Primary Care Commissioning Committee

23 November 2016

Details	Part 1	**X**	Part 2		Agenda Item No.	**5**
Title of Paper:	Primary Care Strategy Health and Wellbeing Strategy					
Board Member:	Jeff Schryer, Clinical Lead for Primary Care					
Author:	Amy Lepiorz, Deputy Director of Primary Care					
Presenter:	Amy Lepiorz, Deputy Director of Primary Care					
Please indicate:	For Decision		For Information		For Discussion	**X**

Executive Summary

Summary	The Primary Care Health and Wellbeing Strategy is currently out to consultation. This paper is to inform Primary Care Commissioning Committee of the work to date and to seek feedback on the proposed content of the strategy.					
Risk	**High**		**Medium**		**Low**	**X**
	This paper is an update on progress and to seek the committees views					
Recommendations	The Primary Care Commissioning Committee is asked: • To note the work to date • To provide feedback on the content of the draft strategy					

Strategic themes

To deliver improved outcomes and reduce health inequalities for patients through better preventative strategies			
To deliver service re-design in priority areas through innovation			
To develop primary care to become excellent and high performing commissioners			**X**
To develop the CCG leadership to work with the Local Authority to be excellent integrated commissioners			
To develop robust and effective working relationships will all stakeholders and partners to drive integrated commissioning			
To deliver long term financial sustainability through effective commissioning and innovative investment across the wider system			
To develop and influence the provider landscape through development of a Locality Care Organisation (LCO)			
Equality Analysis Assessed?		Supports NHS Bury CCG Governance arrangements	**X**

Primary Care Strategy- update on progress

1. Introduction and background

NHS Bury CCG does not currently have a dedicated strategy to base primary care commissioning decisions upon. The development of a Primary Care Health and Wellbeing Strategy was identified as a priority for the newly appointed Deputy Director of Primary Care. This paper describes progress to date and next steps.

2. Progress to date

2.1 Co-production phase

A draft framework for the strategy was developed over the summer. In September this framework was shared with practices via sector meetings. Time was given at sector meetings for practices to discuss the proposed content and to provide input via a co-production approach. Practices were also encouraged to complete a Learning Time Initiative in order to capture individual views. The co-production phase drew out several key themes, these were:

- Workforce- attracting the best
- Empowering patients/self-care
- Children/young people
- Recognition of the pressures on primary care
- Need to work differently
- Length of the document

These themes were then incorporated into the next draft the strategy.

2.2 Consultation phase

Following feedback from the co-production phase a development session was held with Clinical Cabinet. Members of the Cabinet were encouraged to provide their views and the proposed draft for consultation version of the strategy was scrutinised to see if the key themes had been incorporated.

The draft for consultation version is purposefully still a work in progress to ensure that a wider group of stakeholders are able to contribute to the direction described in the strategy. The draft for consultation has been shared with the following:

- The Local Representative Committees- Dental, Medical, Ophthalmic and Pharmaceutical
- The GP Federation
- Members of the Patient Cabinet
- Healthwatch
- Local Authority Colleagues
- Members of the Governing Body
- Members of the Clinical Cabinet
- Member Practices
- The Local Professional Networks- Dental, Ophthalmic and Pharmaceutical

Stakeholders have been asked to provide comment by the 2 December 2016.

3. Next Steps

Following the consultation phase the comments received will be reviewed and the final draft of the strategy will be produced. An Equality and Quality Impact Assessments will also be completed. Assuming no unforeseen delays it is proposed that the strategy will be presented to the December PCCC meeting for ratification.

4. Recommendations

Primary Care Commissioning Committee is asked to note the content of this paper and provide feedback on the draft strategy.

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Primary Care Health and Wellbeing Strategy 2016-2021

Primary Care's contribution to meeting the Bury vision to

'ensure our population is as healthy, happy and independent as possible, living with minimal intervention in their lives. This will be achieved through targeted strategies of self-help, prevention and early intervention, reablement and rehabilitation. When needed, formal care and support will be designed to create a coordinated and seamless health and care system. All services will be person-centred and will build on and develop local community assets.'

NHS Bury CCG

December 2016

High quality care at the right time, in the right place, by the right person

Contents

Executive Summary

This strategy lays out Bury's vision for Primary Care and begins to explore the work that will need to be undertaken to make that vision a reality by 2021. The strategy looks towards our strengths in Bury to the innovation and good practice that already exists and seeks to build on this. It aims to make reality three high level outcomes by 2021. These are:

- An empowered population who are confident in their approach to preventing diseases and self-management of healthcare conditions
- Where care is appropriate or needed this will be person-centred co-ordinated care, leading to an increased consistency and patient satisfaction
- High quality care will be provided by motivated, talented, happy and healthy primary care professionals attracted to work in Bury

It describes 5 key themes with action points that will contribute to meeting these objectives. It recognises the key enablers that will accelerate our progression such as attracting and retaining the best primary care professionals.

The themes, enablers and key action points are:

- Theme One- People powered changes in health and behaviour
    - Asset-based care and social prescribing
    - Early intervention and prevention
    - Self-care and self-referral
    - Focused interventions
- Theme Two- Population based models of care
    - A Bury wide LCO
    - Learning from seldom heard groups
- Theme Three- Consistently high quality care
    - CQC rating of good or outstanding for 100% of practices
    - GM standards embedded in practices
    - Development of all primary care providers
    - Equipping practices to be able to constantly improve
- Theme Four- Inter-professional working
    - Use our skill mix
    - Adopt GM service specifications
- Theme Five- Innovation
    - Creating a sharing and innovative culture

- Enabler One- Workforce

    - Clear workforce strategy
    - Defined education plan
- Enabler Two- Technology
    - begin to move towards a single patient held health and social care record
    - Install Wi-Fi into all GP practices
    - Adopt new technology
- Enabler Three- Finance, contracts and incentives
    - MCP contract
    - Pro-active working
- Enabler Four- Estates
    - Optimise public sector space providing fit for purpose premises
- Enabler Five- Communication and engagement
    - Comprehensive communication and engagement plan

A detailed action plan will be produced that starts to articulate the steps that will be taken. Though this strategy has been produced by Bury CCG it must be owned by the primary care workforce working with the Bury population for it to be successful.

Context

This strategy sets out Bury's ambition for primary care. It describes primary care's contribution to the Bury vision. When this strategy refers to primary care it is talking about it in its widest sense, recognising the contribution made by the workforce in GP, dental, ophthalmic and pharmacy practices. It appreciates that for true change to take place we must also understand and appreciate the input of other professionals working in the expanding primary care sector e.g. physiotherapists, podiatrists, social care staff. The strategy also looks to the third sector, to voluntary and community groups, and to local assets, to improve the health and wellbeing of those living in Bury.

This strategy is designed to complement the direction already set by the Greater Manchester Primary Care Strategy, the GP Forward View and the Bury Locality Plan. The commitments made in those documents will be implemented alongside those described in this strategy.

This strategy builds its case by looking at the positives and how we use them as our foundation for change. The strategy not only describes a positive deviance approach shaped by our strengths, to primary care and wellbeing, but is written in a style that reflects this.

At the time of writing the Health and Social Care system nationally and within the Greater Manchester conurbation is undergoing the most radical change ever seen. The pace of movement is fast; for this reason the strategy focuses on the function rather than the form. It describes where we want to get to with a steer on how we get there. It recognises that the structural models of care required to provide this may change, may yet to be conceived and that priorities may alter with the current pace of change.

The main audience are primary care professionals working in the Bury locality, it describes the CCG's commissioning intentions for primary care and alludes to the work that will get us there. However the vision in this strategy needs to be shared with the whole Bury population and to be translated into terminology that resonates with them.

The strategy describes where we wish to get to by providing the foundations on which commissioning decisions will be made, it does not describe the path we will take to get there. A detailed action plan will be produced that will clearly map the route to our vision. To achieve success the action plan will need to be influenced and owned by all; through co-production. The ambition described by this strategy will be a reality by 2021.

Primary Care and Wellbeing in 2016

We have a lot to celebrate in Bury and strong foundations to build our vision on. We have a history of innovation, for example, pioneering Extended Working Hours as part of the Prime Minister's Challenge Fund and being one of the first areas where all practices have appointments available from 8am to 6:30pm Monday to Friday, ensuring the Bury population has access to a GP at a time that best suits them; general practice making a clear commitment to patients with dementia by embracing new skill sets and ways of working such taking over the routine assessment, diagnosis and management, whilst striving towards 'dementia friendly' status; and introducing the paramedic 'Green Car' scheme as an alternative to taking patients to hospital.

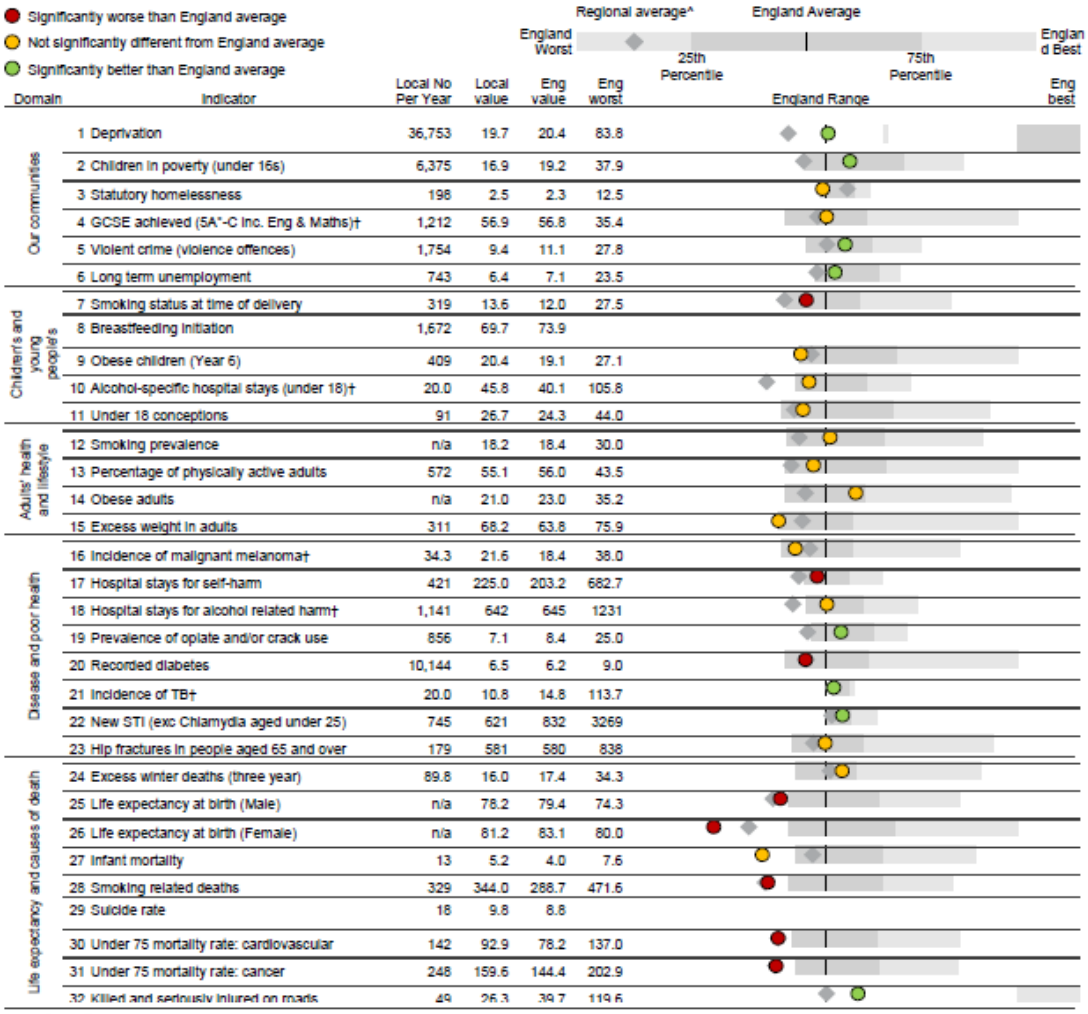
We have also worked closely with our partners, expanding the reach of our innovation. Working with the GP Federation we have jointly commissioned clinical pharmacists to support every practice. We are ensuring parity of esteem, by creating IAPT services focused on patients with LTCs collaborating with the third sector and were one of the first CCGs to adopt the jointly managed optometry and pharmacy Greater Manchester Minor Eye Conditions Scheme. Our work with the Local Authority has seen us excel at delivering NHS Health Checks and meeting our influenza vaccination targets. All of this has been achieved with a historically underfunded but improving financial position, demonstrating our ability to think creatively.

The CCG membership has worked together to achieve the biggest reductions in non-elective admissions in Greater Manchester in 2015/16. We continue to have some of the lowest prescribing costs in the North West and 80% of GP practices that have been subject to a CQC inspection have been rated good or excellent.

Building on our success we can tackle some of the health inequalities that exist within Bury. There is still a gap of 10.7 years for men and 7.4 years for women, between the most and least deprived areas across the borough. Early death rates from cardiovascular incidents and cancer, though improving, are worse than the England average. The challenge ahead of us is demonstrated by looking at the Bury Health Profile 2015 in the figure opposite[1].

[1] Public Health England. Bury Health Profile 2015. Crown Copyright 2015.

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.



Domain	Indicator	Local No Per Year	Local value	Eng value	Eng worst	Eng best
Our communities	1 Deprivation	36,753	19.7	20.4	83.8	
	2 Children in poverty (under 16s)	6,375	16.9	19.2	37.9	
	3 Statutory homelessness	198	2.5	2.3	12.5	
	4 GCSE achieved (5A*-C inc. Eng & Maths)†	1,212	56.9	56.8	35.4	
	5 Violent crime (violence offences)	1,754	9.4	11.1	27.8	
	6 Long term unemployment	743	6.4	7.1	23.5	
Children's and young people's	7 Smoking status at time of delivery	319	13.6	12.0	27.5	
	8 Breastfeeding initiation	1,672	69.7	73.9		
	9 Obese children (Year 6)	409	20.4	19.1	27.1	
	10 Alcohol-specific hospital stays (under 18)†	20.0	45.8	40.1	105.8	
	11 Under 18 conceptions	91	26.7	24.3	44.0	
Adults' health and lifestyle	12 Smoking prevalence	n/a	18.2	18.4	30.0	
	13 Percentage of physically active adults	572	55.1	56.0	43.5	
	14 Obese adults	n/a	21.0	23.0	35.2	
	15 Excess weight in adults	311	68.2	63.8	75.9	
Disease and poor health	16 Incidence of malignant melanoma†	34.3	21.6	18.4	38.0	
	17 Hospital stays for self-harm	421	225.0	203.2	682.7	
	18 Hospital stays for alcohol related harm†	1,141	642	645	1231	
	19 Prevalence of opiate and/or crack use	856	7.1	8.4	25.0	
	20 Recorded diabetes	10,144	6.5	6.2	9.0	
	21 Incidence of TB†	20.0	10.8	14.8	113.7	
	22 New STI (exc Chlamydia aged under 25)	745	621	832	3269	
	23 Hip fractures in people aged 65 and over	179	581	580	838	
Life expectancy and causes of death	24 Excess winter deaths (three year)	89.8	16.0	17.4	34.3	
	25 Life expectancy at birth (Male)	n/a	78.2	79.4	74.3	
	26 Life expectancy at birth (Female)	n/a	81.2	83.1	80.0	
	27 Infant mortality	13	5.2	4.0	7.6	
	28 Smoking related deaths	329	344.0	288.7	471.6	
	29 Suicide rate	18	9.8	8.8		
	30 Under 75 mortality rate: cardiovascular	142	92.9	78.2	137.0	
	31 Under 75 mortality rate: cancer	248	159.6	144.4	202.9	
	32 Killed and seriously injured on roads	49	26.3	39.7	119.6	

Indicator notes

1 % people in this area living in 20% most deprived areas in England, 2013 2 % children (under 16) in families receiving means-tested benefits & low income, 2012 3 Crude rate per 1,000 households, 2013/14 4 % key stage 4, 2013/14 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2013/14 6 Crude rate per 1,000 population aged 16-64, 2014 7 % of women who smoke at time of delivery, 2013/14 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery, 2013/14 9 % school children in Year 6 (age 10-11), 2013/14 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2011/12 to 2013/14 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2013 12 % adults aged 18 and over who smoke, 2013
13 % adults achieving at least 150 mins physical activity per week, 2013 14 % adults classified as obese, Active People Survey 2012 15 % adults classified as overweight or obese, Active People Survey 2012 16 Directly age standardised rate per 100,000 population, aged under 75, 2010-12 17 Directly age sex standardised rate per 100,000 population, 2013/14 18 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2013/14 19 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2011/12 20 % people on GP registers with a recorded diagnosis of diabetes 2013/14 21 Crude rate per 100,000 population, 2011-13, local number per year figure is the average count 22 All new STI diagnoses (excluding Chlamydia under age 25), crude rate per 100,000 population, 2013 23 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over, 2013/14 24 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 01.08.10-31.07.13 25, 26 At birth, 2011-13 27 Rate per 1,000 live births, 2011-13 28 Directly age standardised rate per 100,000 population aged 35 and over, 2011-13 29 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2011-13 30 Directly age standardised rate per 100,000 population aged under 75, 2011-13 31 Directly age standardised rate per 100,000 population aged under 75, 2011-13 32 Rate per 100,000 population, 2011-13

† Indicator has had methodological changes so is not directly comparable with previously released values. ^ "Regional" refers to the former government regions.

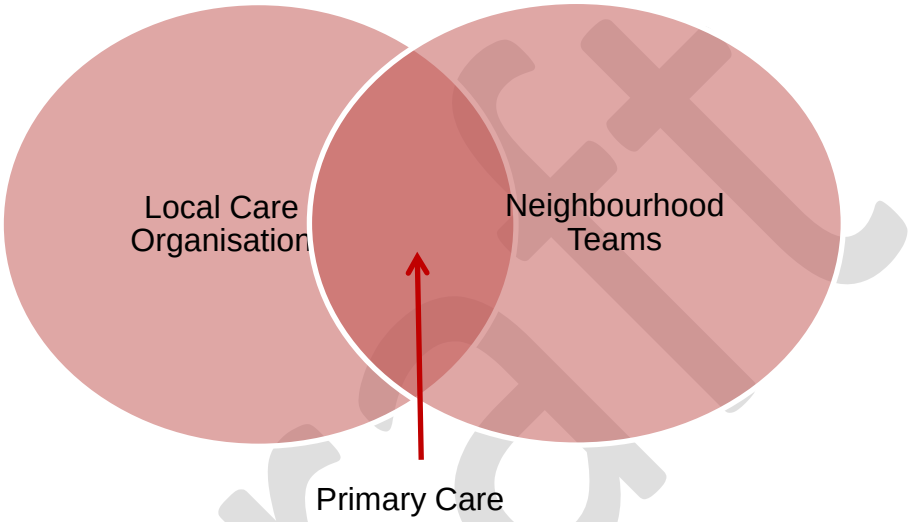
More information is available at www.healthprofiles.info and http://fingertips.phe.org.uk/profile/health-profiles Please send any enquiries to healthprofiles@phe.gov.uk

Challenges and inequalities are not unique to Bury and they are present at a time of unprecedented demand on the NHS, an increasing complexity of patients has led to well documented challenges in primary care. These challenges need to be overcome whilst still maintaining the quality of care that patients require.

With over 100 traditional primary care providers across the locality comprising of 24 dental practices, 31 GP practices, 19 optometry practices and 43 community pharmacies, primary care is ideally placed to support the health and wellbeing of the Bury population. The registered list model held by general practice is complemented by the open access approach of the dental, optometry and pharmacy practices. The primary care architecture is available and this strategy describes how we utilise its full potential.

Primary Care in 2021

This strategy is our opportunity to describe primary care's place in the evolving Bury Health and Social Care System. The health care led development of LCO and the local government led development of neighbourhood teams will succeed by primary care being at the centre. This is consistent with the vision laid out in 'Taking charge of our Health and Social Care in Greater Manchester'[2] and is demonstrated by the image below.



By 2021 primary care will have achieved the following high level outcomes:

- An empowered population who are confident in their approach to preventing diseases and self-management of healthcare conditions
- Where care is appropriate or needed this will be person-centred co-ordinated care, leading to an increased consistency and patient satisfaction
- High quality care will be provided by motivated, talented, happy and healthy primary care professionals attracted to work in Bury

These outcomes will be achieved by working towards 5 key themes and enablers:

- Theme One- People powered changes in health and behaviour
- Theme Two- Population based models of care
- Theme Three- Consistently high quality care
- Theme Four- Inter-professional working
- Theme Five- Innovation

[2] Greater Manchester Combined Authority. Taking charge of our Health and Social Care in Greater Manchester. Dec 2015

- Enabler One- Workforce
- Enabler Two- Technology
- Enabler Three- Finance, contracts and incentives
- Enabler Four- Estate
- Enabler Five- Communication and engagement

To know if we have been successful in achieving our outcomes clear measures will be articulated in our action plans. Some measures will be seen within the lifetime of the strategy other make take a generation to materialise.

Patient Stories

To help demonstrate our vision fictional patient stories have been included throughout to describe what primary care will look like to them.

'Meet the Taylors'

The Taylor family live in the Tottington area of Bury:

Mum Jennifer is 37, works full time, in general is in good health but has a BMI of 28 and struggles to achieve the recommended 30 minutes of activity a day.

Dad Simon is 40, he has been unemployed for the last 2 years since being made redundant. Simon has recently been diagnosed with type two diabetes and is a smoker.

Jennifer and Simon have two children Alex, 18 months and Annie, 3 years. Neither of whom have any know health conditions.

Grandad John is Simon's father. He is 75 years old and lives in the Prestwich area of Bury. The family tend to visit John about once a month but find it difficult to visit more often as they do not have access to a car. John does not like to ask his family for help.

Theme One- People powered changes in health and behaviour

We will…

- *create an asset-based approach to our care supported by a social prescribing scheme*
- *work in partnership to increase prevention and early detection of disease*
- *empower our population to self-care and self-refer where clinically appropriate*
- *focus our interventions to achieve maximal benefits*

Our vision is for a healthy, happy and independent population. This will be achieved by primary care empowering our patients to prevent ill health, enabling them to self-care and providing them with the support required to manage any health and wellbeing conditions they may develop. Every contact with a primary care provider is an opportunity to get to know the patient, to understand and build on their strengths, and to work with the population to meet our vision. This will be achieved by creating an asset-based, every-contact-counts approach. Together we will ensure our population consider their health to be important before it is adversely affected.

Many of the health conditions present in our population could have been prevented or had their severity limited by early intervention. Late diagnosis causes unnecessary suffering to our population and increases pressure on NHS services. In Bury we recognise the expertise of our public health colleagues in the promotion of wellbeing, prevention and early detection of disease. Moving to a single commissioner will reduce some of the current constraints to placing prevention at the heart of everything we do. Commissioning teams in both the CCG and the council are starting to work together and will continue to do so.

We will work together, with our partners to identify areas of focus, key clinical and geographical areas where focussed interventions are required. This approach matched with targeted support for those members of the population ready to change will ensure our actions have the biggest impact. A significant target group are children and young people who need to be equipped from an early age to make lifestyle choices that will allow them to live long, happy, healthy lives. The award winning ‘Baby Teeth DO Matter’ campaign pioneered by our dental colleagues is a source of learning for making meaningful interventions at a young age.

In Bury we have already set the enablers in place to support patients to self-care self-limiting conditions as expressed in the Prescribing for Clinical Need Policy. The

pharmacy-led minor ailments scheme and the optometry-led minor eye conditions schemes have provided patients with a more appropriate route for NHS treatment. This is just the beginning of the cultural change; self-care messages will continue with the ambition that the population will be equipped to access high quality care at the right time in the right place by the right person. We will support our population to take control of their own health and wellbeing, to see this as a priority. Where appropriate we will remove the current barriers that prevent patients from self-referring to services such as IAPTs, district nurse and health visitor services.

To make the change we have articulated we need to move away from the traditional model of looking at what is wrong and trying to fix it. We need to start adopting a positive deviance, asset-based approach, building on our strengths. A key tool in achieving this ambition is social prescribing, enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services. We wish to build on the inspiring work that produced the Bury Directory and the 'I will if you will' exercise programme. We will implement a social prescribing system. This strategy does not define the model that will be introduced; that will be designed by a multi-agency co-production approach. We recognise that for social prescribing to be successful it needs to implemented across the locality, changing routine practice and using the skill sets of the community. Results will take time and we will need to work with the third sector supporting them in meeting this change in demand. We will make this commitment and general practice will be key in the design, implementation and evaluation of the chosen model.

A vision for Grandad John- social prescribing

John is an independent retired gardener who lives alone with 2 cats and a dog. He looks after self, does his own cooking, shopping and cleaning. He is a known COPD patient.

Following an exacerbation of his COPD, which left him extremely breathless whilst on his weekly trip to Bury Market his confidence to go out on his own has decreased leading to social isolation. This has corresponded with an increase in phone calls and visits to the GP practice for vague concerns.

A member of the reception team is a trained care navigator and sits down with John to look at the Bury Directory and they discover together a music group that John might be interested in. John attends the music group and his confidence to go out independently comes back and his contact with the GP practice reduces. Through the group John finds out about the Heaton Park walking group which he also joins- even leading a walk which focusses on the various trees in the park.

Theme Two- Population based models of care

We will…

- *support the creation and development of the emerging Bury wide LCO providing commissioning support and expertise where required*
- *build on our learning from working with seldom heard groups to benefit the whole population*

We have articulated a desire to achieve a person-centred co-ordinated and seamless health care system, placing the needs of the individual and the population at the centre of what we do. This requires a change in the way we structure the numerous organisations committed to improving the health and wellbeing of the Bury population.

Work is already progressing on the development of a LCO for Bury. The Bury GP Federation is a key partner in developing the primary care offer with a focus on out of hospital care. There is a commitment to develop this model from the bottom up recognising that front line professionals and the Bury population have the knowledge and passion to create a care model that meets Bury's needs. The function of the LCO is emerging and the form will develop, we recognise that as relationships advance contractual paradigms will shift.

In Bury commissioners have developed two very high level objectives for the early programmes of work for the emerging LCO. The first focuses around the pressing need to stabilise our urgent care system. The second looks to the future increasing the number of years our population enjoy happy healthy lives. The work of primary care will contribute to both of these objectives.

The LCO will be built around GP registered lists and will have primary care at its heart. The registered list verse resident population dynamic will need to be resolved. The CCG membership sectors will shape and pilot different prototypes sharing learning to develop the optimal model that will be adopted across the whole Bury locality, ensuring our population have access to consistent and high quality care. The CCG is committed to the development of one LCO and supporting its development will be a priority over the period of this strategy.

We have much to learn from the focussed work we have done with seldom heard groups such as the BME community, patients with learning disabilities, asylum

seekers and dementia patients. By translating this learning we will build new models of care that will benefit the whole population.

A vision for Annie- person-centred co-ordinated care under an LCO model

Annie wakes up on a Saturday night coughing, wheezing and hot. Her parents phone the surgery, and are re-directed to NHS 111. NHS 111 take some basic information and pass the call to the out of hours service for triage. A clinical assessment is made and a paediatric nurse sent to see Annie (as the parents have no transport).

The nurse does a full assessment, it seems Annie has been waking up coughing for months, and recently has had a cold. She does a full assessment and decides to treat Annie at home with steroids, antibiotics and an inhaler. She teaches the family how to manage an inhaler and assess how bad Annie's symptoms are. She arranges for Annie to have a call back on Sunday morning and an appointment at the surgery on Monday.

On Monday Annie is much improved. The GP arranges for a review in 3-4 weeks with the practice nurse to assess if Annie might have asthma. At the same time she gives the Dad Simon details of the local smoking cessation advice service.

Theme Three- Consistently high quality care

We will…

- *have 100% of our member practices achieving a CQC rating of good or outstanding*
- *have embedded the GM Primary Care Standards as a minimum quality level marker for member practices*
- *support the development of all our primary care providers*
- *provide member practices with the tools to compare and improve on performance*

Effective, safe and high quality care is a primary motivator for the whole of primary care. Primary care providers in Bury have an ambition to be the best and this is matched by a population desire for us to be the best. The Bury population will be confident that any advice, support or care they receive in Bury will be to the highest possible standard, wherever they are in the Borough.

At a fundamental level contractual compliance is a key marker that a primary care contractor is providing safe, effective and quality services. Monitoring of contractual compliance is not solely in the remit of the CCG, dental, general ophthalmic and pharmaceutical services are commissioned and managed by the GM H&SCP. The CCG has delegated responsibility for primary medical services, GP practices and dental practices are subject to CQC inspections and community pharmacy premises undergo comprehensive monitoring by their professional regulator- the General Pharmaceutical Council. We commit to ensuring all GP practices are fully compliant with their contract and the membership will work together to reach the goal that all of these practices will achieve a good or outstanding rating from CQC. As a CCG we recognise that sub-optimal performance of primary care providers who we do not hold core contracts with is not simply a problem for the GM H&SCP. These contractors provide care for our population and therefore we commit to working with our partners to ensure minimum contractual standards are maintained.

Contractual compliance is just the minimum standard expected; we want to go beyond that to provide the Bury population with the highest quality care in Greater Manchester. General practice has demonstrated its commitment to this goal with all practices signing up to the Quality in Primary Care Contract and all practices will have met these standards before the end of 2018 demonstrating excellence and reducing inequalities in care. This work is further complemented by our commitment to achieving designated Quality Premiums. Achievement of these goals brings triple

rewards; they drive up standards, reduce inequalities and provide funds which will be invested in primary care.

The GM H&SCP are developing more provider-specific standards for the remaining three primary care providers and we make a promise to play our role in the successful implementation of these standards. All of the standards include a focus on patient safety and a culture of sharing learning and continuous improvement to embed a safety culture in primary care is a must do.

For us to truly tackle inequalities we not only need to work across organisations to identify and address variance, but take a pro-active approach- spotting and addressing challenges before they become ingrained. Regular triangulation of the quality indicators held by various organisations will help us to achieve this pro-active management. We have already invested in technology that will support this and a successful monitoring system will be developed and incorporated in the assurance process. By using this technology practices can benchmark their performance against their peers, giving them the ability to consistently improve the high quality of services they provide.

The Healthy Living Practice Framework was pioneered by pharmacy contractors, supported by Public Health England and aims to make every contact in a community pharmacy count. The GM H&SCP are working with dental, ophthalmic and primary medical services providers to develop suitable frameworks for these contractor groups. The Dementia Friendly Pharmacy Framework sees pharmacy teams take pro-active steps to support patients with dementia in their neighbourhoods; again work is taking place to develop suitable frameworks for the whole of primary care. It is clear that we need to and will support the implementation of these concepts creating over 100 health and wellbeing hubs within our locality. Each of these hubs will bring with them their own ideas generating fresh innovation.

Consistent high quality care results in improvements in patient safety. The most common health intervention that a patient receives is the taking of medication either over the counter or prescribed. We have a strong high performing Medicines Optimisation Team that have a track record of working with GP practices eliminating un-necessary treatments, promoting evidence based care and are already paving the way to consistently high quality care.

A vision for Jennifer- Reduction in antibiotic prescribing rates

Following a cold Jennifer develops a chesty productive cough. She is coughing up clear phlegm, has a slightly raised temperature and generally feels under the weather. She rings her GP practice seeking a prescription for antibiotics. The trained receptionist triages the patient and recommends that Jennifer visits her local pharmacist.

The pharmacist assesses Jennifer's symptoms after ruling out any red flag symptoms and diagnosing a simple viral infection they offers Jennifer some simple self-care advice. Jennifer is advised to make an appointment with her GP if her symptoms do not improve after three weeks. Whilst at the pharmacy the pharmacist signposts to Jennifer to the pharmacy's weight loss service explaining the benefits of maintaining a healthy BMI.

The pharmacist makes a note of the consultation on the patient's record which can be accessed by the patient's GP capturing the advice given.

Focus on Antibiotic guardiship

Increasing resistance to antimicrobials and a lack of new drugs means a greater risk of infections that cannot be treated, making routine medical care riskier and resulting in more deaths - so antimicrobial resistance affects us all.

The government published a UK Five Year Antimicrobial Resistance Strategy in 2013 which aims to slow the development and spread of antimicrobial resistance. Between April 2015 and August 2016 Medicines Optimisation supported practices to achieve a 12% reduction in antibiotic prescribing rates in Bury by:

- updating the primary care prescribing guidelines and training of practice staff on responsible antibiotic prescribing
- sourcing the provision of national tools to support GPs in the face of patient demand
- undertaking regular audits and feedback to prescribers to evidence inappropriate prescribing
- providing benchmarking data at monthly sector meetings to ensure this initiative retained a high profile;
- working with local microbiologists and urologists to reduce long term prophylaxis for UTIs.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/244058/20130902_UK_5_year_AMR_strategy.pdf

Theme Four- Inter-professional working

We will…

- *utilise the skill mix of our primary care providers to bring more services outside of hospital*
- *move to LPN supported GM service specifications for services commissioned from primary care providers*

Achieving co-ordinated and seamless care built upon local assets will see a shift of services from secondary care allowing patients to be cared for closer to home. This shift will require primary care professionals to continue to work closely not only with their secondary care colleagues but with each other and the third sector. The GP Federation is already leading this work with emerging priorities around patients in care homes, multidisciplinary teams and self-care.

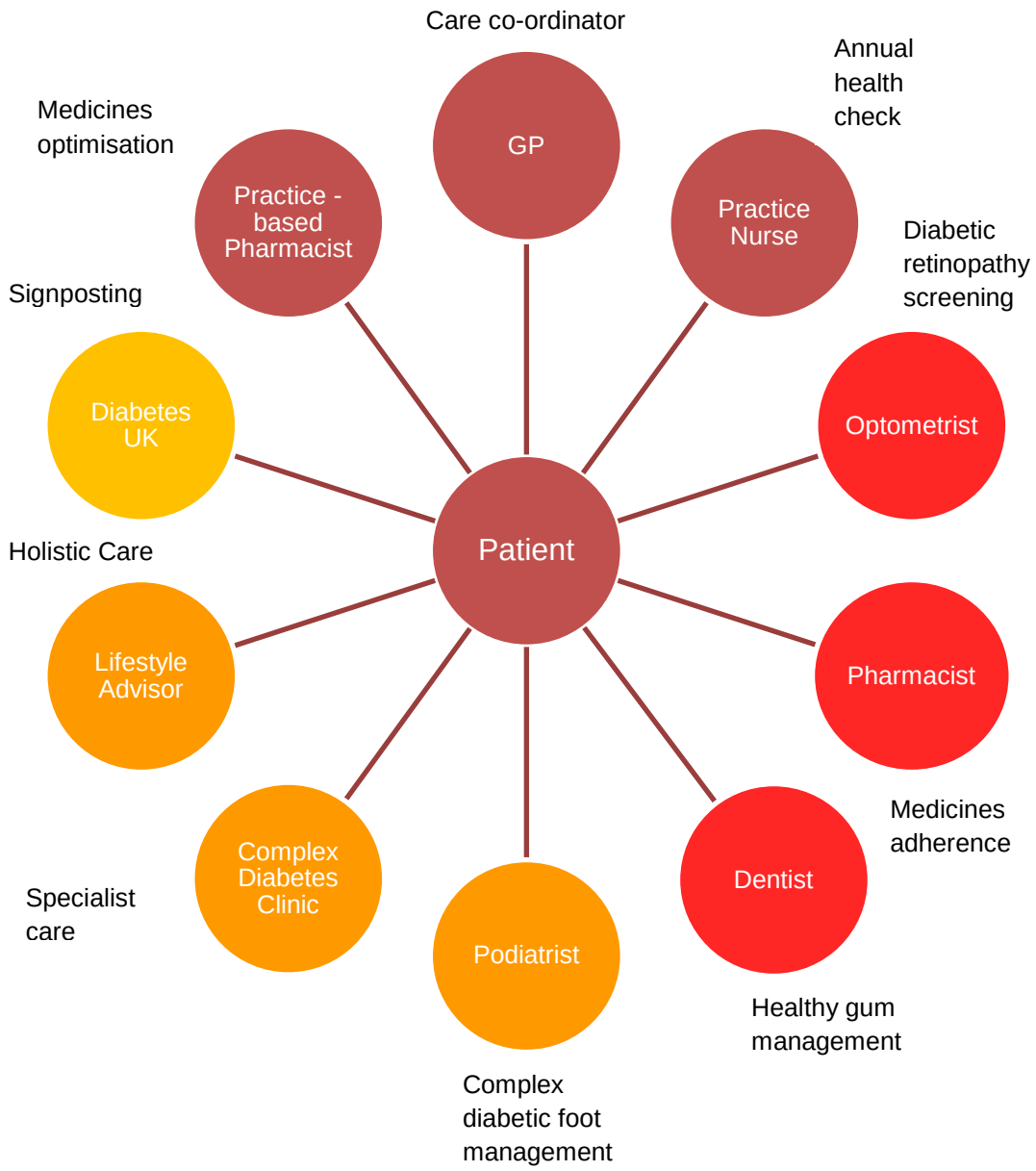
We will build on successful models of inter-professional working, such as the Clinical Pharmacists in General Practice pilot, Extended Working Hours, IAPTS practitioners working in primary care, Healthier Radcliffe and learning from the successes of our own Medicines Optimisation Team to further strengthen the primary care offer. We recognise that the movement of services from secondary care cannot all fall on to one provider, but by working together using the skill mix of the whole of the traditional and non-traditional primary care workforce and by adopting news skills and ways of working we will meet our vision.

The CCG is fortunate that as a membership organisation it has a vast resource of knowledge and experience in primary medical services within its structure. We will continue to use this expertise to develop stronger relations across the whole of primary care. With the current commissioning arrangements comprehensive knowledge and understanding of the potential of dental, ophthalmic and pharmacy colleagues is not within the CCG. LPNs exist for all three of these professional groups. LPNs are Greater Manchester wide networks of commissioners and providers in the respective professional groups reporting to the GM H&SCP.

We will build links with these networks, listening to their suggestions and seeking their views on how to achieve a seamless primary care system. LPNs have created model service specifications and referral pathways for commonly commissioned services across Greater Manchester, such as minor ailment schemes and cataract referral refinement services. Where we are commissioning one of these services we will move towards the specifications designed by the relevant professional groups. Where new services are created we commit to considering commissioning where there is a clear connection to our vision and the aims of our locality plan.

A vision for Simon- Inter-professional working in practice

A number of professionals are in involved in treatment of Simon's diabetes. All of these professionals use their particular skill set to empower Simon to self-manage his condition, providing support when needed. Their co-ordinated approach allows Simon to lead a happy, healthy life.



Theme Five- Innovation

We will…

- *create an environment that encourages innovation and the sharing of learning*

The Greater Manchester Health and Social Care Partnership have been very clear that the aims of devolution cannot be achieved by continuing to do more of the same. Equally we know that we cannot achieve our vision without change. We have a history of innovation and are not afraid to adapt and challenge our ways of working. We are proud of this. We empower our workforce, population and partners to think differently, to try new things, to encourage leaders at all parts of the system, to share learning and innovation. We will build on learning from the wider health and social care system, from across Greater Manchester, England and the World. Where evidence exists for a new scheme we will use that to introduce locality wide change. Where schemes are new and not supported by an evidence base we will follow a process of positive enquiry and evaluation.

As part of the devolved Greater Manchester Health and Social Care System we are very fortunate. Devolution is being supported by a dedicated transformation fund which will be spent on the Greater Manchester population, without the need to compete with other areas of England. Bury is just one locality in this devolved system, we need to be proactive, clear on our ambition and how we will achieve our vision, ready with plans to bid for funds as they are announced. Clear, uncomplicated mechanisms will be designed to ensure innovative ideas are captured and developed in expedient timescales, eliminating unwarranted bureaucracy.

A vision for Alex

Enabler One- Workforce

We will…

- *undertake a skill mapping exercise which will inform a comprehensive workforce strategy that articulates how we will attract and retain the highly-skilled primary care professionals to the Bury locality.*
- *produce a clearly defined education plan*

Our vision of a happy and healthy population extends to our workforce. The health and wellbeing of those providing primary care in Bury must be one of our main priorities, our positive deviance approach, which builds on our strengths, is not limited to the population. Primary care professionals should be ambassadors to the population leading by example and Bury CCG along with all other organisations in the Bury system should be enabling people to achieve this vision. The CCG will continue to have strong links with our memberships and recognises that stress often occurs at times of change. Though the structure of our relationship may change, the CCG remains committed to supporting its membership.

To achieve our vision we need to develop and nurture our workforce to create strong leaders with a clear Bury identity. Clinical leadership across the whole of primary care is vital. We will support the development of our leaders. Support will be given to our workforce to prepare them the changes ahead, our commitment to education and training remains and opportunities to share knowledge across the whole of the primary care workforce will be developed. This will be articulated in a clear workforce, education and training strategy for Bury. Proactive and united team working will enable us to create a caring an efficient NHS for our population, continuity of patient care will be the norm not just an aspiration.

We need to consider the skill mix held across primary care. The GP Five Year Forward View state a commitment from NHS England to increase the number of GPs by 5,000, but this will not be enough by itself. Bury will need to maximise the skill set of all health professionals. A skill mapping exercise will take place to identify our strengths and opportunities to work together. By working together to meet the Bury vision we will create a locality where talent is attracted and retained. Working with Health Education England will strengthen our ability to engage with students showing them what an excellent and exciting place Bury is to work. We will promote inter-professional working, adopting evidence based jointly owned clinical pathways and promoting excellence. Organisational structures should no longer be barriers to inter-

professional working the LCO will provide learning that will need to be harnessed and shared.

The workforce strategy will include how we will support our member practices both in terms of education (which will be articulated in a clear plan) but also with resilience. We have already started to demonstrate our commitment to this with the successful application to join the Productive General Practice Programme. Working closely with our colleagues in the GM H&SCP will see the introduction of care navigators and a bespoke General Practice Resilience Programme. This will be supported by investment to create headroom to allow practices to engage in development.

Enabler Two- Technology

We will…

- *begin to move towards a single patient held health and social care record*
- *install Wi-Fi into all GP premises*
- *continue to embrace technological advances that support improving health outcomes for our population*

Bury has always been at the forefront of IT, early adopters of technology that will reduce unnecessary administrative burden and create a seamless patient journey. We will continue on this path of innovation. We wish to move to a system where a patient holds their own electronic record containing all their health and social care information which can be accessed by appropriate care professionals throughout the patient journey. This will improve efficiencies, safety and allowing the patient to only have to tell their story once.

Technology will be used to support communication amongst primary care providers, the roll out of NHS mail to all providers and the recently granted access to Summary Care Records for community pharmacists is just the beginning. Robust IT systems are needed with excellent back-up systems and the ability to share records will support us in providing seamless care between the different professionals supporting patients to meet their health goals. There will be a move towards online consultation system and new digital approaches to help support our membership to find 'Time to Care'. All GP practices will be equipped with Wi-Fi which contributes to safe home visits by maximising the use of Vision Anywhere®.

We live in a 24/7 world where for a lot of our population accessing the internet is a daily norm, we need to embrace technology giving our population the tools and support to self-care by steering them in the direction of reputable websites and mobile apps, sharing evidence based practice in a manner that suits them.

Enabler Three- Finance, contracts and incentives

We will…

- *welcome the new MCP contractual model*
- *move to a more pro-active way of working allowing us to make the most of the advantages devolution brings*

A key enabler to achieving the LCO model described in theme two is the introduction of the Multi-Speciality Community Provider (MCP) contract. This nationally developed contract will allow the creativity and flexibility required to support our vision. It will be fundamental in removing barriers that exist due to current constraints, allowing organisations to work together.

We will move to rewarding the outcomes of interventions, rather than the volume that take place, recognising that some outcomes may take a number of years to be realised. We do not just want a happy and healthy population today, we will put the contractually mechanisms in place to ensure that this vision continues for the next 10, 20, 30 years and beyond. Outcome-based incentives will allow gains as well as risks to be shared. Key to this is the quality of the data held by our membership practices and plans will be developed to raise confidence in the data held allowing robust commissioning decisions to be made.

We are committed to ensuring patients receive high quality care, at the right time, in the right place, by the right person. This will see the movement of more services into the community, this again strengthens our need to be pro-active in our thinking ensuring that we have access to transformational funding.

The table below shows the CCG's current spend on primary care. This includes the core Primary Medical Services payments delegated from NHS England and the additional services commissioned from primary care providers. The CCG is already committed to investing a further £3 per head non-recurrently into Primary Medical Services by 2018/19 and as services move from hospital this investment will grow.

(table of investment to be included after consultation phase)

Enabler Four- Estates

We will…

- *work with our public sector colleagues to ensure best use of current estates, providing fit for purpose premises for our services*

Our estates vary significantly in terms of quality, condition and suitability. These estates need to cope with increasing patient activity as care moves out of hospital. Primary care premises are not merely places to receive health services but assets located in the heart of our communities. We equally have void spaces within our own estate portfolio and our move to integrated commissioning and care provides us with the opportunity to make best use of the whole of the public services estate infrastructure. A detailed estates plan is outside the scope of this strategy, responsibility for that is within the remit of the Strategic Estates Group. Our steer to them is that we require:

- High quality, fit for purpose, affordable estates
- Void spaces should be minimised and this may be achieved by the movement of services within a locality
- Where the rationalisation of existing public sector estates has been exhausted bids for new premises will be supported

Enabler Five- Communication and engagement

We will…

- *develop a comprehensive communication and engagement plan*

Communication and engagement is vital. The Bury vision can only be delivered if we are all clear on what we are trying to achieve, working together and communicating with our population. We need to develop ways to share good practice, celebrate and build on our successes, to learn together.

Fundamental to any communication and engagement plan is to ensure there are clear, consistent message that all primary care professionals promote. We need to work with our population in new innovative ways allowing them to take responsibility for their own healthy lifestyle choices and access to the most appropriate support for their health care needs.

The communication and engagement plan will not only explore how as a CCG we communicate with our member practices, but will also include communication between the whole of primary care, our population and our partners.

Glossary

GM H&SCP	Greater Manchester Health and Social Partnership
IAPT	Improving Access to Psychological Therapies
LCO	Local Care Organisation
LPN	Local Professional Network
LTC	Long Term Condition

Prioritisation Plan

The various commitments in this strategy have been grouped into different priority waves as demonstrated in the table below. Where available the current benchmarking information has been included to help track progress. Detailed performance measures will follow in the high level action plan.

Wave One			
Outcome	Theme/Enabler	We will…	2016 benchmark
An empowered population who are confident in their approach to preventing diseases and self-management of healthcare conditions	People powered changes in health and behaviour	Create an asset-based approach to our care supported by a social prescribing scheme	Currently no social prescribing scheme in place
		Empower our population to self-care and self-refer where clinically appropriate	Prescribing for clinical need policy Minor ailments scheme
Where care is appropriate or needed this will be person-centred co-ordinated care, leading to an increased consistency and patient satisfaction	Population based models of care	Support the creation and development of the emerging Bury wide LCO providing commissioning support and expertise where required	LCO in its infancy
High quality care will be provided by motivated, talented, happy and healthy primary care professionals attracted to work in Bury	Consistently high quality care	Have 100% of our member practices achieving a CQC rating of good or outstanding	25/31 practices rated as good or outstanding. No practice rated at inadequate
	Technology	Install Wi-Fi into all GP premises	Funding agreed for roll-out
	Workforce	Undertake a skill mapping exercise which will inform a comprehensive workforce strategy that articulates how we will attract and retain highly-skilled primary care professionals to the Bury locality	Health Education England workforce study[3] shows an older than average GP workforce
Wave Two			

[3] Health Education England. Health Education England, working across the North West. General Practice Workforce Survey 2016. NHS Bury CCG

Outcome	Theme/Enabler	We will…	2016 benchmark
An empowered population who are confident in their approach to preventing diseases and self-management of healthcare conditions	People powered changes in health and behaviour	Work in partnership to increase prevention and early detection of disease	
Where care is appropriate or needed this will be person-centred co-ordinated care, leading to an increased consistency and patient satisfaction	Finance, contracts and incentives	Welcome the new MCP contractual model	
	Communication and engagement	Develop a comprehensive communication and engagement plan	
High quality care will be provided by motivated, talented, happy and healthy primary care professionals attracted to work in Bury	Consistently high quality care	Have embedded the GM Primary Care Standards as a minimum quality level marker for member practices	5 out of 9 of the GM standards in the process of implementation
		Provide member practices with the tools to compare and improve on performance	Agreement to roll out the QlickView® system
	Inter-professional working	Utilise the skill mix of our primary care providers to bring more services outside of hospital	
	Estates	Work with our public sector colleagues to ensure best use of current estates, providing fit for purpose premises for our service	
	Workforce	Defined education plan	
Wave Three			
Outcome	Theme/Enabler	We will…	2016 benchmark
Where care is appropriate or needed this will be person-centred co-ordinated care, leading to an increased consistency and patient satisfaction	People powered changes in health and behaviour	Focus our interventions to achieve maximal benefits	
		Build on our learning from working with seldom heard groups to benefit the whole population	
High quality care will be provided by motivated, talented, happy and healthy primary care	Consistently high quality care	Support the development of all our primary care providers	
	Inter-professional	Move to LPN supported GM service specifications	

professionals attracted to work in Bury	working	for services commissioned from primary care providers	
	Innovation	Create an environment that encourages innovation and the sharing of learning	
	Technology	Continue to embrace technological advances that support improving health outcomes for our population	
		begin to move towards a single patient held health and social care record	
	Finance, contracts and incentives	Move to a more pro-active way of working allowing us to make the most of the advantages devolution brings	