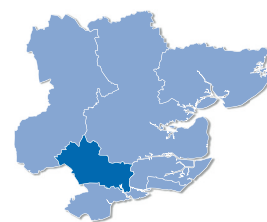
The pages which follow represent the work of the Clinical Commissioning Groups across Essex. These cover the individual geographies and demographics, priority areas for the CCG, aspirations and key milestones.

While working to a common framework, each CCG has developed their section of the document, addressing key local concerns and contextualising the overall strategy and vision.

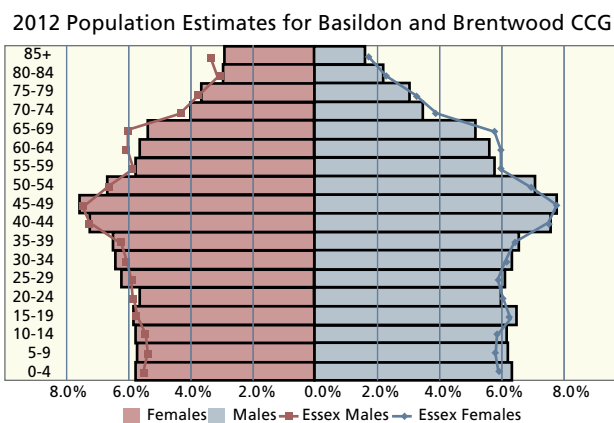
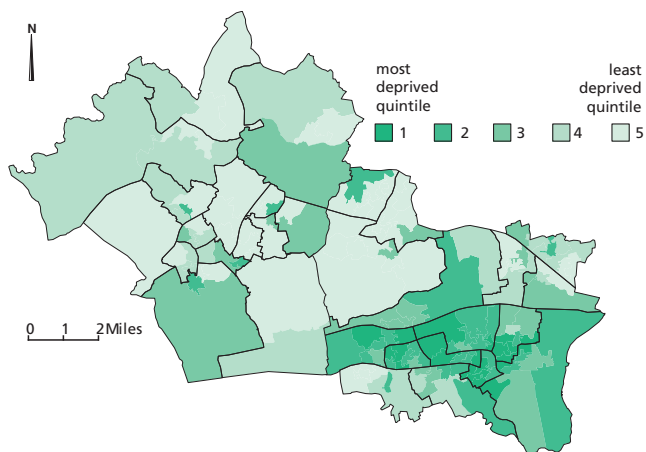
Basildon and Brentwood

Area and demographics

Basildon and Brentwood CCG serves a population of 264,630 within a geographic area of south Essex that contains the towns of Basildon, Billericay, Wickford and Brentwood together with a number of smaller villages in surrounding rural areas. The CCG serves a population of contrasts, with some areas of Basildon Town ranking as among the most deprived in England, whilst some areas north of the A127 ranking as some of the most affluent nationally. Figure 1 below shows quintiles of deprivation — Index of Multiple Deprivation (2010), together with the location of the CCG’s 45 GP practices.

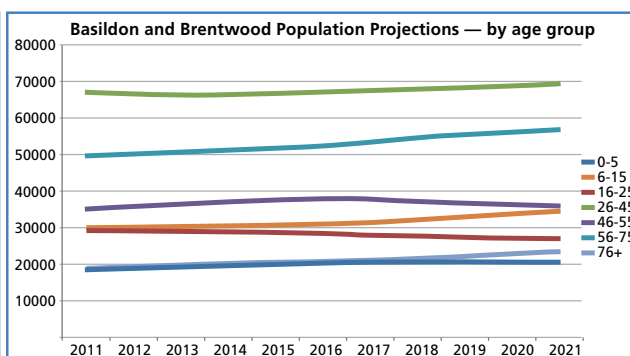
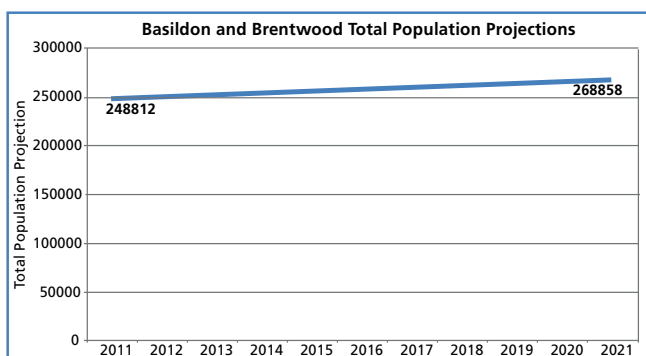


The population served by BBCCG is generally younger than that of Essex, with a greater proportion of its population in the 0 to 39 age group. The proportion of the population of Basildon and Brentwood aged between 55 and 75 is smaller than that



of Essex as a whole as shown in figure 2. However the population structure differs between Basildon District in the south which has a younger population structure than England’s and Brentwood Borough in the north which has a considerably older population structure than England’s.

Figure 1 (left) Deprivation quintiles
Figure 2 (right) Population estimates



Whilst the total population of Basildon and Brentwood is projected to increase by 20,046 people from 2011 to 2021 (Figure 3), this increase is not evenly distributed between the population bands. The largest absolute increases in population from 2011 to 2021, and increases in structural percentage can be seen in the 56-75 and 76+ age bands, whilst the 16 to 25 age band is projected to fall in absolute numbers and structure (figure 4).

Figures 3 and 4: population projections.

Priority Areas for the CCG

Given the projected demographic shift toward an older population noted above, it is apparent that the year-on-year increases in demand and the complexity of patient needs reported by primary care practitioners in BBCCG, is almost certain to continue. For some local service providers, these pressures will represent a challenge to sustainability in their present form on the basis of either quality or financial viability.

The following are our priority drivers for change:

Quality:

There is still a high degree of variation in GP services, both in delivery and outcome.

Many people in our communities who are not high risk or regular users of the health service are not satisfied with their current ability to access the NHS on an episodic basis, whilst others who require greater continuity of care are receiving fragmented services. With A&E services already under considerable pressure, access to GP services will be exacerbated by a further strain on capacity as well as population growth.

We have some very poor GP premises in our most deprived areas.

Capacity:

There is expected growth of up to 25,000 new residents in Basildon and Billericay over the coming 2-5 years, based on proposed and progressing housing developments. Our current GP workforce and estates will not meet expected demand. A significant proportion of the growth will be in the Pitsea area, which already faces pressures.

7% of GPs are now aged over 65, with 40% in the 50-64 bracket. Recruitment and retention are problematic locally, and as a whole Essex has one of the lowest concentrations of GPs for population in England, at 0.66 GPs/1000 population compared to 0.74 GPs.

Commissioning:

Whilst we have some very good commissioned services in place, the system has become very complicated with a high degree of overlap, and involves too many handovers between organisations and services.

Health and social care services offered to people with long term conditions and people living with frailty need to be commissioned in a more co-ordinated fashion, to ensure greater integration of provision as well as more effective engagement with individuals and carers in planning their own care.

Aspirations

BBCCG's five year vision of service identifies the need for:

- 1 The establishment of excellent Primary Care consistently across Basildon and Brentwood, to improve quality of care and support workforce development.
- 2 The creation of Named GP teams which will work in close collaboration with accountable professionals from the community health (mental & physical) and social care sectors, to ensure vulnerable people at risk of deterioration are offered services which are personalised, effectively co-ordinated, integrated and evidence-based. The effectiveness of these teams will be further enhanced through greater collaboration between practices working in networks. The degree of collaboration is expected to vary, and it is anticipated that some practices will take this to the point of formalising their relationship within a Federation model.
- 3 The development of specialist pathways of care, integrating existing community, acute and specialist service provision for designated indications. Such pathways will be evidence based and time limited.

These three core components are explored below, with some emergent ideas as to how this will be delivered forming the basis of consultation with GP member practices, as well as with patients and other stakeholders as part of BBCCG's wider "Care Conversation".

NHS Outcomes Framework 5 domains resources

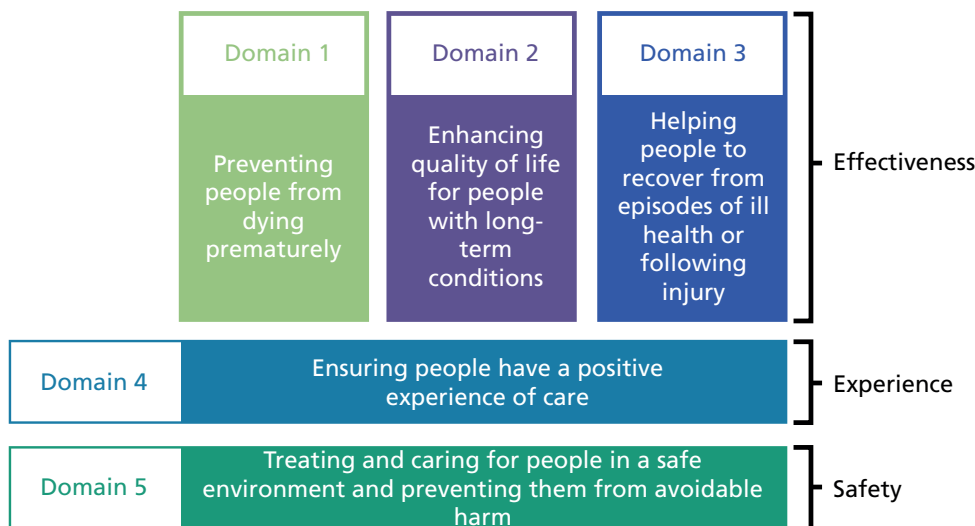


Figure 5

The NHS Outcomes Framework 2014 to 2015
Department of Health; 12 November 2013

www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015

Our Mission is:

What do we mean by high quality care?

How will we measure success?

What will my care look and feel like?

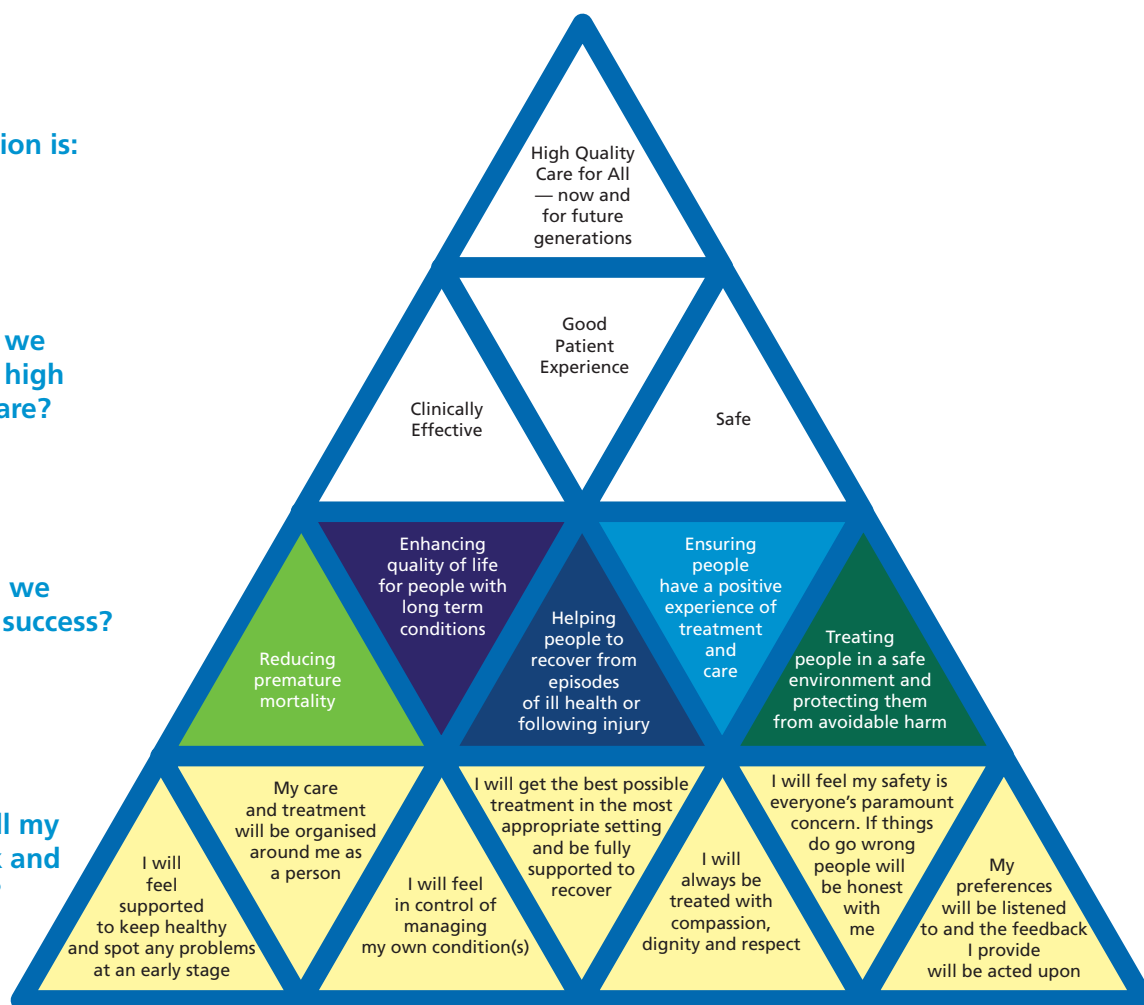


Figure 6:
What this means for patients

Establishing ‘Excellent Primary Care’ across Basildon and Brentwood

We have a total of 45 practices, clustered into 4 localities:

We will use the questions highlighted against “What will my care will look and feel like” to understand the current patient/user of services perspective and set the baseline position and quality markers from which improvement will be measured.

Going forward, we will also use the questions to gain practice perspectives by asking, “what will the care look and feel like for my patients/users of services”.

	Total patients (actual)	Average practice list size
Arterial	67128	4972
Brentwood	76077	9510
Partnership/BIC	66020	5502
SEMC	56194	5352
BBCCG	265419	6032

We will support the development of ‘Excellent Primary Care’ by practices across Basildon and Brentwood from three defined perspectives:

- Patients/users of the services
- Individual GP Practices
- Whole health and social care system

In relation to the patient/user of services we are looking at how we can:

- Improve access to services by matching access to the needs of the population i.e. achieving an appropriate balance of provision between those people requiring

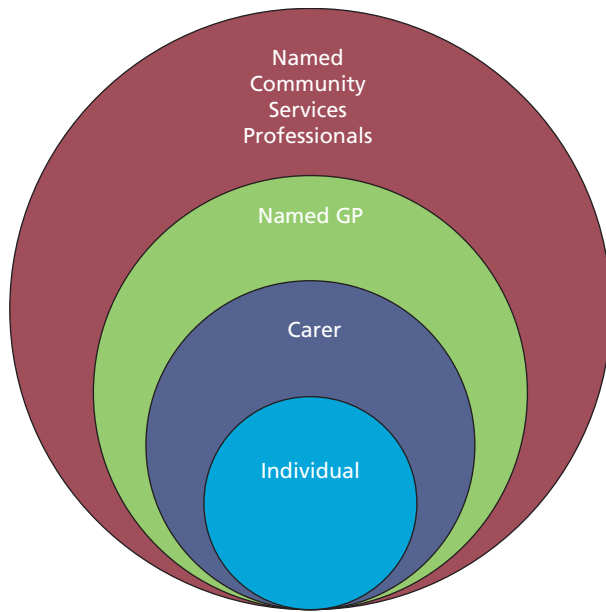


Figure 7:
Named Community
Services

*Named Community
Services Professionals:
responsibility for co-
ordination of specific
elements of physical and
mental health and social
care*

*Named GP:
holistic and ongoing
responsibility for co-
ordination of care*

*Individual:
their plan, developed in
conjunction with carer as
appropriate.*

rapid access for urgent or non-complex conditions and those who require longer/regular consultations, offering continuity of care for long-term conditions and frailty.

- Improve experience in relation to both the environment (premises), and the patient/citizen/community experience (Figures 5 and 6 above)
- Improve clinical outcomes in a way that improves the overall quality of the patient experience

From a **practice** perspective we are looking at how we can:

- achieve excellent clinical outcomes whilst managing the challenges of increasing complexity of need and demand for services
- work with our practices to ensure the right balance between demand and practice capacity
- continue professional development.

From the **wider health and social care system** perspective we are looking at how we:

- ensure that our primary care services are able to fulfil their pivotal role in the delivery and co-ordination of services within the wider health and social care environment, whilst genuinely placing individual service users at the centre of the process (see figure 7 above)
- look for new and innovative ways of delivering existing services which achieve genuine integration and continuity of services 7-days a week.

Once we have a locally agreed picture of what “Excellence in primary care” is, we will work to ensure that every person within the CCG’s population has access to a consistently excellent standard of care 7-days a week.

This will be done by promoting greater collaboration between practices as a means of achieving more effective working with other community health and social care providers, and supporting each other in the delivery of Excellent Primary Care.

An additional anticipated benefit of greater collaboration and new and more innovative ways of working is that it is likely to improve the attractiveness of the CCG in terms of the recruitment of both experienced GPs and trainees.

Everyone Counts: Planning for Patients 2014/15 to 2018/19,

NHS England; 20th December 2013 - paragraphs 36 and 37, p14

www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

Named GP Teams

The recommendations contained in “Everyone Counts: Planning for Patients 2014/15 to 2018/19” published by NHS England last year stated that funding would be provided for one year (2014/15), to support practices in the delivery of the ‘Accountable GP’ role.

In BBCCG, our aim is that everyone with an identified long term need has a named ‘accountable professional’ who, working as part of a wider health and social care team, is accountable for co-ordinating care and maximising outcomes for their patients in order to secure greater independence, control and self-reliance.

The CCG recognises that it is likely that planning for, commissioning, and embedding the additional services required to deliver this aim and achieve meaningful outcomes will take time. Therefore, it is planned to extend the funding for a further year, to March 2016.

In order to do this the CCG will be ring-fencing £1.24m (a sum equivalent to £5 per registered patient-weighted population) to support practices in the delivery of the ‘Accountable GP’ role. These funds are not an additional allocation to the CCG, but will be drawn from the existing commissioning budget.

Increasing Capacity

We would expect to see an increase in our primary care workforce by approximately one whole time GP for every 2,000 new residents. This would only take account of existing additional capacity if this was local to the need, since GP services are very location specific.

We wish to develop more training practices to help with recruitment and retention of GPs. We would aim to increase by a further three training practices over a three year period.

For each new GP required, estimate is a further 80-100m² of space to accommodate each GP and supporting/utility services, either in existing or new premises. This would be at the lower end of this range if expansion of existing premises proves possible.

We do not anticipate the anticipated level of growth to have major infrastructure implications for community or hospital services, but this is dependent upon the demography of the new population.

Key milestones

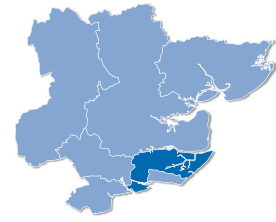
BBCCG has developed a set of key milestones and timelines through which the implementation of the vision will be delivered.

SECTION 1: CONSISTENCY	Apr– Jun	Jul–Sep	Oct–Dec	Jan–Mar	Apr–Jun
	2014	2014	2014	2015	2015
A. The CCG will work with each practice to identify the configuration of staff and resources and achievement against key quality indicators, identifying patterns and correlations between these factors across the patch in order to inform the process of developing models for the delivery of excellent primary care.					
B. The CCG will work with practices to improve the effectiveness of existing resource utilisation, and increase the level and range of resources available within the community					
C. The CCG will work with Patient and Community Reference Group and Patient Participation Group members to ensure they are fully involved in the development of the local strategy.					
D. The CCG will support the development of patient education programmes for specific patient groups.					
SECTION 2: HIGH QUALITY					
E. Basildon and Brentwood CCG will work with NHS England to drive quality improvement and where appropriate support performance visits. To achieve excellence in primary care we will agree high quality markers with all practices and work with NHS England to ensure all practices achieve at least the minimum standards.					
F. Basildon and Brentwood CCG will review key issues and will develop a programme within protected learning to support practice level improvement to achieve best practice					
G. Basildon and Brentwood CCG will work with all local GP practices to ensure good access to services that are appropriate to their differentiated patient population.					
SECTION 3: RESPONSIVENESS AND ACCESSIBILITY					
H. The CCG will create an environment that encourages better access to primary care services. Services available 7 days week need to be clearly defined and communicated, link to Out Of Hours (OOH) to avoid duplication, and to clearly state that patients won't always see their own GP.					

Primary Care Strategy Milestone Plan 2014/15 and beyond

SECTION 4: INTEGRATED SERVICES	Apr– Jun 2014	Jul–Sep 2014	Oct–Dec 2014	Jan–Mar 2015	Apr– Jun 2015
I. The CCG will work with practices to improve the effectiveness of existing resource utilisation, and increase the level and range of resources available within the community, through improved integration of planning and service provision with other health and social care providers.					
J. The CCG will:					
- ensure that each practice is aware of, and engaged in, the development and implementation of integrated health and social care services within Basildon & Brentwood as initiated by the Better Care Fund					
- work with local GP practices to explore the potential for improvements in provision through more effective intra-practice collaboration, leading to the development of new organisational structures					
- explore the possibility of commissioning a 'Prime Provider' model for the management of the health and social care needs of people aged 75 years and over, which may include the provision of primary medical services. In this case the CCG will work in partnership with NHS England to develop an APMS contract model.					
SECTION 5: SUSTAINABILITY					
K. The CCG will work with the NHS England Area Team and LMC to develop a sustainable model primary care provision.					
SECTION 6: PREVENTATIVE					
L. The CCG will develop and promote a new model of self care that helps to reduce unplanned activity at the hospital eg more frequent assessments to facilitate earlier intervention, improved communication with GP, prevention of admission e.g., village agent/neighbourhood co-ordinator:					
SECTION 7: RESOURCES					
M. The CCG will develop a workforce succession plan for primary care including future role for nurses and AHPs, and a recruitment drive/programme for GPs to increase the number of training practices.					

Castle Point and Rochford

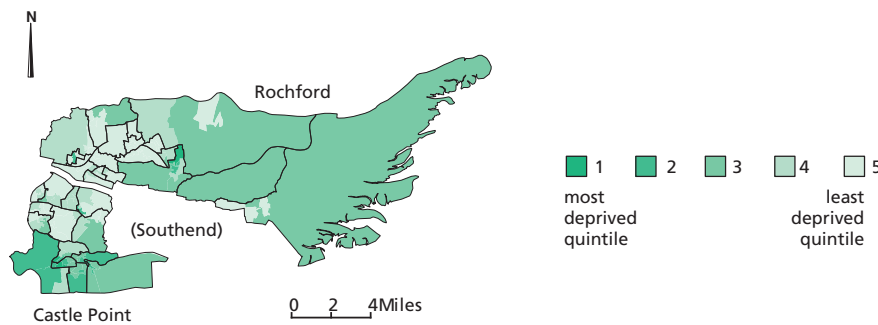


Introduction

The success of Castle Point & Rochford (CPR) CCG is dependent on our ability to transform primary care. This is because a key requirement of CCG success is the ability to move activity out of the acute hospital setting. If the shift is from acute to community care it is likely to have a minimal impact on cost, demand will probably rise, and quality will almost certainly fall. The shift needs to be directly into primary care so that it is linked to the core gatekeeper role of general practice.

But for this shift to take place primary care needs to change. Currently most practices in CPR CCG speak of concern at the prospect of more work. Primary care in CPR CCG is full, and has no capacity for additional activity. More worryingly, most practices lack the capacity or capability to expand to be able to take on more activity.

For primary care the situation is only likely to get worse. Local enhanced services have been split between CCGs, NHS England and public health, with some offered to other providers through Any Qualified Provider (AQP). NHS England is already trying to bring standardisation to the way the core contract is implemented. Notional rent looks certain to be time limited, and access to capital is highly likely to be down to individual practices as the days of NHS handouts to practices are coming to an end.



Left: This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2010 by Lower Super Output Area). The darkest coloured areas are the most deprived.

Geography

Castle Point and Rochford localities make up a large swathe of land surrounding the Southend locality. Each locality is served by its own borough council.

The CCG is made up of 28 practices across two distinct localities that map borough council boundaries (11 practices in Rochford and 17 practices in Castle Point). A list of practices by locality and population served is set out below. Their total registered population (taken from the Attribution Data Set in April 2011) is 177,000. This compares to an average for all 212 CCGs in England of 261,000.

The table below shows how the CCG population is expected to grow by 2015, 2020, and 2025. This is based on applying weighted averages of ONS population projections by age and Local Authority to the CCG's population.

The CCG's registered patients live in a single upper tier Local Authority which is Essex County Council, and the CCG accounts for 12% of its population.

Based on the average level of deprivation this CCG is ranked 180 out of 212 CCGs (where 1 is the most deprived). 3% of the CCG's population lives in an LSOA that is one of the 20% most deprived in England.

CPR CCG's main acute provider is Southend University Hospital NHS FT (SUHFT) and accounts for 46,077 (83%) of overall admissions. These represent 43% of SUHFT's total admissions.

Year	Population	Age 75+
Current (2011)	177,091	16,536
2015	181,491	18,817
2020	188,086	22,445
2025	194,855	27,492
Average annual growth rate 2011 to 2020	0.7%	3.5%
England average annual growth rate 2011 to 2020	0.7%	2.3%

Table : CCG Population Growth

Primary care vision in CCG

Our CCG vision is providing easy access to high quality, responsive primary & community care as the first point of call for people in order to provide a universal service for the whole population and to proactively support people in staying healthy.

The aim is to increase the proportion of episodes of morbidity that are commenced and completed in primary care without recourse to the acute services. Core aspirations linked to emerging Primary Care strategy and local strategic plans are set out in the table below.

CPR aspires to see a shift of up to 5% in resources from hospital providers into primary care over next 5 years equating to a transfer of £10m within the SEE system (£5M for CPR).

Why our Primary Care Needs to Change

Throughout our engagement with practices, we have heard that general practice and wider primary care services face increasingly unsustainable pressures and that general practice wants and needs to transform the way it provides services to reflect these growing challenges. The case for change is not unique to CPR CCG.

- An ageing population, growing co-morbidities and increasing patient expectations, resulting in a large increase in consultations, especially for older patients, e.g. 95% growth in consultation rate for people aged 85-89 in ten years up to 2008/09
- Number of people with multiple long term conditions is set to grow from 1.9 to 2.9 million from 2008 to 2018
- Increasing pressure on NHS financial resources, which will intensify further from 2015/16
- Growing dissatisfaction with access to services. The most recent GP Patient Survey shows further reductions in satisfaction with access, both for in-hours and out-of-hours services. 76% of patients rate overall experience of making an appointment as good
- Persistent inequalities in access and quality of primary care, including the twofold variation in GPs and nurses per head of population between more and less deprived areas
- Growing reports of workforce pressures, including recruitment and retention problems.

Our CCG clearly acknowledge that primary care needs to change if it is to cope with

RAYLEIGH & ROCHFORD DISTRICT LOCALITY			
	No	Name	Pop
	F81123	Lewis & Partners	18,487
	F81061	Conner S & Partners	7,046
	F81125	Cyrus C S & Partners	16,155
CCG Governing	F81065	Ramanathan S & Partner	4,529
Body GP Members	F81066	Kuriakose	5,721
— Dr Steve Taylor;	F81690	Singh B	2,913
Dr Mike Saad	F81089	Freel J F & Partners	9,953
(Chair); Dr Biju	F81007	Kothari C U & Partners	11,370
Kuriakose & Dr	F81675	The Practice Leecon Way	2,302
Mark Metcalfe	F81704	Jayaweera A H I	3,071
	Y00984	Bajen JM & Partner	8,122
	LCG Total		89,669
CASTLE POINT LOCALITY COMMISSIONING GROUP			
	F81142	Patel R M & Partners	6,190
	F81096	Kamdar M K & Partners	11,374
	F81699	Suleman-Qureshi U	2,366
	F81205	Ghauri J B & Partner	3,626
	F81051	Chavda & Partners	7,529
	F81700	Rahman H U & Partner	4,140
	F81075	Lester M J & Partners	12,363
CCG Governing	F81667	Gardiner R A	3,171
Body GP Members	F81101	Khalil SM & Partners	6,342
- Dr Sunil Gupta	F81001	Hiscock S C & Partners	11,045
(Accountable	F81739	Jena R & Partner	2,589
Officer); DR Roger	F81032	Patel P A	2,353
Gardiner; Dr Kashif	F81070	Brown B J & Partners	6,245
Siddiqui & Dr	F81618	Waiwaiku K N	3,691
Mahesh Kamdar	F81661	Sodipo JA	1,936
	F81740	Chaudhury	2,097
	F81713	Gill S & Partner	2,883
	LCG Total		89,940
CASTLE POINT AND RAYLEIGH CCG TOTAL			179,609

future demands and challenges. Some of the key challenges impacting this need to change are:

- Increase in Older Population
- More Chronic Diseases
- Rising GP workload exacerbated by recruitment difficulties

- Financial Pressures on NHS
- Increased Patient Expectations.

Our key priorities for primary and community care can be summarised as:

- Reducing variation in the quality of primary care
- Support for preventative care, wellbeing and early diagnosis of health problems
- Improved access to primary care on a 24/7 basis, supported by 111 and Out of Hours (OOH)
- Integrated approaches (linked to Better Care Fund) to care for the elderly and those with long term conditions
- Personalised care-planning and self-management
- Rapid, convenient access to planned and outpatient care, with more care provided out of hospital.

Preserving Strength in General Practice

There is widespread agreement that, in supporting reform of primary care, we must take great care to build on the strengths of general practice:

- Registered lists: providing basis for coordination and continuity of care. About 99% of the population is registered with a general practice in the UK
- Generalist skills: looking at physical, psychological and social needs in the round, managing risk/uncertainty, and connecting people with more specialist diagnosis, care and support.
- Central role in management of long term conditions, supported by the Quality Outcomes Framework (QOF).
- Highly systematic use of IT to support management of long term conditions, track changes in health status and support population health interventions like screening & immunisations.

Underlying Objectives for General Practice

We need to create an environment that enables general practice to play a much stronger role, as part of a more integrated system of out-of-hospital care, in:

- 1 Proactive co-ordination of care, particularly for people with long term conditions and more complex health and care problems.
- 2 Holistic care: addressing people's physical health needs, mental health needs and social care needs in the round.
- 3 Ensuring fast, responsive access to care and preventing avoidable emergency admissions and A&E attendances.
- 4 Preventing ill-health, ensuring more timely diagnosis of ill-health, and supporting wider action to improve community health and wellbeing.
- 5 Involving patients and carers more fully in managing their own health and care.
- 6 Ensuring consistent high quality of care: effectiveness, safety and patient experience.

We need to ensure that this is rooted in the needs of local communities and the priorities that Essex Health and Wellbeing Board have identified for our local populations.

Scale, integration and investment

Although there is no single blueprint for effective provider models, our practices are coming to the view that they won't be able to improve care and access for patients unless:

- General practice operates at greater scale, for instance through networks, hubs, and federations or practice mergers
- ...but scales up in a way that preserves the greater relationship continuity that comes from individual practice units
- General practice is at the heart of a wider system of integrated out-of-hospital care, working on a more systematic, collaborative basis with community health services, social care, voluntary/charitable organisations, community pharmacy and other partners (our emerging frail elderly hub is a key example of this in operation).
- There is a shift of resources from acute to out-of-hospital care, but with need for local flexibility as to how far this flows into general practice and how far into wider community services that 'wrap around' general practice.

CPR CCG Locality Practice 'Hubs'

Although the Governing Body acts to take decisions on the vast majority of CCG business, members have agreed to maintain two locality groups ('Castle Point' and 'Rochford') for more direct practice involvement in decision making where every practice is represented. The Locality Groups meet monthly and also act to both approve the commissioning plans and to seek direct assurance from the Governing Body that it is delivering the plans.

The Locality Groups are also the forum for considering any changes to the CCG Constitution ahead of proposing these to NHS England. Each practice has nominated a GP practice representative who will be responsible for a number of important CCG commissioning activities within their practice.

Member practices are engaged in the operation of the CCG through this CCG locality structure, which will operate as a forum for members to hold their GP Governing Body representative to account and to work with them to influence and support the CCG in achieving its strategic ambition. Whilst sitting outside the formal committee structure, the localities are the 'power house' of the CCG membership organisation.

These two localities create natural boundaries to create 'hubs' to consider and implement service models in primary care that see practices working under enhanced partnership operational arrangements.

We need to create a primary care strategy that is meaningful to our practices. A good place to start is to look at 'Practice Hub' models. This is building and grouping our member practices around our localities (each serving around 85,000 people). Of course, Practice Hubs are not the only answer. But they point the way, and start to create a picture of what the future of primary care could look like in CPR CCG.

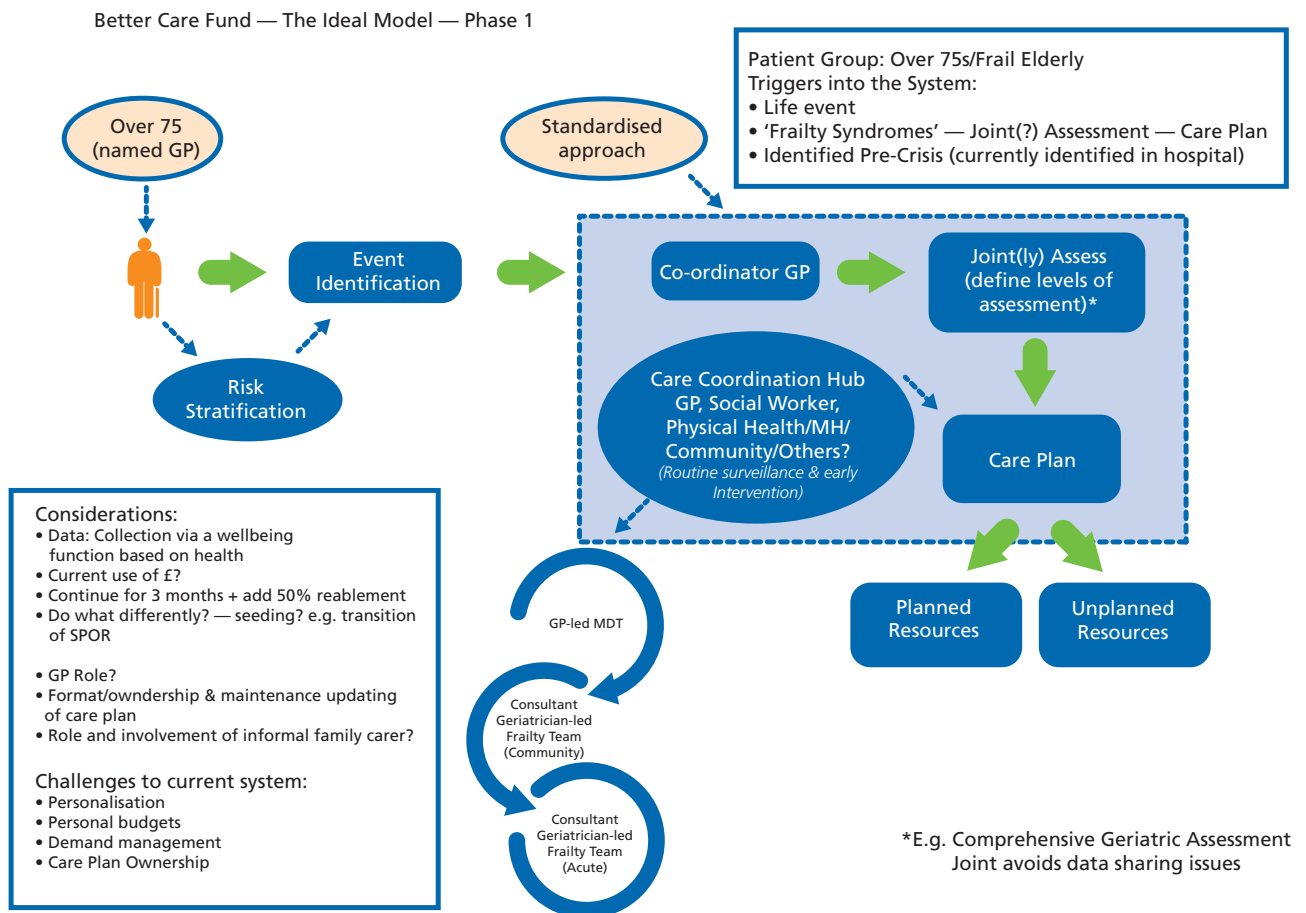
Practice Hubs and localities are the ideal mechanisms that primary care can use to change how they operate. If the member practices in our CCG understand what is required of primary care through the CCG core business, and can use the strengthening of inter-practice relationships that CCGs bring, there is an opportunity for our practices to start to work together to reshape their own businesses. The challenge for a CCG is to create a primary care strategy that maps directly to the business strategy of each individual member practice.

Practice Hubs in Operation

A developing integrated service model where we see the 'hubs' operating in the management of 'frail elderly'. The emerging model below sets out the pathway with the co-ordinating hub clearly evident with GP practice leadership and accountability at the centre.

The ambition of CPR CCG primary care strategy is to ensure it is totally aligned with the core business strategy of each of its practices. If the two can work together then primary care can rescue their businesses, and the CCG can be successful.

Previous primary care strategies were always top-down creations that had little relevance to individual practices. CCG primary care strategies, if CCGs can succeed in making them relevant and owned by their member practices, have the potential to truly transform primary care.



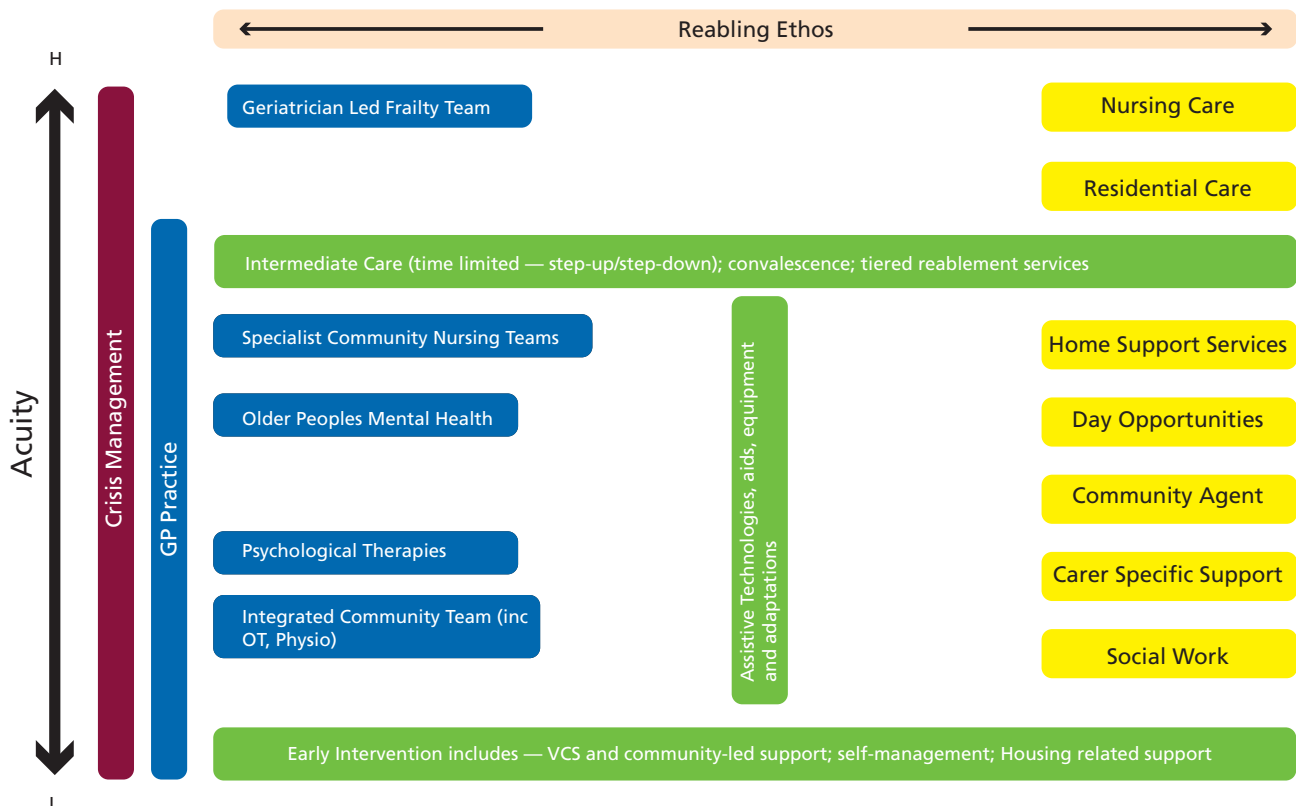
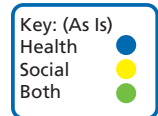
How do we promote these changes?

- 1 Empower our patients: information, choice and control.
- 2 Stimulate and support clinical leadership and innovation in our CCG.
- 3 Free up time and resources: root out bureaucracy and promote more productive practice.
- 4 Build consensus around key responsibilities and accountabilities of general practice.
- 5 Consider using the GP contract to create stronger focus on whole-system outcomes.
- 6 Support safe, controlled investment in primary care and community services.
- 7 Market management: tackle poor performance and bring in new providers to stimulate innovation and improve capacity, for instance in deprived areas.
- 8 Workforce development: build capacity and create rewarding primary care careers.

All of the above will require concerted cross-sector working by partners, both nationally and locally. NHS England and CCGs cannot do this alone.

The Ideal Model — Resource Requirements — Phase 2

highlighted below are the resource requirements that are required to support the integrated model (the key indicates the current providers of these services). These services will all form part of the integrated model with delivery of these to be developed.



Workforce and Skill

Based upon a retirement survey undertaken by the LMC in 2012, results indicate that within CPR CCG alone, NHS England can expect to see 28% of its GPs retire in the next five years with 14% of those opting to retire within the first one to three years.

GP Age Profile (excluding Locums, Registrars and Retainers — data correct at time of document production)						
	Under 50	50-54	55-59	60-64	65-69	70+
Basildon & Brentwood	49%	19%	14%	8%	6%	4%
Castle Point & Rochford	38%	17%	17%	14%	9%	5%
Mid Essex	53%	21%	16%	7%	2%	1%
North East Essex	61%	16%	12%	8%	1%	2%
Southend	41%	12%	16%	13%	7%	11%
Thurrock	47%	7%	16%	14%	5%	11%
West Essex	65%	13%	14%	5%	2%	1%
Essex	54%	16%	15%	9%	3%	4%

This reduction in GPs is only based upon retirement figures and does not take into consideration any other reasons that a GP may choose to leave general practice within CPR. Although this information is only an indication for Essex, based upon the age profile information above, it can be surmised that there is likely to be significant retirements in CPR and Essex-wide.

These survey results are also supported by a British Medical Association survey carried out in 2011, which also identified that 25% of the GP workforce across the country expressed an intention to retire in the next five years.

Alongside potential retirement of GPs across Essex over the next five years, there is also an indication that Practice Nurses and Nurse Practitioners are likely to begin retiring over this period, although at this present time, age profiling data is not available to underpin this assumption. Work will be undertaken to produce an age profile in respect of Practice Nurses and Nurse Practitioners and also a survey undertaken, similar to that undertaken by the LMC, to ascertain the level of potential retirement and the factors that have contributed to reaching that decision.

The profiling of the clinical workforce within general practice when considered alongside the demographic projections provided by the Office of National Statistics become significant as projections indicate a 5% increase in GP practice list size and an expected increase in primary care consultation of 7% (or 12% if historical trends are taken into account) over the next five years.

CPR CCG will work in partnership with NHS England Area Team to support initiatives to retain and attract GPs to Essex.

Primary Care Training and Development

Primary care plays a vital part in the delivery of our Strategic Plan and in improving patient outcomes. One of the five CCG goals included in our plan is to reduce the variability of primary care quality and outcomes so that patients across the localities receive the same high standard of care.

The CCG would like to commission a project looking at primary care quality and their capacity to deliver this Strategic Plan and achieve improvement in the outcome indicators. This work would be completed during 2014/15 to inform a longer-term strategy to improve primary care quality and reduce variation in patient outcomes across the CCG geography.

The intention is that our CCG will support the Area Team to invest in a programme of targeted primary care development to enable delivery of the Strategic Plan and the outcomes included in the High level Ambitions. The purpose of this development programme is to:

- Support high quality care in primary care and community settings (ensuring access for all)
- Improve the identification and management of a range of conditions
- Provide more care closer to the patient and by doing so decreasing reliance on acute hospital care
- Aim is to shift resources currently invested in secondary care to primary care with the workload.

The primary care development programme would operate using a variety of different training approaches — including peer-to-peer and specialist-led programmes, formal learning events, clinical protocols and practice-based audits — to achieve targeted improvement in the following areas included in the Integrated Plan:

- Early identification and accurate diagnosis of long-term and other priority high prevalence conditions
- Enhanced ability to manage long term conditions, to avoid hospital referral and support better patient outcomes
- Medicines management knowledge in order to provide quality, cost-effective prescribing and support
- Management of patients in primary care where part of an agreed pathway/shared protocol
- Good understanding of agreed local pathways and local service configuration to enable referrals to be made to the right service for each patient's needs, at the right time

Practice staff training will focus on our strategic priority areas, which include long-term conditions (diabetes, respiratory and CVD), mental health (including dementia care), and planned care, aimed at supporting a shift of care setting in specialities like dermatology and ophthalmology.

The scope of the development programme would not include formal GP training, nor is it intended to replace the CPD programme. The programme is designed to be complementary to other training resources for primary care staff and will operate in alignment with formal training programmes. We would ensure that the wider training and workforce issues emerging from our Strategic Framework and this Integrated Plan are reflected in training plans over the next five years and beyond.

CCG Headline Aspirations

Headline Aspirations	Month / Year Complete
Core Primary Care Strategy Aspirations supported by our CCG	
1. Estate: Make full use of premises. Endeavour to ensure that any void primary care estate is fully utilised.	Dec 14
2. List Size: Encourage Individual GP practices to move towards having a minimum list size of 4,500 patients serviced by the equivalent of 2.5WTE GPs and/or develop close associations with neighbouring practices to share skilled resources.	Mar 16
3. GP Workforce: CPR would support Primary Care Strategy aim to increase number of GPs working in CP&R through the establishment of more training practices and enhanced roles within hubs/localities that attract professionals.	Linked to Strategy
4. Practice Nurses: CPR would support Primary Care Strategy aim to increase number of nurses working in CP&R through the enhancement of nurse practitioner training and enhanced roles within hubs supported by LETB	Linked to Strategy
5. Quality & Standards: As per the above initiatives to increase quality and reduce variability, we will be working with practices which are currently unable to evidence that they are delivering high quality care in line with CQC standards, to avoid the risk of potential decommissioning.	Ongoing
6. Technology: Increase the % of CPR GPs using text messaging service to remind patients of their appointments	Apr 15
7. Federation/Networks: CPR GP practices aim to create Federated structure with focus on forming a virtual hub covering CCG population	Apr 15
8. Integration: CPR has arrangements in place with community provider to ensure HV/District Nurses are aligned to individual practices.	Jan 14
9. Activity Impact: 10% shift of activity alongside shift in resources from acute to primary care.	Apr 18
10. Hub / LTC Management: CPR patients with LTC to have a named clinician/managed by a specialist within a hub or hub created as specialist practice for patients with LTC.	Apr 15
11. Hub clinics (frail elderly) provided by GP practices / within a hub / hub delivering clinics.	Apr 15
12. Community Pharmacy: The CCG will support AT initiative that will undertake triage, diagnosis and treatment of minor illness in a pharmacy setting / write prescriptions for a limited list of medications from pharmacy or as part of primary care team in general practice / fully integrated into primary care team delivering consultations, prescribing, immunisations	Apr 15
13. Pharmacists: take on a greater role in managing supplies of repeat medicines enabled by batch prescribing and electronic prescriptions / pharmacists will request or carry out appropriate routine monitoring e.g. blood tests and be able to re-authorise repeat medicines. This will be integrated with face to face discussions with the patient about their medicines / A holistic patient centred medicines service focussed on patient wellbeing, enablement and joint decision making, working closely with the patients GP.	Apr 15
14. Pharmacists: managing straightforward conditions such as allergic rhinitis, hayfever, dry and itchy skin / management of long term conditions such as asthma or chronic pain, in the pharmacy, linked to and supported by GP hubs, specialist pharmacists will be employed within hubs to be part of specialist teams caring for patients with LTC.	

CCG Specific Aspirations

	Headline Aspirations	Month / Year Complete
15	Innovation: CCG Innovation Group agrees approach to reducing variation, including training and development plans, access and productivity initiatives. Key initiatives include electronic patient assessment tools, and roving GP car.	Dec 14
16	Training: Secure support to deliver training programme and agree future priorities and funding.	Jun 15
17	Practice Engagement: Plan and deliver a programme of Practice Visits to present emerging CCG Strategic and Operational Plans so practices clearly understand their role and responsibility in delivery.	Jun 14
18	Practice Engagement: Agree and support individual practice to operationalise their development plans.	Ongoing
19	Integration: Working with Better Care Fund Programme to implement a plan to address gaps in supporting self-management in long term conditions such as local Diabetes Integration initiative.	Apr 15
20	Integration: Further develop risk stratification for vulnerable elderly, linking to Better Care Programme work, care-co-ordination and Community Multi-Disciplinary Team development.	Apr 15
21	Referral Management: Continue to develop referral support services, in particular peer review.	Apr 14
22	Diagnostics: Develop diagnostics strategy and implementation programme.	Dec 14
23	Care Homes: Reduction in emergency admissions from care homes.	
24	Workforce: Number of GPs working in CPR will increase through the establishment of more training practices and enhanced roles within hubs that attract professionals.	
25	Consider the provision of Urgent Care in Primary Care: The CCG will consider the provision of Urgent Care/Darzi Centre in CPR localities with view to relieving pressure on Acute A&E services.	

CPR CCG agreed initiatives for primary care are set out below with key milestones.

Develop CCG-wide GP Federation

The CCG practices are working together to establish a Federation with a view that over the next five years they will work closely together. This will benefit patients in the CCG area as there will be more opportunity to transfer services from the acute to the community. Additionally working closely should provide the following opportunities:

- to make efficiency savings/economies of scale, for example in back-office functions or the procurement of practice services
- to improve local services integration across practices and other providers
- to strengthen clinical governance and improve the quality and safety of services
- to develop training and education capacity.

A project is currently being implemented by GP Clinical Leaders to design GP Federation model across the CCG.

Leads: Dr Riz Khan, Dr Mahesh Kamdar

Consider Poly Clinic Model

The CCG's Clinical Leadership Team is currently reviewing primary care access and this will incorporate the 24/7 day working into this model, taking the form of commuter/poly-clinic model.

Lead: Dr Riz Khan, Dr Mahesh Kamdar

Technology

The CCG is currently reviewing the use of technology to support the poly-clinic model e.g. telephony, telehealth, text reminders to patients to reduce DNAs, etc.

Lead: Dr Kashif Siddiqui

Co-ordinated GP Home Visits

The CCG is undertaking a review of the current GP home visit arrangements, to identify the potential benefits of utilising a home visits model that will deal with crisis calls to surgeries. The proposed model would ensure patients are seen (and treated) early by a GP and if the patient needs to attend hospital, it would enable them to be seen early to ensure speedy transfer for investigation and potential discharge on same day.

Lead: Dr Sunil Gupta

Integrated Hub Service Model and Multi-disciplinary Working

Development of differing models of service delivery, to utilise and optimise the skills of multidisciplinary teams.

Lead: Kevin McKenny, Emily Hughes, Dr Mike Saad

Concentrated Clinical Expertise

The CCG is currently exploring the benefits of concentrated clinical expertise to reduce unnecessary demand on secondary care services. This is to be achieved through peer to peer referrals undertaken based on specialised skills e.g. dermatology, ophthalmology, minor surgery etc.

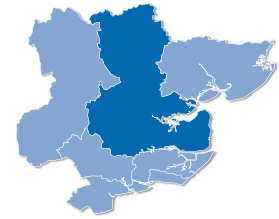
Lead: Dr Mark Metcalf, Emily Hughes

Increased Capacity in Primary Care

The CCG is undertaking a review of primary care capacity across the localities; this will include GP, practice nurse, nurse practitioners and HCA capacity, linked to District Nursing and community support.

Lead: Tricia D'Orsi, Dr Mike Saad

Mid Essex



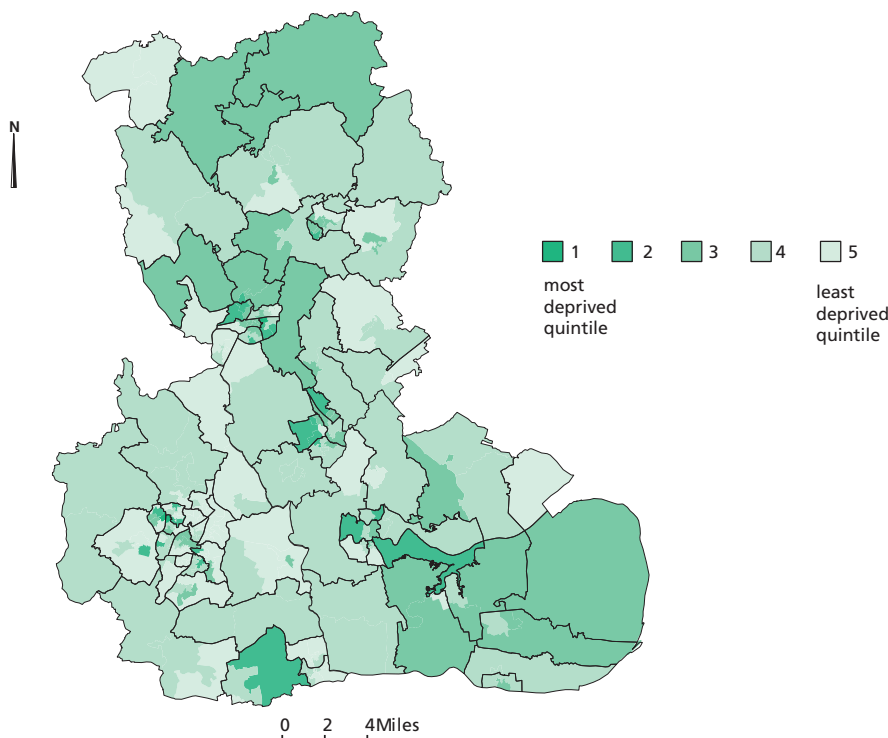
CCG Vision for integration

Mid Essex CCG is working with Essex County Council to develop integrated health and social care services across mid Essex. These services will initially focus on the frail elderly, long term conditions and our local immediate care systems. Primary care, and in particular care delivered by general practice, has been a cornerstone of the NHS since its inception and a strong, sustainable primary care system is essential. High quality, accessible Primary Care services will be central to the development and success of these integrated services.

CCG Outcomes

Linked to its Vision, the CCG's overarching defining outcomes are:

- Mid Essex residents to live a healthier and longer life
- Mid Essex residents to be supported to look after their health and wellbeing
- Reduction health inequalities for Mid Essex residents by narrowing the gap in life expectancy
- Mid Essex residents to be provided with good quality, harm-free and affordable healthcare
- Mid Essex residents who are frail and have a long term condition to receive integrated health and social care services to reduce demand on local services
- Mid Essex residents to be supported to access and use healthcare services appropriately.



Left:
This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2010 by Lower Super Output Area). The darkest coloured areas are the most deprived.

Population Demographics & Inequalities

In terms of population projections to 2021, Mid Essex will see only small increases in most age groups except in people aged 6-15 years and those aged over 55 years. The

actual growth in the latter group for Mid Essex will be significant, with a 28.7% growth in those aged 65-75 years and 38.9% growth in those aged over 75 years. This will have an impact on all services and the CCG will work closely with its partners to ensure they commission the right level of service provision. There are some pockets of deprivation in each district. Despite an upward trend in life expectancy, there are significant pockets of inequality clearly related to deprivation, lifestyle choices and poor engagement with statutory agencies.

Local Infrastructure and Primary Care Capacity

There is a significant variation in patient to GP ratio across Mid Essex. Chelmsford 1,331/GP, Braintree 1,653/GP and Maldon 1,849/GP. The CCG and NHS England should review the level of GP provision to ensure safe and effective practice in primary care.

Disease Management and Prevention

The disease registers show a lower than expected proportion of people with ill-health, especially for cardiovascular conditions and diabetes. More effort is required to improve disease ascertainment and to identify, support and treat people at risk of ill-health earlier.

The proportion of people who consume excessive levels of alcohol and who are overweight is growing in Mid Essex. First line interventions, such as regular physical activity and healthy eating, must be proactively promoted in primary care to tackle the rise in obesity.

Immediate Care and GP Referrals

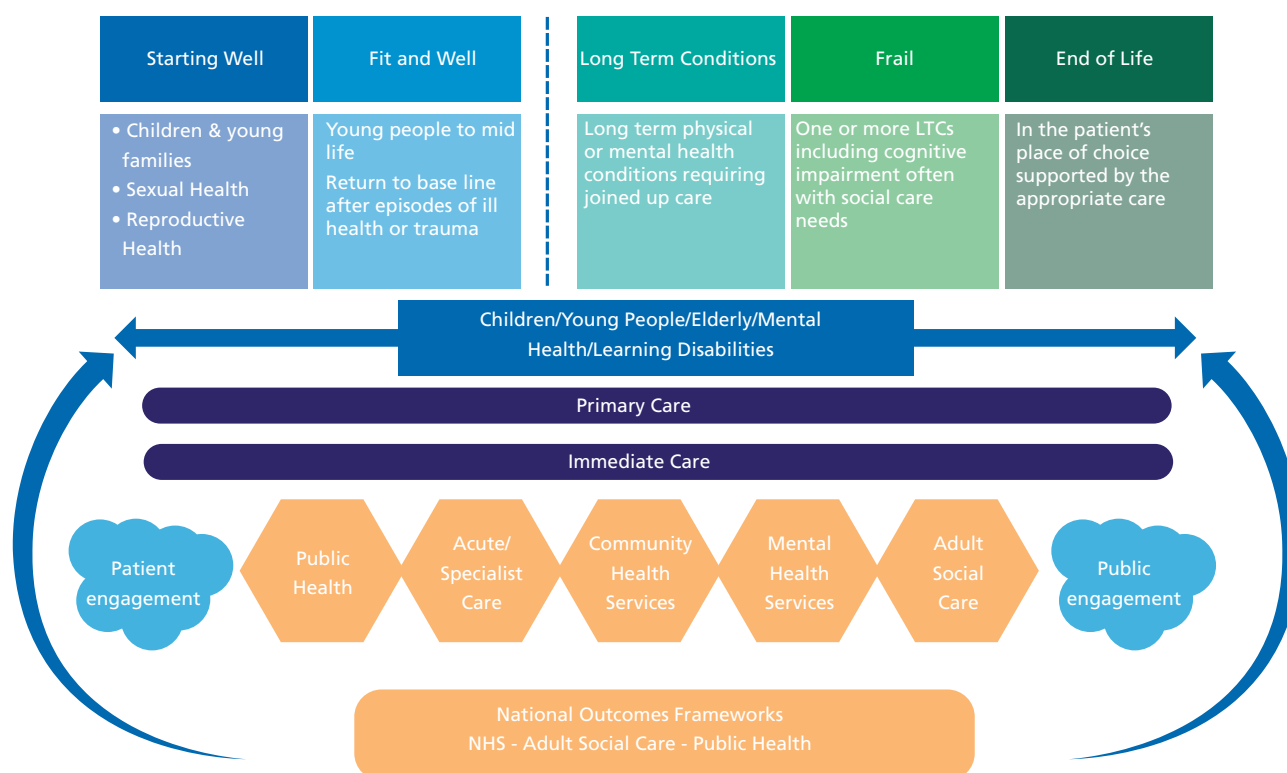
Although Mid-Essex is a high performing CCG when compared with others, there is still a need to reduce demand on immediate care and to ensure effective management in primary care, including a number of conditions described as ambulatory care sensitive where this can be managed better. The public continue to report concerns about access to primary care, especially in regards to out-of-hours and rural dispersion of services and these concerns will be addressed. The CCG's referral rate for first outpatient appointments is one of the lowest in the country, with an average GP referral rate per 1000 patients of 12.58 compared with the Essex average of 15.15 and England average of 16.70.

Priority areas

The following are topics that the CCG consider as potential priority areas, many of which are associated with long term ill health:

- GP Referrals
- Diabetes prevention and better identification
- Circulatory disease prevention, identification & management of hypertension
- Mental Health prevention, early identification and management
- Neurological services
- Prescribing costs
- Lifestyle risk factors — better prevention strategies, including falls

MECCG — Building Strategy around Phases of Life



Priority Areas for the CCG membership

Our strategic vision is built on a compelling case for change with a clear set of reasons for improvement in order to realise three essential deliverables:

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

The clinical vision for the CCG concentrates on optimal care being provided in the different “phases of life” as well seeking to reform and improve services which support this (immediate care, primary care) at less than the current cost.

We want to improve the health of the people in Mid-Essex and ensure healthcare services are meeting public expectations. The population profile of Mid-Essex is ageing rapidly leading to greater demand on local health services. Hospital is not always the answer: more care can be delivered in primary care and community settings than ever before, and patients benefit from care provided closer to home. We want to deliver the transformation of primary care services. There are workforce challenges which currently affect delivery of the best quality care and optimal patient outcomes. We need to adopt new models of care and best practice which can deliver better health outcomes for patients. We want to make best use of our local taxpayers’ money.

GPs and their practices will play an important role in influencing the strategy and will need to understand how a primary care strategy will affect their commissioning decisions for acute, mental health and community services. The strategy will succeed with the clinical ownership of GPs, working in conjunction with our local authority and health partners. The strategy aims to help address the challenges and opportunities presented in reshaping the local NHS. It should be read in conjunction with the CCG’s Integrated Plan and Out of Hospital Strategy.

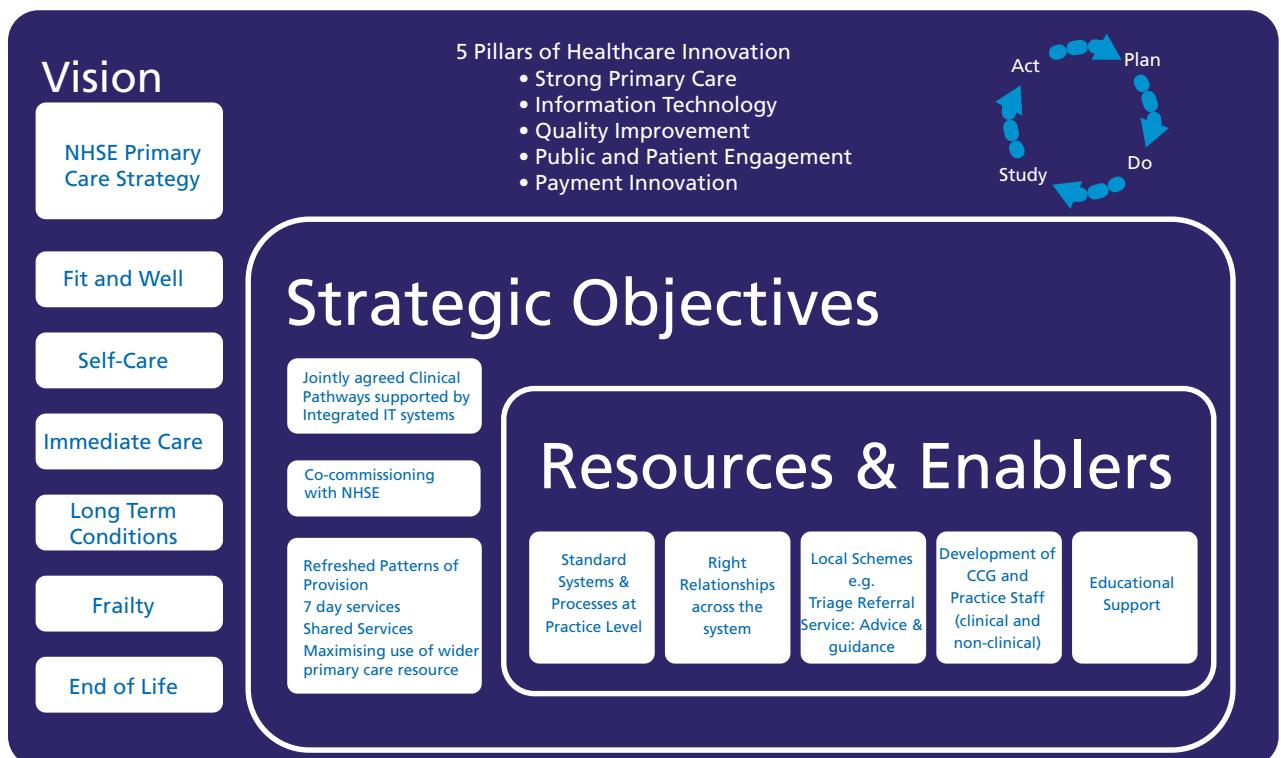
Healthcare in Mid Essex is required to change for the following reasons:

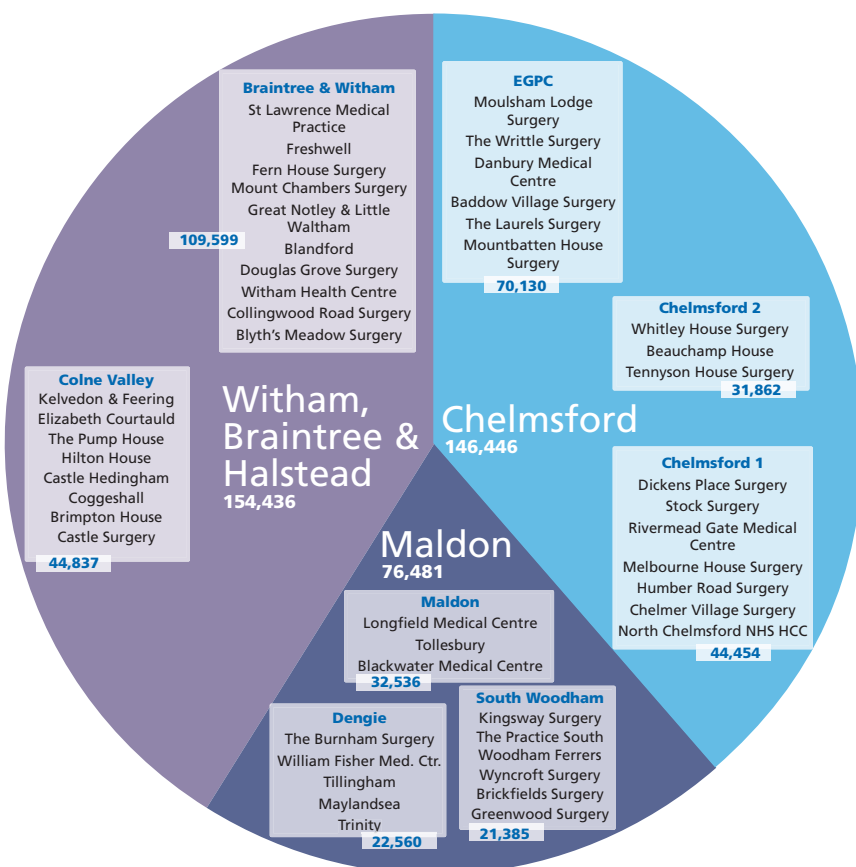
- ❖ To ensure that clinicians are at the forefront of the planning for future commissioning of care
- ❖ To relieve the pressure on wider NHS and primary care resources and ensure that services are both configured and used appropriately to ensure optimal clinical outcomes, minimise wasted resources, and an improved patient experience
- ❖ To optimise the roles and responsibilities of patients within their own care, to promote optimum use of NHS resource and patient empowerment
- ❖ To enhance the integration of health and social care to minimise the fragmentation of patient care
- ❖ To ensure there is a primary care workforce that is fit for the future, with the ability to attract GPs in particular, and make better use of community pharmacists
- ❖ Because information is poorly shared across partner organisations, which serves to inhibit both the delivery of patient care and their subsequent experience of the care delivered
- ❖ We are currently operating in a system that is financially unsustainable.

Aspirations

MECCG's vision is to support primary care to thrive and develop in Mid Essex and to drive the delivery of its Five Year Plan, including transformation programmes, enabling patients to be treated as close to home as possible in a timely manner, while recognising that primary care includes provision of clinical services by community pharmacists, optometrists and dentists as well as GP practices.

Delivery of the Primary Care Work Programme is twofold:





GP Practices in localities and sub-localities showing registered patients as at April 2014

- 1 To support GPs in delivering a consistently high standard of care to patients across Mid Essex through reduction of variability and in building local capability and capacity.
- 2 To support GPs in the transformation of how primary care is delivered, moving towards strengthened surgery/primary care based practice and creating shared provision of services by working closely with all primary care healthcare practitioners and social care in an integrated service.

Having high quality and equitable primary care chosen by patients and local residents is central to our vision. We recognise the need to be linked with the community, acute and mental health strategies so that patient pathways are seamless and the health economy works well. Improving health outcomes and significantly reducing inequalities remains a key focus. Access, clinical effectiveness and patient experience are key components of our direction of travel. The strategy promotes a patient-centred integrated care service. The CCG aspires to see a shift of activity from acute into community, where appropriate.

Practices will work together collaboratively across each sub-locality, building care networks to support their patients, working with wider primary care e.g. community pharmacists, social care and community health services. Patients will be registered with one practice but have access, through the collaborative network, to healthcare from local GPs and other healthcare professionals such as therapists with expertise in their conditions, and access to social care if needed. Practices will work more closely and collaboratively with social care, voluntary and community services to support local populations. IT systems will support information flowing electronically, so it is there when needed for patient care. Systems will provide incentives for providing the right care at the right time, and practices and other healthcare providers will be remunerated for the outcome — rather than the volume — of services provided. Tools will support care teams to co-ordinate a patient's care better across many different settings and providers. GPs will have access to better information about performance so that practice leadership can set goals on how to improve and serve patients better, and support primary care's role as commissioners.

Milestones

A significant amount of this remains dependant on some of the discussions the CCG is having nationally regarding the current under-funding in Mid Essex, local discussions with NHS England regarding the resources required to sustain high quality primary care and the pace of change required across the system. It is recognised that as a CCG we are a clinically led, membership organisation which means the details with regard to our forthcoming two and five year plans are still yet to be finalised. As a CCG we are also currently undergoing a sustainability review which will seek to make recommendations across the Mid Essex health care system including Primary care.

Essential to the delivery of the vision is a need to provide ongoing support and development to our membership community, and a clear communication and engagement plan to maintain the dialogue and mandate from our practice constituencies.

Equally important is maintaining communication and engagement with the public, our patients, wider primary care, our partner organisations and the voluntary sector.

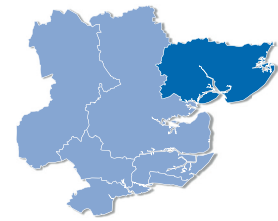
Key objectives:

- Greater alignment with NHS England to ensure understanding of strategy and resource implications — *NHS England Primary Care Strategy*
- Engagement with GP members, working through sub-locality lead commissioning GPs, to support development and transformation of primary care.
- Implementation of a Self-Care Aware Approach to Demand Management by actively supporting, promoting and empowering patients and the public with information about safe self-care, and in so doing address: Access, Capacity, Demand, Referrals, Quality, and Satisfaction
- Movement to a position of jointly shared risk and opportunities between primary and secondary care through development and implementation of long-term conditions pathways — from patient referral to appropriate care (primary or secondary) to being at home.
- Greater alignment with secondary care colleagues and in and between surgeries to ensure the right level of triage including:
 - development of Triage Referral Services (internal and external) to include Advice and Guidance
 - meaningful collaborative network working also involving community pharmacists and optometrists
 - development of GP/primary care networks with, where appropriate, specialist portfolios across the system but ensuring GP led continuity of care
 - clarity about peer review and specialist enhanced services.
- Use of Practice Portfolios to support change. This will include:
 - Baseline of capacity and capability at each practice
 - Use meaningful benchmarking as business intelligence to appropriately support practices
 - Identification of workforce and skill-mix issues, and assessment of learning and education needs to facilitate consistent methods of organising work and reducing variability in quality of service provided
 - Recognition of exemplar GP practices and sharing of good practice
 - Identification of learning and education needs to facilitate consistent methods of organising work and reducing variability in quality of service provided
- Exploration of incentives with all parts of the system-lead provider model; alliance contracting; support for GPs who are doing well
- Establishment of contracting mechanisms to facilitate movement of resources around the system, supporting development of primary care.

Priority initiatives for 2014-15

	Key initiatives	Start Date	End date
1	GP upgrade/migration to new clinical systems commences	May-14	Sep-15
2	PIMMS Practice Incentive Scheme finalised and rolled out	May-14	Jul-14
3	Develop practice portfolios, benchmark practices, prioritise practices identified and practice visits commence	May-14	Jul-14
4	Establish the Primary Care work stream and ensure sufficient capacity to support the delivery of the Strategy	Jun-14	Jul-14
5	Consult on the CCG Primary Care Strategy and contribute to NHS England Primary Care Strategy	Jun-14	Sep-14
6	GP summit — Practice variation and GP engagement	Jun-14	Jun-14
7	Deadline for CCG to express interest in co-commissioning (20th June 2014)	Jun-14	Jun-14
8	Ensure primary care staff understand collaborative networks and their role within them as member practices and providers of services — commence briefings	Jun-14	Sep-14
9	Ensure primary care contributes to the development of out of hospital care, maximizing skills and resources and upskilling as necessary	Jun-14	Mar-15
10	Encourage practices to work collaboratively and support the development of a provider organisation / federation	Jun-14	Mar-15
11	Improve the quality of referrals — devise training package with EQUIP	Jun-14	Mar-15
12	Centrally collate and share learning from significant events identified in primary care	Jun-14	Mar-15
13	Contribute to the Reconfiguration of Immediate Care programme board	Jun-14	Mar-14
14	Contribute and comment upon the development of the NHS England primary care estates strategy	Jun-14	Sep-14
15	Roll-out the use of the United Health risk stratification tools into routine practice — PID agenda permitting	Jul-14	Aug-14
16	Roll-out the use of Eclipse Live and embed within routine practice	Jul-14	Sep-14
17	Drive improvements in primary care prescribing through PIMMS and sub-locality practice pharmacists	Jul-14	Mar-15
18	Work with CCG member practices to respond to the Area Team of NHS England red-flag visits regarding quality and performance	Jul-14	Mar-15
19	Establish links with the LMC, LDC, LOC and LPC and ensure the CCG maximises input from all primary care contractors	Jul-14	Mar-15
20	Review and develop CCG Quality and Performance reports and send out monthly	Aug-14	Mar-15
21	Establish links with Healthwatch, PPGs and Patient Forum to explore strategies to promote self care	Sep-14	Nov-14
22	Training packages start — EQUIP	Sep-14	Mar-15

North East Essex



Summary

Primary care, and in particular care delivered by general practice has been a cornerstone of the NHS since its inception. Its delivery model has evolved through the years but potentially faces its greatest challenge with the introduction of the Health and Social Care Act 2012.

Whilst GP services will be commissioned by NHS England, it will be imperative that Clinical Commissioning Groups support and encourage the development of primary care services.

Our strategic vision is built on a compelling case for change with a clear set of reasons for improvement in order to realise four essential deliverables:

- Access across seven days a week
- High quality and equitable primary care services that improve patient outcomes
- Reduction in health inequalities
- Value for money to our residents.

Our case for change focuses on the following factors:

- Changing population — the population living longer, the increase in the population numbers and the change in demography
- Increasing health and wellbeing needs
- Variations in access to primary care medical services
- Variations in clinical quality and patient health outcomes
- A changing workforce profile and changing skills set needed for new models of care
- Changes to care provision.

GPs and their practices will play an important role in influencing the strategy and will need to understand how a primary care strategy will affect their commissioning decisions for acute, mental health and community services.

The strategy will succeed with the clinical ownership of GPs and working in conjunction with our local authority and health partners.

The strategy aims to help address the challenges and opportunities presented in reshaping the local NHS. It should be read in conjunction with the CCG's 2 year operational plan, 5 year strategic plan, Care Closer to Home Strategy, End of Life Strategy and Urgent Acre Strategy.

The recommendations are:

- 1 To have a clear focus for primary care around addressing the improvements in health outcomes and overall quality. This would include supporting continuing improvement in the quality and productivity of primary care services, ensuring universal quality standards of service delivery.
- 2 To establish integrated care networks of practices to collaborate with other health and social care providers on population based services. It is expected that the patient will have an improved experience, with a better managed episode of care by reducing duplication across the provider services.

- 3 To work as a catalyst for encouraging practices to work together with a focus on enablement and empowerment of member practices to build a shared sense of responsibility and capacity to support the implementation of the strategy
- 4 To capitalise on opportunities for partnership working, particularly with the Area Team of NHS England, neighbouring CCGs, health and care providers across the patient pathway — both in the health and third sector and other agencies such as Health Education England, Local Medical Committee and GP Primary Choice
- 5 To encourage universal population coverage of health care, fairness, equity and transparency in the way general practice services are commissioned and assurance of value for money.
- 6 To produce a workforce plan, in collaboration with the Essex Workforce Steering Group, that supports succession planning and enhanced role of GPs, nurses, practice managers and other allied practice staff. This will need to consider links to all health professionals in the integrated care model including pharmacists and community staff.
- 7 To support the development of premises fit for purpose and sufficient for the needs of the growing population.
- 8 To maximise the role of information management technology to ensure practices are able to access high quality information relating to their patients in order to improve quality and value for money.
- 9 To harness the skills of other independent contractors and allied health professionals to support and complement those of General Practice in order to make best use of the varied workforce to deliver high quality care.
- 10 To ensure the CCG has sufficient capacity to support the implementation of the Strategy

Introduction

NHS North East Essex Clinical Commissioning Group (NEE CCG) recognises that good primary care is the bedrock of a cost-effective healthcare system for its population. Primary care is the first point of contact for over 90% of patients and service users. General practitioners (GPs) play a crucial role in coordinating chronic disease management, health promotion, diagnostics and early intervention, and treatment information management.

The NHS England primary care strategy covers the role of independent contractors within the current and future health system, and closely links with other existing and emerging strategies such as the Joint Strategic Needs Assessment, Public Health Annual Report, Pharmaceutical Needs Assessment and the Health and Wellbeing Strategy.

This section covers the North East Essex CCG view on how primary care can contribute to the overall strategy and vision. There are examples of good practice in general practice across NHS NEE CCG. The hard work and dedication of staff across general practice has delivered real improvements for patients that we want to build upon and ensure equitable access to all those who use the primary health care services. However, significant variation in the clinical quality of general practice provision persists with differential health outcomes for our residents.

Our case for change focuses on the following factors:

- Rapidly changing population — the population living longer, the increase in the population numbers and the change in demography
- Increasing health and wellbeing needs
- Variations in access to primary care medical services

- Variations in clinical quality and patient health outcomes
- A changing workforce profile and changing skills set needed for new models of care
- Changes to care provision.

Our strategic vision is built on a compelling case for change with a clear set of reasons for improvement in order to realise four essential deliverables:

- Access across seven days a week
- High quality and equitable primary care services that improve patient outcomes
- Reduction in health inequalities
- Value for money to our residents.

The reasons for change are:

We want to improve the health of the people in North East Essex and ensure healthcare services are meeting public expectations.

We want to respond to the requests from the public through our big care debate to improve general practice access and delivery.

The population of North East Essex is rising rapidly leading to greater demand on local health services.

Hospital is not always the answer. More care can be delivered in primary care and community settings than ever before and patients benefit from care provided closer to their home.

We want to deliver the transformation of primary care services.

There are workforce recruitment and retention challenges which currently affect delivery of the best quality care and optimal patient outcomes.

We need to adopt new models of care and best practice which can deliver better health outcomes for patients.

We want to make best use of our local taxpayers' money.

GPs and their practices will play an important role in influencing the strategy and will need to understand how a primary care strategy will affect their commissioning decisions for acute, mental health and community services.

The plan will only succeed with the clinical ownership of general practice working in conjunction with our local authority and health partners.

The plan aims to help address the challenges and opportunities presented in reshaping the local NHS.

It should be read in conjunction with the CCG's End of Life, Urgent Care and Care Closer to Home Strategies.

Context

The NHS structure and approach to health care is changing. This document is being developed at a time of unprecedented change within the NHS. The CCG has a central role, working with local medical committees and clinical leaders, to support local GPs to take on increasing commissioning responsibilities.

The CCG is committed to working with GPs, colleagues in local authorities, the voluntary sector and patient representatives and groups, to make sure we maintain a sustainable, safe and high quality local health service.

GPs and their practices will play an important role in influencing the strategy and will need to understand how a primary care strategy will affect their commissioning decisions for acute, mental health and community services.

Clinical commissioning groups (CCGs), as commissioners of health care services are accountable to NHS England.

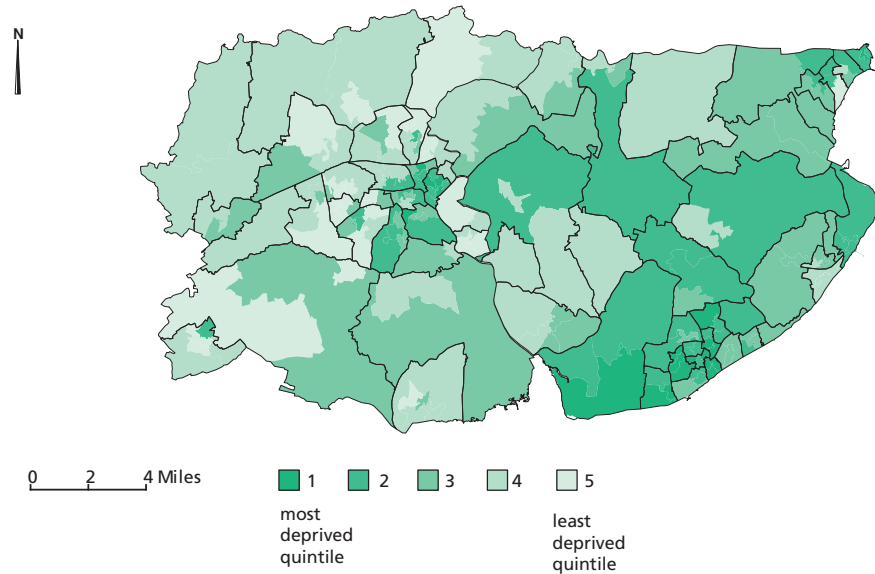
The responsibility for primary care contracting and overseeing services provided by independent contractors is overseen by NHS England and Local Area Teams. However, CCGs have a clear responsibility to work with the NHS England to improve the quality of primary care.

Our commissioning strategy aims to improve the health, social and quality of life outcomes for our population by improving the productivity and sustainability of services with a strategic shift towards services focused around people not organisations. Our ambition through our urgent care strategy is to reduce the complexity of the system and make it easier for patients and their families to navigate their way through the services. This will mean that fewer people will be admitted to hospital in an unplanned way as services will support patients to reduce the chance of getting into crisis.

This strategy will have an impact on primary medical service providers and will result in a new set of challenges and issues. The outcome will be a significant change in the delivery, quality and set up of general practice. The imposition of new contractual arrangements will increase the workload of general practice and may lead to increasing disillusionment amongst the workforce. This makes it even more essential that the CCG and NHS England work to support and collaborate with general practice and GP leaders.

North East Essex CCG covers the boroughs of Colchester and Tendring. We have 43 member practices organised into 6 local forums, with a registered population of 325,000.

Right:
This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2010 by Lower Super Output Area). The darkest coloured areas are the most deprived.



Case for Change

Our vision for developing primary care to deliver high quality, sustainable safe and affordable care is built on a compelling case for change:

- Demographics/population projections
- Big Care Debate/patient experience/call to action
- Clinical and quality variation in primary care
- Workforce
- Access
- Hospital activity
- Financial/ value for money
- GMS contract/enhanced services
- Primary care infrastructure/estate
- Primary care IM&T
- Partnerships

Vision for Primary Care from 2014/15

Our vision is to have high quality, safe, equitable and sustainable primary care across North East Essex. We know that this is also the requirement of the patients of North East Essex following the extensive work we have done with our population through the Big Care Debate.

We recognise that primary care alone will not deliver the care needed for our population. We must ensure that support for patients accessing services in their community are commissioned to align with primary care services.

Improving outcomes both clinical and from the users experience perspective are key to ensuring that services are commissioned for patients and not organisations.

The Health and Social Care Act 2012 puts general practice in a unique position as both a provider and commissioner of health services. This has resulted in the CCG having the benefit of the experience and knowledge of front line clinical and non-clinical staff at the heart of the organisation. It enables the concerns and issues of patients to be fed into the CCG and ultimately influence and shape the planning, commissioning and delivery of services.

The fundamental purpose of the CCG is to improve the effectiveness of clinical care and patient experience and the member practices have an active role in contributing to the delivery of this objective. However, it is recognised that practices are independent businesses, responsible for their own viability and sustainability through a national contract with NHS England whilst being member practices of the CCG. The CCG will help and support primary care to understand and develop its understanding of the responsibilities of its many roles within the system.

General practice has evolved and developed significantly from its original form and origins. Many practices and individual GPs have been champions of innovation, enterprise and quality improvements. However, if general practice is going to meet its new role and responsibilities as well as maintain its international reputation as a model of care that delivers value for money and is well regarded by its users, it will need to adapt significantly. We will build on the strong values and professional ethos to be found in our general practice.

General practice will need to have a relentless focus on improving the quality of care to patients consistently across all practices in North East Essex. This drive will need to

focus on and proactively use and interrogate data and information. This will mean that practices will need to get used to publishing and reporting on quality to their patients, peers, partners, commissioners and regulators. NEE CCG will work with NHS England as the commissioners of primary care services to drive improvements in quality of care in general practice.

NHS England — through the development of the GP contract and policy guidance, JSNA's produced by Public Health colleagues and CCGs' outcomes — has identified specific areas where general practice can have a big influence on patient health and care outcomes:

- Using information available to them to identify those patients at risk
- Using their unique position to undertake the role of co-ordinator of care
- Developing and implementing individualised care plans
- Capturing the themes and requirements from those care plans to inform commissioning requirements and intentions
- Supporting urgent care services to avoid unnecessary admission to hospital and manage patients before they reach a crisis situation
- Supporting patients to navigate the health system and inform commissioning intentions on how to reduce complexity
- Working with other providers, especially those in care homes, to ensure that patients who are residents have access to services that support them staying in their own homes.
- Providing assurance and reassurance to patients who value continuity of care in a setting that is familiar and recognisable.
- Utilising the information they have, the knowledge and skill required to be a GP by treating the patient as a person and taking into account their history, personal circumstances and care needs.

Primary care services should be about delivering outcomes for patients. These outcomes will need to be a combination of health improvement, prevention, quality and experience. General Practice needs to be able to listen to its patients' experiences and adapt service delivery to meet their needs.

NEE CCG and NHS England will work together to enable primary care services in North East Essex to positively engage and respond to patients views and experiences.

General Practice cannot work in isolation and needs to have services wrapped around it to meet the needs of a population that has more complex needs which are not restricted to the traditional health model. Individuals often need a number of disciplines to support them either in their day to day living or through an episode of care. The principle of integration of services across health and social care and physical and mental health is supported by the CCG. Regardless of which commissioner commissions the service and which provider provides the service, services should be commissioned for people and not organisations.

NEE CCG will work with commissioning partners to ensure that services are commissioned that will meet the needs of the local population. The make up, size and geographical spread of these communities need to be defined, but as a principle the CCG supports services being provided to communities within the community and that general practice will be the hub to these services.

The CCG supports the principle behind practices working together to establish a logical and sustainable hub of services — whether this is 20,000 patients or another still to be determined number. However, what is important is that the hub is made up of services that make sense for that community and is not a pre-prescribed model.

The CCG will work with NHS England and local practices to establish a model that meets the needs of the patients registered at NEE practices.

The formation of a GP provider organisation has facilitated the opportunity for practices to offer a wider range of services to support the strategy outlined in our care closer to home strategy.

The CCG will continue to support the development of GP Primary Choice through our market development programme.

Commissioning Philosophy

Our aim as a CCG is to commission, high quality services, which are seamless from a patient perspective and which are sustainable in the medium term.

Our values that support this approach:

- Patient centred
- Integrity
- Inclusiveness
- Improvement.

Our team:

- Will develop to be the best we can be
- Will listen carefully
- Lead by example
- Invest in our people
- Dream Big
- Be resilient and confident.

Our approach:

- Buy people-centred services
- Commission for outcomes not organisations
- Use all legitimate means to get what our population needs.

This will mean for our patient partners:

- We will listen and engage
- Be honest and open
- Focus on personalisation and self-determination
- Be an advocate for them
- Secure good outcomes
- Empower
- Support to self-manage.

In our role as a system leader we will:

- Lead the system
- Influence and facilitate
- Shape the future
- Set clear expectations
- Determine needs
- Assure services
- Understand experience
- Address inequalities.

For our providers they can expect us to:

- Challenge and collaborate
- Manage providers and the market
- Develop a common value set
- Develop providers that are
 - Patient-centred — who understand the value of experience
 - Innovative
 - Flexible and responsive
 - Sustainable.

Enablers

- Primary Care estate
- Technology.

New ways of working in general practice

The CCG believes that any new ways of working that will support a new model of care should emerge organically within North East Essex. Local context must play an important role in determining the form and function of any new model as will the support from the local GPs and their staff. We will learn from the experiences of other areas and consider with partners the different models currently being worked throughout the country. These include:

- Networks or federations
- Super-partnerships
- Regional and national multi-practice organisations
- Community health organisations.

North East Essex CCG is keen to work with local practices, with GP Primary Choice, the Essex LMC, NHS England, Healthwatch and patient groups to develop a service that will continue to provide comprehensive, first-point-of-access advice, diagnosis and treatment, together with ongoing care co-ordination.

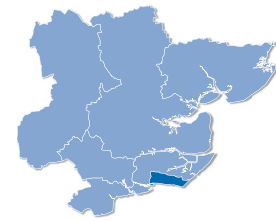
Critically North East Essex needs a model that will balance the need to realise the benefits of organisational scale with preserving the personal and local nature of general practice. The CCG and our patients are keen to develop a model that preserves the local practice as the first point of contact for patients and where organisational scale enhances — not undermines — the local accessibility and nature of primary care.

In order to do this NEE CCG will work with NHS England, LMC and Health Education England to support the development and sustainability of clinical and managerial leadership within general practice. Sustainable GP leadership is vital if primary care is to find the confidence to transform.

Whatever the outcome of this work, we acknowledge the following principles:

- In order to increase the scale, scope and capacity of general practice there will need to be a change to the current organisational structure and delivery model
- There will be a need to preserve the local small scale points of access to care that are so valued by the patients of North East Essex.
- General Practice will need to develop its use of different disciplines and skills, maximise the use of technology, and increase organisational efficiency
- General Practice needs to be given capacity and capability to undertake this strategic planning
- General Practice needs to recognise the value of professional practice management
- Clinical and Managerial leadership within general practice needs to be developed
- The strong history of independence and innovation needs to be harnessed
- General Practice needs to recognise that the traditional roles that practice staff have undertaken will need to be redesigned.

Southend-on-Sea



Our vision for primary care in Southend-on-Sea

Citizens in Southend-on-Sea will be able to access high quality care centred around their needs as individuals, provided by integrated health and social care teams operating out of their GP practice.

Vulnerable citizens will receive responsive, proactive care from their wider GP practice team and patients will only go to hospital when they need specialist or emergency care and there is no better alternative available in the community.

About NHS Southend Clinical Commissioning Group

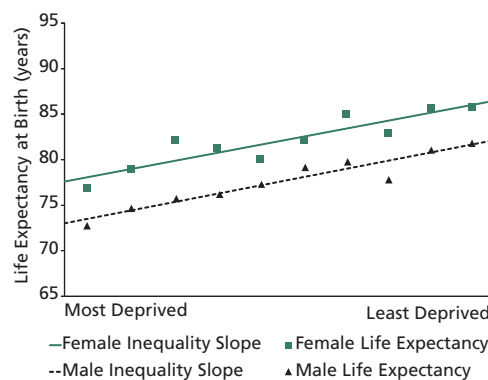
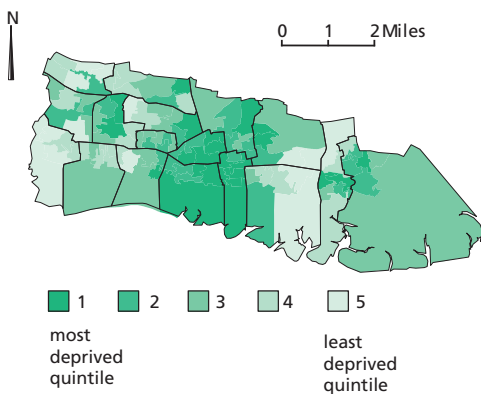
Southend-on-Sea is 42 square kilometres in size and is the largest conurbation in the East of England. As the sixth most densely populated area outside of London it has 4,187 people per square kilometre compared to the national average of 411.

Located on the north side of the Thames Estuary approximately 40 miles east of central London, it is bordered to the north by Rochford and to the west by Castle Point.

The total estimated population for Southend-on-Sea as at mid-2012 was 174,838 (ONS). Since 2008 the population of Southend-on-Sea has increased by 7.2%. The population increase of Southend-on-Sea is almost double the national population increase of 3.9% over the same period.

18% of the people living in the Southend CCG area are aged 65 or over, compared to the England average of 16.7%. The local population in this age group is expected to increase in number by 14% by 2020. 23.7% of the population is in the 0-19 age group.

With the growth of an aging population and the drive to ensure earlier identification of some chronic conditions, we can expect to see a rise in disease prevalence and consequent demand for health and social care services.



Left: This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2010 by Lower Super Output Area). The darkest coloured areas are the most deprived.

Right: The lines on this chart represent the Slope Index of Inequality, which is a modelled estimate of the range in life expectancy at birth across the whole population of this area from most to least deprived.

The health of people in Southend-on-Sea varies against the England average. Life expectancy varies across the areas of the town. Life expectancy is 9.1 years lower for men and 8.8 years lower for women in the most deprived areas of Southend-on-Sea than in the least deprived areas. Life expectancy for men is similar to the England average, whereas for women it is lower than the England average.

Southend has higher levels than the national average for smoking prevalence, percentage of inactive adults, hospital stays for alcohol related harm, and injuries due

to falls in women over 65. Southend also has lower levels of breast cancer screening coverage and breastfeeding.

Deprivation levels (as measured by the Index of Multiple Deprivation or IMD) in Southend-on-Sea are higher than average and there are about 7,600 children that live in poverty. The average IMD score for Southend CCG is 23.6 (2012) compared to the England average of 21.5. The Southend health system serves a resident population of over 180,000 people.

In addition to the resident population, the Southend health system — particularly the urgent care system — is subject to additional pressure from more than six million visitors who come to the town each year.

Southend CCG is made up of 36 member GP practices and covers Southend, Leigh, Westcliff, Shoeburyness and Thorpe Bay areas. We work with our practices to improve the quality of primary care and we engage with individual member practices via our GP members forum. The forum is used to consult with practices about commissioning plans and proposed service developments.

We are a clinically-led organisation - GPs see patients every day and understand the health and social needs of the people of Southend. This puts them in the best position to shape healthcare for the people they serve. Together with Southend Borough Council we will continue to take a joint approach to health and social care. We are also committed to addressing health inequalities, in collaboration with other agencies and the voluntary sector.

Our health and social care system vision, values and priorities

We aim to ensure that everyone living in Southend-on-Sea has the best possible opportunity to live a long, fulfilling, healthy life.

We want:

- Our children to have the best start in life
- To encourage and support local people to make healthier choices
- To reduce the health gap between the most and least wealthy
- People to have control over their lives as independently as possible
- To enable our older population and those adults with social care needs to lead fulfilling lives as citizens

We will deliver this by:

- Planning and operating as a single system — maximising our offer to the citizens of Southend-on-Sea by integrating services that are influential to health and wellbeing
- Understanding the needs of the people living in Southend-on-Sea and proactively addressing these to improve their health outcomes
- Providing access to the right care, at the right time, and in the right setting
- Creating an efficient and effective system that is focussed on quality of care and achieving the best outcomes for our citizens, delivered within our resources

Our values, which have been shaped by our staff and stakeholders, fully align with the principles laid out in the NHS Constitution.

Clinically led

Clinicians will play a central role in leading our organisation.

Centred on patients, families and carers

We will place patients, families and carers at the centre of everything we do.

Equalities

We will be relentless in our efforts to reduce inequalities in our population and ensure that the services we commission are accessible to all who need them.

Safety

All providers we commission must demonstrate that delivering a safe service is their top priority. Safeguarding training will be provided to all staff groups.

Quality

We will strive to maximise quality by promoting optimal use of evidence-based guidelines.

Best use of public money

We will demonstrate strong population involvement, governance and accountability to ensure we are achieving best value for money.

Excellence and professionalism

We will create a professional environment that motivates its people to perform and excel.

Working across organisations in partnership

We will be proactive in seeking opportunities to advance our cause through joint collaboration with neighbouring commissioners, the commissioning support unit, acute, community and mental health trusts, local council, and other key stakeholders.

The future of primary care in Southend-on-Sea

Southend CCG wants to see an integrated, flexible and responsive primary care-led health system providing wider primary care at scale, with people only going to hospital where there are no other community-based options for them. We need to work to break down the distinction between primary/community and secondary care to allow true, clinically-led teams working for the benefit of patients. We want to see clinicians freely moving between the hospital and community settings to provide the best fit services centered around pathways of care and the person they are treating. We know that primary care cannot stay the same as it is now and continue to operate within the constraints of growing pressures on budgets and demand from increasing morbidity.

The NHS has been set a challenge to deliver seven-day services. This also applies to primary care and Southend CCG wants to ensure people are able to access the most appropriate urgent services for their needs across primary, community and secondary care every day of the week. Southend has been chosen as one of 14 Integrated Pioneer sites nationally — we have been recognised as having made significant progress already on this journey but there is more to do. We need to ensure as a system that services work together across traditional boundaries, putting citizens at the heart of what we do in order to deliver the change required.

Our clinical executive committee and our clinical lead for integrated care will focus on integration as one of their key priority areas of work. Our clinical leads will take a lead role in developing better integration of services, developing and implementing new ideas through innovation at member practice level to complement initiatives through the Integrated Pioneer and Better Care Fund work.

As an Integrated Pioneer, Southend CCG has already made significant inroads into

developing integrated services. We wish to continue this work to see our member practices at the centre of delivering health care services across primary, community/ social and secondary care with people only going to hospital where it is the only option available to them.

We believe that GP practices are ideally placed to become the centre for co-ordinated, proactive care for their registered patients. Many more hospital services are now provided in the community or by primary care than ever before. We would wish to see hospital care as the last resort for our population, used for serious accident and emergency services or for specialist care which cannot be delivered elsewhere. The majority of patient care should be delivered in primary and community settings. We will test a hub model of delivering wider primary care at scale, evaluate its success and use this and ongoing feedback from our partners and member practices to determine the right model of primary care across the rest of Southend-on-Sea.

We need to help people access the right service at the right time. People can be confused about where to go for urgent or out of hours services. By centering services around general practice, improving access and providing wider primary care at scale, we can help people access the most appropriate service for them and ensure that hospitals are only used as a last healthcare resort.

We also wish to see our practices opening all day to enable people to make appointments and collect prescriptions. We recognise that this may be difficult to achieve for our smaller practices, however by working together they will be able to share these responsibilities. IT solutions will be needed in order for practices to work together and treat each other's patients. The CCG will work with its Commissioning Support Unit (CSU) IT team and within the GP IT scheme to exploit opportunities for appropriate access to patients' electronic records system.

The new GP contract will also see practices developing more automated services, such as online appointment booking, and the CCG will support its members to achieve this through its CSU.

GP practices at the heart of our local health system

We recognise that GP practices are the cornerstone of the health system, and account for at least 80 per cent of all patient contact.

It is a priority for us to work with our member GP practices to support improvement in the quality of primary care and share good practice to strengthen the ability of our members to respond well to demographic and contractual changes. This is particularly important in Southend as it may be more difficult for our smaller practices to respond to the recent changes to the national GP contract, the emerging NHS England Essex Primary Care Strategy and the requirement to develop seven-day services.

We will submit a formal expression of interest to NHS England to set out how we wish to develop co-commissioning of our GP services. By doing this we will be able to focus on supporting all practices to provide high quality care and to ensure that the people of Southend-on-Sea are able to access wider primary care services at scale, building on the work being done as part of the Integrated Pioneer programme. We aspire for people to be able to access appropriate primary care services throughout the day and to ensure that the people of Southend are able to access the right care, at the right time and in the right place. This will be achieved by developing an integrated care system delivered across networks of practices where staff work across organisational boundaries to provide the most appropriate care for the citizens of Southend-on-Sea.

People choose their GP surgery. They are free to register with the practice of their choice if they live within that practice's boundary, and they are free to change their practice too. Our vision is for this choice to continue. However, we recognise that our smallest practices may struggle to meet increasing demands placed on them by the health needs of their population, by the need to develop wider primary care services at scale and to move to seven-day services while continuing to drive improvements in

service quality. We believe practices need to think big and feel small and the CCG, working with the Local Medical Committee for south Essex, will support our member practices to develop and implement their own GP Federation in order to meet these challenges, as well as providing individual support to any practices choosing to merge or join together in networks or hubs.

Looking after the most vulnerable

We will support our member practices through the provision of primary care transformation funding which will help practices respond to changing requirements on them — to improve their access and responsiveness, provide more proactive care to their most vulnerable patients wherever they live, and to support innovation among our member practices to develop new systems for caring for their patients to ensure they remain in the community for as long as possible. We will also support practices in their delivery of the new enhanced service for avoidable admissions.

We recognise that delivering our aims will involve spending less on hospital-based care and spending more in the community. We wish to see hospital health professionals enabled to work outside their traditional estate, in the community in partnership with community health professionals. Essentially, the patient should determine how we provide services, rather than traditional systems or boundaries.

The national GP contract for 2014/15 sets out that each elderly patient will have their care co-ordinated by their GP practice with a named GP alongside a new enhanced service for avoidable admissions, which will help them provide this. In addition the CCG will commission a local community service to provide proactive care for those registered patients living in care homes. We will support those smaller practices who wish to come together to share the delivery of these services.

One of the many strengths of general practice lies in the registered list system. This enables co-ordinated care to be provided to those that are ill and also the co-ordinated provision of ill health prevention services, such as screening and immunisation. Practices can build on this system by working together and this has already started across Southend as smaller practices are running multi-disciplinary team meetings for the benefit of vulnerable patients.

Involving and engaging the citizens

Many of our practices already listen to and act on their patients' views through their patient participation groups. The CCG has set up a new forum for patient participation group representatives to come together, share experiences and best practice, and challenge the CCG and its practices to make change happen where it is needed. We wish to encourage all practices to set up effective patient participation groups to listen to their patients and use this to improve the quality of the services they provide, as well as contributing to the forum to improve services across Southend-on-Sea.

We will implement a patient and public engagement and involvement steering group to represent different communities from our local population. This group will support the CCG strategically in developing and implementing our communications and engagement strategy, including our strategy for equality and diversity. The group will provide an important role as a critical friend to ensure that the CCG effectively engages its citizens in commissioning local health services.

The CCG will support member practices to improve access to their services. Working with their practice participation groups, GP surgeries will understand what is important to their registered patients and what adjustments they can make — for example, the provision of services in the evenings or weekends to better meet the needs of commuters or those of working age. By working together, practices can improve their capacity to provide services outside of traditional opening hours. The formation of a new GP federation in Southend will enable this to happen.

Co-commissioning of GP services with NHS England

We will submit a formal expression of interest to NHS England to set out how we wish to develop co-commissioning of our GP services. By doing this we will be able to focus on supporting all practices to provide high quality care and to ensure that people are able to access wider primary care services at scale, building on the work being done as part of the Integrated Pioneer programme. We aspire to people being able to access appropriate primary care services throughout the day, and to ensuring that the people of Southend-on-Sea are able to have the right care, at the right time and in the right place. This will be achieved by developing an integrated care system delivered across networks of practices where staff work across organisational boundaries to provide the most appropriate care for the citizens of Southend-on-Sea.

We will test a hub model of integrated health and social care in one of our larger practices as part of our integrated pioneer programme. This model will comprise a multi-disciplinary, self-managed team approach supported by professionals including GPs, practice nurses, community nurses, community mental health services and social care workers who will provide proactive care to vulnerable patients. Initially the focus is proposed to be the frail elderly housebound and those with clinical depression.

We know that patients value the registered list system of GP practices. In Southend particularly, we have a mixture of some very large practices (our largest is around 25,000 registered patients) to very small practices (our smallest has less than 1,000 registered patients) and 19 of our 36 member practices are single-handed contractors. We recognise that our smallest member GP practices may struggle to meet the increasing demands of providing wider primary care services at scale, including seven-day working, while the morbidity of their registered patient population continues to rise. As such we will work with our member GP practices and provide investment through primary care transformation funding to deliver improvements in access and patient experience, and to enable them to deliver proactive care to their most vulnerable patients living at home and in residential care.

Improving the quality of primary care and addressing unwarranted variation

We will focus on supporting improvements in the quality of primary care provided to the people of Southend-on-Sea through co-commissioning. We will also support member practices in their development of a GP federation in Southend, which will enable GP practices to work together to achieve better patient outcomes and to strengthen the resilience of our member GP practices.

We will work with practices identified as not compliant with the Care Quality Commission standards to ensure that all health services provided for the citizens of Southend-on-Sea reach at least minimum quality standards.

We have identified that there is significant variation in clinical practice including referral rates and prescribing, among our member practices. We have begun a pilot project that uses specially designed software, placed on GP practices' own computer systems, to analyse clinical practice by specialty. The analysis will then be used to identify unwarranted clinical variation, and design a bespoke educational package to address this. We will review the success of this pilot and determine how to support practices to address unwarranted clinical variation.

We will continue to provide educational and training support to the GPs in our member practices through peer review sessions and GP forums, as well as commissioning joint clinical education services from our neighbouring CCG, Castlepoint and Rochford. Our investment in protected time for GP practices, one afternoon per month for ten months per year, shows our commitment to education and training for every member of staff in our member GP practices.

Primary care premises

As we provide more services within the community across seven days, there may well be pressure on primary care estate, particularly if practices merge or come together in networks sharing larger registered populations, or provide services through a new GP federation. We wish to work with NHS England to develop a specific strategy for Southend-on-Sea in order to see this delivered. We will also work with our partners to share public sector estate, where this is possible and efficient.

We will support NHS England in reviewing the primary care estate in Southend and developing a primary care premises strategy for Southend. A number of our GP practices share premises but operate completely separately. We will support practices, both co-located and across separate sites, wishing to find opportunities for working together to improve efficiency and effectiveness and to respond to the requirements of developing wider primary care services at scale.

Southend CCG wishes to see more services provided in the community and is already investing in community-based services designed to prevent people from being admitted to hospital unnecessarily. We wish to see continued and increased use of these services such as community geriatricians, specialist multi-agency case management of complex patients and specialist paramedics whose aim is to keep patients in their own home.

Supporting the development of local providers

Our member practices are working with the South Essex Local Medical Committee to develop a GP federation for Southend-on-Sea. This is supported by the CCG which currently has two main local providers of health services — Southend University Hospital Foundation NHS Trust and South Essex Partnership Foundation NHS Trust

We also recognise the value of our local third sector providers and, through the Social Value Act and other mechanisms, we wish to see our local providers (including primary care) develop and be able to bid for services against other larger providers. We wish to see larger providers work in partnership with our local providers to strengthen our local market and enable people to receive health care services in existing health care premises and from familiar health professionals.

Education, training and workforce planning

The CCG is committed to the engagement of its member practices through education. The CCG holds six GP forums per annum for its member practices within CCG-funded protected time to enable peer review, training and education to be provided in response to developing services and technologies. It also enables member practices to contribute to help shape the provision of services for Southend people and allows space for innovation. With our recently strengthened clinical lead structure, the education and training we provide for member practices will become truly clinically-driven and clinically-led. This professional support for GPs, nurses and practice staff, along with other initiatives currently being considered, will continue to make Southend an attractive place to work.

The CCG will continue to provide support to any of its member practices experiencing difficulty and is committed to supporting NHS England in improving the quality of primary care. Through our support for the establishment of a GP federation, our training and education programme, support for the Quality and Outcomes Framework and bespoke support for individual practices experiencing difficulty, we will ensure that we continue to improve services for patients. A successful bid to co-commission primary care will enable Southend CCG to fully support our member practices to provide high quality, proactive care at scale for their registered populations.

The NHS England Essex primary care strategy includes a section on workforce development. Our member practices report difficulties in attracting and retaining the GP workforce, as well as practice nurses and we believe that around 60% of our GP

workforce is made up of salaried GPs. We have joined an Essex-wide workforce planning group, led by NHS North East Essex CCG to develop actions to address our workforce issues in partnership across Essex. We will develop our strategy and approach through this group over the coming year.

Key milestones for delivery

http://southendccg.nhs.uk/governing-body-papers/doc_download/484-southend-ccg-operational-plan-2014-16

Our detailed milestones are set out in the CCG's two-year operational plan which is available on our website. Our co-commissioning expression of interest also sets out how we intend to develop our detailed plans to enable us to move towards our vision of wider primary care at scale. Some of these key milestones can also be seen below.

Objectives

- Support the development of a GP federation
- Support the development of seven-day urgent services in primary care, improved access and wider primary care at scale
- Reduce unwarranted clinical variation in GP practices
- Support GP practices to improve patient experience of primary care
- Reshape our clinical lead structure to strengthen clinical leadership and engagement with member practices.

Activities

- Continue our programme of member GP practice visits, particularly focussing on supporting practices with specific needs
- Support the Local Medical Committee to facilitate discussions with GPs about the development of a GP federation in Southend
- Complete D4 analytics pilot scheme, which uses innovative software to enable GPs to drive improvements and reduce unwarranted clinical variation, and widen the programme to use at scale upon successful completion
- Develop and submit our co-commissioning expression of interest with full engagement of local stakeholders, patient groups and our member practices
- Develop and implement mechanisms to invest primary care transformation funding in order to improve access and services for over-75s and reduce emergency admissions
- Identify and work with practices to develop wider primary care at scale and implement 7-day services using transformation/ federation funding
- Benchmark data from the GP patient satisfaction survey and Friends and Families Test (FFT) and distribute it to our practices
- Share benchmarked data with our practice patient participation group forum and agree how they can work within their practices to support improvements in access and patient experience
- Develop a wider project to support improvements in access and patient experience in our GP practices
- Target practices with poor patient satisfaction and offer them bespoke support to improve their systems
- Utilise the GP member forums as a tool for engagement, education and innovation as well as networking and peer support
- Appoint new clinical leads and embed their role in driving the GP member forum

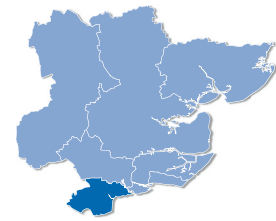
programme and leading practice visits

- Implement clinically-led monthly digest e-newsletter for member GPs.

Governance

- Strategic direction developed in conjunction with GP clinical lead and shaped through members forum
- Clinical executive sign-off of the clinical case for new schemes as appropriate (conflicts of interest registered and declared at each meeting with appropriate exclusion of members as required)
- Quality, Performance and Finance committee sign off when services are commissioned from member practices in line with our detailed financial policies
- Clinical executive approval of member forum programme from 2014/15.

Thurrock CCG



Area and demographics

Thurrock lies on the River Thames immediately to the east of London. Thurrock hosts two international ports which are at the heart of global trade and logistics and is strategically positioned on the M25 and A13 corridors, with excellent transport links west into London, north and east into Essex, and south into Kent.

Thurrock's current population is 157,000 (2011 census) — an increase of over 10% since 1991, and is projected to be 207,300 by 2033.

A greater proportion of its population is 0-14 and 30-44 compared to rest of England, and by 2033 the population group aged 50-64 is projected to increase by 50%, and the population group aged 85 plus is projected to double.

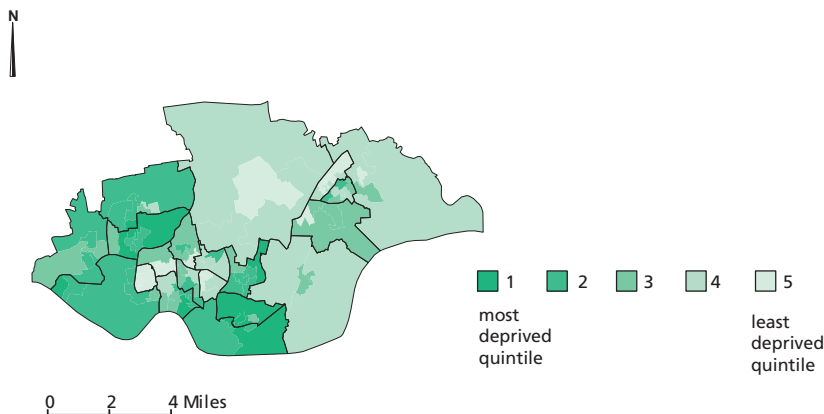
Over the last decade, ethnic diversity in Thurrock has increased at a rate faster than the national average as the population grows. The increase in the ethnic mix can in part be attributed to substantial inward migration to Thurrock from East London and also rising levels of international, economic migration from parts of Africa and Eastern Europe.

These data show that 85% of the Thurrock population are white and the second largest group are Black / African / Caribbean / Black British (7.8%).

The Primary care provision consists of 42 GP Practice locations (Main and Branch) and 167,946 registered patients as at 1 April 2013. There are also 21 Dental practices, 18 Opticians practices and 32 Pharmacies.

Thurrock is currently under-doctored. Stanford, Corringham, Tilbury, Grays, South Ockendon and Aveley all have a shortage of GPs. Furthermore, 30% of the current Thurrock CCG GP workforce is over the age of 60.

There are high levels of deprivation within Thurrock — with 12.4% of people living in the 20% most deprived areas of England.



Left:
This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2010 by Lower Super Output Area). The darkest coloured areas are the most deprived.

With expected ageing and growth of the population we can expect a rise in disease prevalence and consequential increase in demand on health and social care services.

Mortality rates have been significantly worse in South West Essex than the East of England average.

Average disease prevalence for all practices is greater in four of the eighteen Quality Outcomes Framework (QOF) conditions compared to the national average. These are hypertension, hypothyroidism, obesity and diabetes.

It is estimated that approximately 75% of the primary care estate in Thurrock is not fit for purpose.

The prevalence of dementia in Thurrock is predicted to increase in future years, particularly among the over 65s — rising by 13% by 2015.

22% of Thurrock adults are smokers, with smoking prevalence and smoking-related deaths significantly higher than the national averages.

About 25.1% of Year 6 children and 28.1% of adults are classified as obese. This is significantly higher than the average for England.



Thurrock Health Summary indicator outliers

Long term unemployment - **Significantly worse than England average.**

Breast feeding initiation - **Significantly worse than England average**

Obese children (Year 6) - **Significantly worse than England average**

Adults smoking - **Significantly worse than England average**

Obese adults - **Significantly worse than England average**

People diagnosed with diabetes - **Significantly worse than England average**

Smoking-related deaths - **Significantly worse than England average**

Priority Areas for the CCG

Vision & Values

Thurrock CCG's vision is that **"the health and care experience of the people of Thurrock will be improved as a result of our working together"**. Members will work together with stakeholders to ensure that commissioned services are of the highest quality, making most effective use of resources and bringing care closer to home. To achieve this vision, we will design services within available resources around the agreed needs of people, working collaboratively with our partners ensuring positive regards to all.

Working closely with Thurrock Council, Thurrock CCG has been instrumental in the development of the Thurrock Health and Wellbeing Strategy. This overall strategy has four key aims, which are priority areas for the CCG and the council

- ❖ Every child has the best possible start in life
- ❖ People stay healthy longer, adding years to life and life to years
- ❖ Inequalities in health and wellbeing are reduced
- ❖ Communities are empowered to take responsibility for their own health and wellbeing.

In order to achieve the vision and aims, primary care needs to change because:

- There is a shortfall in GP capacity coupled with the fact that 30% of the current Thurrock CCG GP workforce is over the age of 60. Attracting new clinicians into the area is paramount but continues to be a challenge. Much of the primary care capacity is in single handed practices.
- It is estimated that approximately 75% of the primary care estate in Thurrock is not fit for purpose, with many GP practices not suitably located or capable of housing modern, advanced primary care services. Estates surveys have identified issues ranging from Disability Discrimination Act (DDA) compliance and internal decoration to structural repairs and building extensions. Providers will need to take these issues into consideration when planning their future delivery of services. Potential premises actions that could be explored immediately are for Chadwell Clinic where a complete review is needed to establish feasibility of transfer of community services to adjacent primary care locations.
- Financial and delivery pressures for the CCG and the council — council funding continues to reduce, while Thurrock Unitary Authority is already the third lowest spender on adult social care in the country.

- For both the CCG and the council, unplanned care admissions continue to rise. Demographics show an increase in the frail elderly population and those living with multiple complex long-term conditions.
- CQC reports are highlighting training needs for practices and estates issues.
- Significant challenges from the impact of children’s safeguarding within primary care.
- The current model of primary care is outdated and needs to reflect a whole person approach, working in collaboration with a range of partners — both clinical and non-clinical.

Aspirations

The challenge for primary care in Thurrock is significant. However there are a number of strong enablers that give the system a good starting position.

- The CCG, jointly with the council, will continue to put the citizen’s voice at the centre of its service planning and decision making — this relationship has already been identified as strong and this is championed through the Health and Wellbeing Board.
Timescale — on-going.
- With the council, build a network of prevention and early intervention through Local Area Co-ordination and Asset Based Community Development (ABCD) in order to maintain citizens in the community within the widest determinants of health to avert “crisis situations”. Building on this, the council and CCG will develop joint neighbourhood solutions. An enabler for this is the potential to change contracting models for unplanned care with BTUH
Timescale — on-going, to deliver further integration with health
Note that South Ockendon Hub is already used well by local GPs.

Local Area Co-ordination

- Support for vulnerable people within their community to prevent crisis.
- Support recovery post crisis.
- Support around the “whole person” that understands their circumstances and works with them to achieve a good life.
- A method of connection: between the individual and supportive networks and network-to-network to grow community and individual resilience.
- Providing assistance to navigate the complex and disparate systems that a vulnerable individual encounters.

- Optimising the structural reforms from the integration agenda between health and social care, Thurrock CCG will use all the enablers given in the reforms to deliver value-for-money high-quality jointly-commissioned services with the council. Work is well underway to describe the ambition through the stewardship of the Health and Wellbeing Board and CCG Board. Key to this is building on jointly commissioned/provided services that support primary care and avoid hospital admissions, as is commissioning and building on solutions that focus on prevention and early intervention — RAAS and enablement services
Timescale — 2015/16 to full integration.
- Optimising the opportunities presented by recontracting Thurrock Health Centre (THC) services, including the walk-in element and extended hours provision. As

the strategic intent with the council focuses on the frail elderly and unplanned care agenda in its widest sense (note there is a pressure from unplanned paediatric admissions), the unplanned care system including THC, Orsett Minor Injuries Unit and BTUH A&E.

Timescale — through to 2015/16

- Working with NHS England to optimise the delivery of new primary care provision due to the significant population growth in Thurrock in the next seven years and beyond. Joint CCG/council provision in state of the art buildings with services close to the community will be the ambition. The CCG is also working with the council to look at the deployment of current 106 monies.

Timescale — on-going

- Workforce — as illustrated in the profile, Thurrock is challenged when it comes to GP recruitment. The CCG will work across Essex with all CCGs to look at strategies that will bring the required workforce into the patch.

Timescale — on-going

- Estate — TCCG will work closely with the Council and NHS England to explore creative possibilities to improve the quality of the primary care estate.

Timescale — on-going

- Contracting levers and federation — Because of its high numbers of single handed GPs, the CCG will work with the primary care community to federate in the Thurrock hubs. This will define geographical areas for service provision across health and social care. New or replacement GP practices will be commissioned with a minimum list size of 4,500 patients serviced by the equivalent of 2.5WTE GPs. The aim is to ensure peer review and support, provide choice of GP to registered patients and to make general practice a more attractive place to work. There are also issues with the delivery of the APMS contracts including unidentified clinical leadership and remote contract holders.

Strategic objectives include:

- The number of GPs working in Thurrock will increase through the establishment of more training practices and enhanced roles within hubs that attract professionals into Thurrock
- Patients will be able to access their practice at all times throughout the contracted hours of operation (8:00am to 6:30pm Monday to Friday)
- Number of nurses working in Thurrock will increase through the enhancement of nurse practitioner training and enhanced roles within hubs
- Practices which are unable to evidence they are delivering high quality care will be supported to improve in the first instance but ultimately decommissioned if there is insufficient improvement with patients distributed to practices operating in the defined hub.

Timescale — on-going

- Possible locality groupings for discussion
- Optimising other primary care provision, pharmacists, optometrists and dentists within the community hub model championed in Thurrock. This should include the provision of out of hours services and the management of patients with long term conditions.

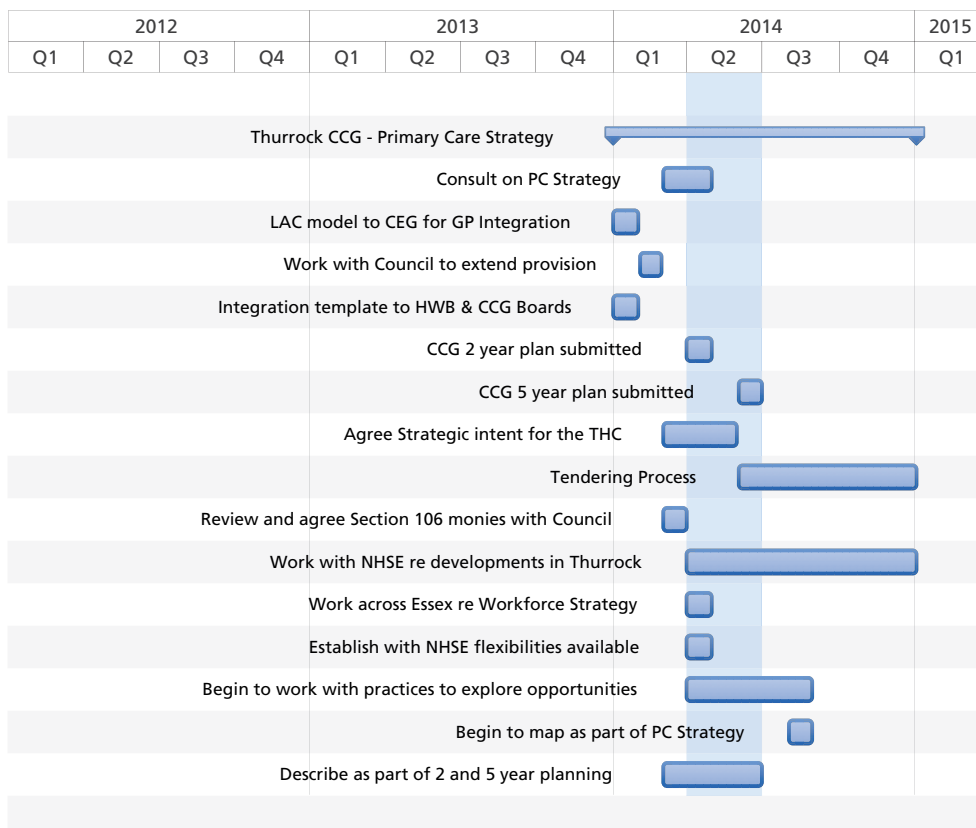
Timescale — on-going

- Resource shifts — it is acknowledged that resources will need to move from acute provision into the community integrated hubs. The CCG will look to model the changes required as part of the 5 year plan and integration plan with the Council.

Timescale — June 2014

Key milestones

Title	Ambition
Consult on PC Strategy	The CCG, jointly with the council, will continue to put the patient voice at the centre of its service planning and decision making Timescale — on-going
LAC model to CEG for GP Integration	With TUA, build a network of prevention through local Area Co-ordination service in order to maintain patients in the community with the widest determinants of health to avert 'Crisis situations' Timescale — on-going
Work with Council to extend provision	As above
Integration template to HWB & CCG Boards	Optimising the structure reforms from the integration agenda between health and social care Timescale — 2015/16
CCG 2 year plan submitted	As above
CCG 5 year plan submitted	As above
Agree Strategic intent for the THC	Optimising opportunities presented by the recontracting for the Thurrock Health Centre Services including the walk-in element and the extended hours provision. Timescale — through 15/16
Tendering Process	As above
Review and agree Section 106 monies with Council	Working with NHS England to optimise the delivery of new primary care provision due to the significant population growth in Thurrock in the next 7 years and beyond. Timescale — on-going
Work with NHSE re developments in Thurrock	As above
Work across Essex re Workforce Strategy	Workforce — as illustrated in the profile, Thurrock is challenged when it comes to GP recruitment. The CCG will work across Essex with all CCGs to look at strategies that will bring the required workforce into the patch Timescale — on-going
Establish with NHSE flexibilities available	Estate - TCCG will work closely with the Council and NHS England to explore creative possibilities to improve the quality of the primary care estate - Timescale - on-going
Begin to work with practices to explore opportunities	Contracting levers and federation Timescale — on-going
Begin to map as part of PC Strategy	Optimising other primary care provision, pharmacists, optometrists and dentists within the community hub model championed in Thurrock Timescale — on-going
Describe as part of 2 and 5 year planning	Resource shifts - it is acknowledged that resources will need to move from acute provision into the community integrated hubs. The CCG will look to model the changes required as part of the 5 year plan Timescale — on-going



Public consultation feedback

Following our public engagement event on 29 April 2014 in which the CCG shared the Primary Care Strategy public discussion document with citizens of Thurrock, we have identified the following themes from the feedback we gathered.

Citizens were asked:

'How do you feel about the case for change to Primary Care?'

The following captures their response to what made sense:

- Improved integrated care-pathways, close to home — through 'Hub'-model
- Better use and promotion of pharmacies
- Savings and efficiencies: offering more to patients using same/similar resources
- Improve patient participation, involvement and empowerment
- Improved workforce: local development, recruitment and retention

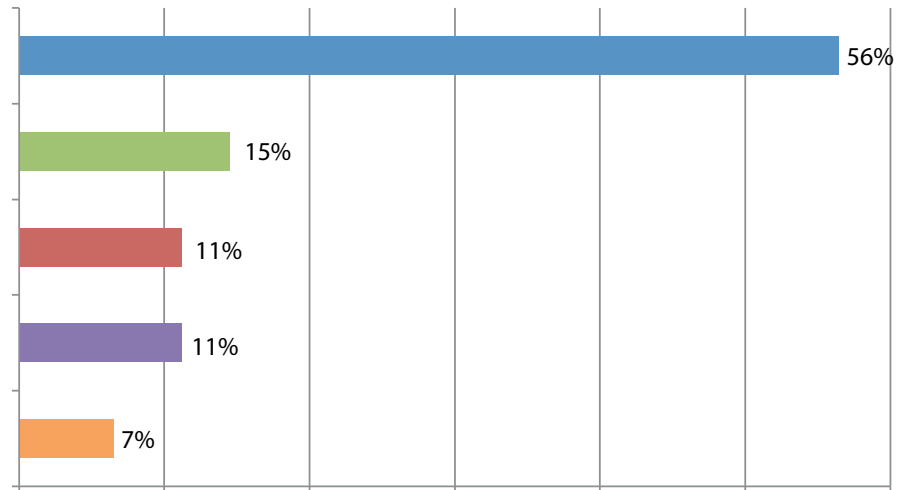
The following captures what citizens did not understand and/or were not clear about:

- Timeline for implementation
- Role of voluntary services within creation of Hubs
- How will we respond to workforce shortage?
- Understanding enhanced role of pharmacy services within the new Hub model
- Clarification on operationalising Hubs within existing premises

Finally citizens thought the following key themes were missing from the Primary Care Strategy:

- Role and integration of mental health within Hubs
- Financial sustainability of the Hub model and the wider financial impact upon the health economy
- Understanding the patient journey in the future
- Concern on centralisation of service may mean worse access for some
- Further analysis required on gaps in workforce eg, nursing.

Proportions of people feeding back on various aspects of the consultation.

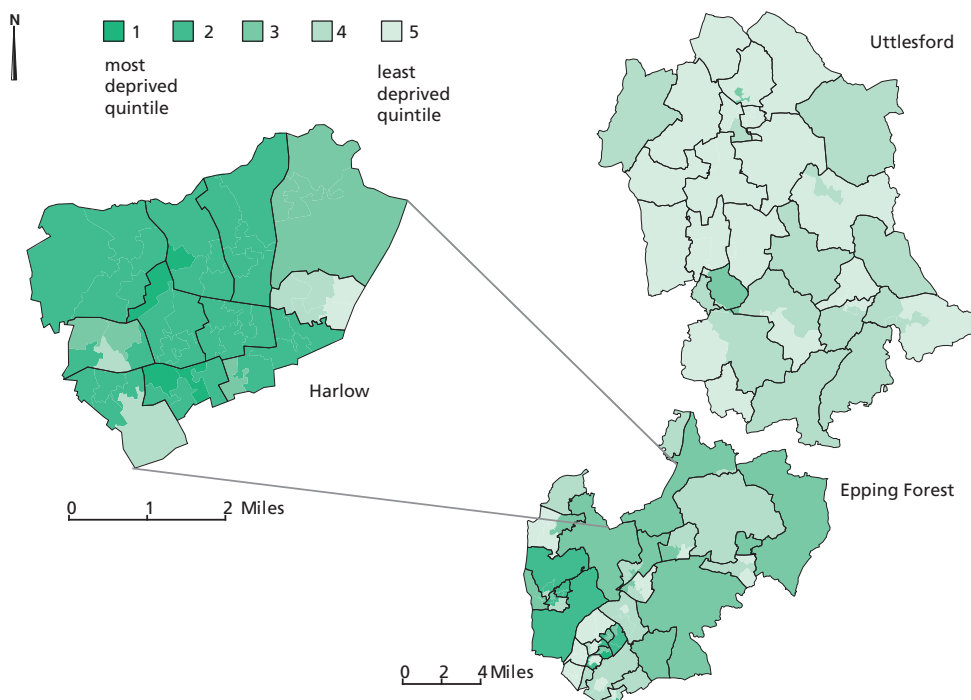
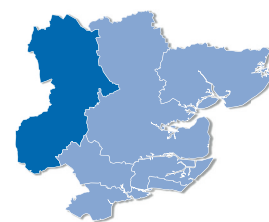


- Improved integrated care-pathways, close to home — through 'Hub'-model
- Better use and promotion of pharmacies
- Savings and efficiencies: offering more to patients using same/similar resources
- Improve patient participation, involvement and empowerment
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West Essex

Area and demographics

The population of West Essex is currently 290,000. The area is made up of 3 localities, Harlow, Epping Forest and Uttlesford. Each has a very different population profile and different health needs. By 2021 the population is expected to grow to circa 320,500. The population of West Essex equates to 21% of the Essex population. The population distribution across the 3 localities is circa 126,000 in Epping Forest, circa 82,700 in Harlow and 81,200 in Uttlesford.



Left: This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2010 by Lower Super Output Area). The darkest coloured areas are the most deprived.

There are proportionately more people aged 65 or older in West Essex than in the rest of the country, and fewer people aged 15-34. Uttlesford tends to have an older population, and Harlow a younger population. Epping Forest has slightly more older people and fewer young adults. Over the next few years there will be an increase in the proportion of people in West Essex who are 65 or over, especially those aged 85 or over.

There are 38 general practices in West Essex. In addition, there are 34 dentists, 47 community pharmacies and 12 dispensing GP practices and 18 opticians.

Princess Alexandra Hospital (PAH) is the main acute Trust for the residents of West Essex. A significant proportion of people attend Addenbrookes (to the north), Whipps Cross (to the south) and Broomfield (to the East). PAH also provides services to many people from East Hertfordshire. South Essex Partnership Trust (SEPT) provide a range of community services. Mental health services are contracted from the North Essex Partnership Foundation Trust.

Specific issues for Harlow

Harlow typically has the poorest outcomes across the three localities although not usually significantly different from the national average. Harlow has the highest rate in Essex for premature mortality. Mortality from lung cancer and bronchitis, emphysema and other COPD are particularly high, combined with the highest smoking rates, especially among manual workers. In reviewing the draft local plan for which consultation has recently been completed, it is evident that there is significant

population growth planned in the area. Growth options to 2031 range between 12,500 to 15,000 dwellings with a further high growth option of 20,000 dwellings under consideration. Population growth for these developments ranges between 30,000 to 48,000. This represents a potential increase of between 36% and 58% in population with a significant impact on health services.

Specific issues for Epping Forest

Smoking rates in Epping Forest are in the second lowest quintile yet when it comes to manual workers it is in the second highest quintile. It has the highest quintile for alcohol admissions. It is an outlier for falls admissions. Whilst Epping Forest has about national average for 'return to home after hip operation' this should be viewed in context: both Harlow and Uttlesford are significantly above the national average, so, relatively, this is a poor outcome for Epping Forest. Mortality on circulatory diseases (also diabetes) is often on par with or worse than Harlow.

Epping Forest District Council is considering growth options of between 6,400 dwellings and 10,200 across the whole district within the Plan period of 2011/12 to 2032/33. Population growth for these developments ranges between 15,000 and 23,909. This represents a potential increase of between 12 and 19% in population with a significant impact on health services.

Specific issues for Uttlesford

Uttlesford typically is significantly better than national average on reported indicators. It is a significant outlier for incidence from skin cancer (all ages and under 75). Fuel poverty and excess winter deaths are high. Early neonatal mortality (<7 days) is high in Uttlesford, though the numbers are small. This should be viewed against better rates for all other infant related mortality. In reviewing the draft local plan for which consultation has recently concluded it is evident that there is significant population growth planned in the area. The level of growth proposed is in the region of 5,495 dwellings with an impact on population estimated at 13,886. This represents an increase in population of around 17% and a significant impact on health services.

To ensure that the commissioning of primary care services is informed by local needs and closely integrated with the commissioning of integrated health and social care services, WECCG will work with the NHS England area team to jointly commission primary care services.

Priority Areas for the CCG

The CCG is working with patients, professionals, service providers and other local partners such as the County Council and the District Council to transform services. The CCG ran a comprehensive involvement programme and identified the following principles to guide our commissioning.

This vision, informed by local people, provides the blueprint for a transformation programme to create a person-centred, seamlessly integrated service. It is a framework for professionals from health and social care to work in multi-disciplinary teams to provide high quality health and social care to meet the needs of West Essex residents. The vision relies on integration and a greater role for primary care. The CCG will also have to change fundamentally how it works to support this new system.

Underlying principles for transformation in West Essex CCG

- Quality first — Patient safety, clinical effectiveness, improved clinical outcomes and care for people as people
- Significantly shifting the point of care — right care is provided at the right time and in the right place
- Integration between health and social care as a key enabler for delivery
- Connected transition of care and support between professionals and organisations
- Provision built round and responsive to the different needs of our communities and localities
- Maximise productivity and efficiency where appropriate
- Allows individuals to take responsibility for their own health and retain independence where appropriate.

The CCG is focusing on new models of care in five high impact areas where improvement can make the biggest difference to the health and wellbeing of the CCG population:

- adult mental health services
- child health and maternity services
- urgent care
- ambulatory-care-sensitive conditions
- frailty

The CCG's transformation work is guided by the principles above and brings together clinical specialists, patients, carers and service providers for that clinical area.

The main points of our vision for Health and Social Care (2014 - 2024)

- 1 The GP, or surgery, will provide a front door to many types of services — specialist nurses, midwives, health visitors, specialist clinicians with expertise in diabetes or mental health, social care and voluntary sector as examples.
- 2 Where possible, care will be delivered at home, or in primary care or community care settings.
- 3 Different professionals will act as care coordinators and care managers, and

support timely access to the right services.

- 4 Health and social care staff with an increased input from the voluntary sector, will aim to provide people with the information and support they need to keep themselves healthy and well.
- 5 Ideally, people will only be admitted to hospital if they need 24/7 clinical/medical supervision, major surgery, or trauma care after a serious accident and/or access to highly specialist services such as less common cancer treatment. The hospital will aim to make sure that people are able to leave hospital as soon as possible, knowing that services provided at home or in community locations to support recovery and rehabilitation as required will be available.
- 6 We will develop clinically effective, evidence based pathways delivered in and through primary care as part of a long term sustainable approach to demand.

High quality primary care services with the necessary capacity and resources are essential for the delivery of this vision. Primary care needs to adapt in the light of significant challenges and opportunities:

- Efficiency expectations — a standard national price through the NHS England contract changes will lead to reduced income for some practices in West Essex leading practices to review what services they provide and how they provide them.
- Demand is increasing and some practices find it difficult to meet patient expectations with regards to access.
- Skills and service levels vary between practices, leading to variation in patient experience. There are opportunities to share skills and working models between practices. There are opportunities for some practices to do more for patients with ambulatory sensitive conditions; including supporting patients to manage their conditions, optimising medicines and having deterioration plans in place as an alternative to hospital visits.
- Closer working relationships between practices and the wider primary care team (social care, nursing, community pharmacists and therapists) are needed to optimise service delivery for those who are frail or have mental health problems. There are also opportunities to streamline provision with hospital clinicians.
- Premises for practices vary — some facilities are out of date and will not meet future demand, others offer further space to enable service transformation or will when in place (Stansted).

The 38 GP practices in West Essex vary in size from 2,000 patients up to 22,000 patients. These pressures make it particularly challenging for smaller practices to meet future requirements without new ways of working with other practices. This has been a key driver for practices across West Essex to form into two GP Provider Companies described below.

Vision

See our full vision document *My health, My future, My Say — a vision for the West Essex health and care system 2014 — 2024* on our website www.westsexccg.nhs.uk and <http://www.westsexccg.nhs.uk/Document%20Library/key-documents.htm>

Our overarching vision for primary care in the future will be:

- Integrated with other providers, providing a seamless service to patients.
 - High quality and accessible.
 - Practices working together to provide efficient services, sharing skills as appropriate.
 - Coordinating the healthcare system from a patient's perspective.
 - Focus for prevention and early intervention
 - Developing clinically effective, evidence-based pathways delivered in and through primary care as part of a long-term sustainable approach to demand.
-

1. Practices Working Together Differently

The majority of GMS and PMS GP Practices in West Essex have joined together to form two GP Provider Companies

- Stellar Healthcare: Harlow and Epping Forest (210,000 population)
- Uttlesford Health: the Uttlesford locality (85,000 population)

The companies provide a new organisational model which enables the delivery of extended primary care services on a larger scale across GP Practices and support practices in working together on the operational delivery of services. In the first instance this will include the provision of GPSI services and extending primary care services to increase the quantity and consistency of ACS conditions managed in the community. There are opportunities for the companies to develop new models of primary care delivery in other areas such as services for frail patients, working closely with the community provider SEPT. The CCG intends to work with the companies as part of a two year pilot to develop new models of care linked closely to General Practice provision.

2. Locality and Sub-Localities Hubs

West Essex practices currently work together as 3 localities: Harlow, Epping Forest and Uttlesford. Each locality will determine sub-locality arrangements or hubs as:

- a consistent basis for running a wider primary care team with practices working together and including social workers, community nurses and health visitors
- a basis for premises planning and utilisation to enable services between practices to best meet local need

We expect there to be 2-4 hubs per locality. This could include a single site as the focus for a particular hub (e.g. Saffron Walden Hospital) or use of 2 or 3 sites in a hub area where premises are constrained.

3. Access

The CCG aims to ensure a consistent response from NHS providers when patients with primary care needs contact the NHS through calling their surgery, calling 111, 999 or attending A&E. This requires:

- GP Provider Companies exploring opportunities for practices to work together to improve access for on the day demand. Future models of care may include shared home visiting arrangements for more efficient use of time, longer appointments for certain conditions, shared provision of extended GP practice opening hours, out of hours care and 7 day provision of services, implementing best practice for use of telephone and virtual assessments.
- Ensuring pharmacists play a significant new role in the community both from the high street and within traditional primary care teams in prevention, routine long term disease management, optimising medicines use, signposting and providing healthy lifestyle advice.
- Developing 111 services as the smart choice for patients as the access point to health information, advice and services.
- Working with PAH to develop primary care led urgent care services at the hospital site to assess and manage patients attending as a walk in urgent or emergency case.

Whilst this vision describes future changes, it is essential that this builds on and maintains the areas of excellence in existing primary care services including the high quality relationship and confidence that many patients report that they have with their GP practice team.

In addition to signing up to the principles within the NHS England strategy, the CCG is able to make the following statements in line with the CCG's 10 year vision for health and social care.

- GP Companies will be the lead providers for pathways for ambulatory-care-sensitive conditions such as respiratory and diabetes care
- There will be a significant shift of activity from secondary to community and primary care.
- All of our transformational care pathways delivered within primary care will encourage, and facilitate, integration between primary, community, secondary, social care and the voluntary sector (where appropriate).
- By 2018 we will have identified a solution to integrated information systems across organisations and across health and social care.
- By 2015/16 we will have increased our investment in, and be jointly commissioning the voluntary sector with Essex County Council.
- All of our transformational care pathways delivered within primary care will incorporate patient self-management and self-care opportunities.

Key Milestones

GP Provider Companies

- Transfer of the Central Referral Service to GP Provider Companies Autumn 2014. This includes the provision of GP Special Interest services and referral triage support.
- Contracts in place with GP Provider Companies to provide extended Ambulatory Sensitive Conditions.
Timescale — Autumn 2014.
- Agree further contracts for service provision which could include frailty, access and satisfaction improvement.
- Reviewing progress with the extended primary care pilot
Timescale — Summer 2015.

Developing Primary Care Hubs

- Agree an operating model for primary care with practices and community service providers which will define the geographic areas and practices included in each hub, and the community services that will operate at locality level or sub-locality hub level.
Timescale — Summer 2014.
- Develop an Estates Strategy to support the delivery of primary care hubs.
Timescale — Autumn 2014.

Commissioning plans closely connected to primary care

- Frailty programme: the CCG will work with SEPT (as lead provider for frailty programme) to implement systematic earlier detection of the onset of deterioration of known conditions, working differently with diagnostic services, pharmacy and nursing homes, including technology based solutions such as telecare as appropriate; developing more bespoke frailty clinics in primary and community care.
Timescale — Summer 2014.
- Integrated commissioning arrangements in place with Essex County Council for learning disabilities, older people, working age adults and children's services.
Timescale — Summer 2014.
- Urgent Care: primary care led front door in place by Autumn 2014; plans for future specification of 111 and Out of Hours GP services.
Timescale — Spring 2015.
- Mobilising our communities - we will work with our partners in Essex County Council and District Council to move towards the pooling of investment and introducing a collaborative approach to commissioning from the voluntary sector to an agreed set of outcomes that moves away from the short term grant approach to funding cycles, giving longer term stability to organisations.