NHS
Shropshire
Clinical Commissioning Group

Shropshire CCG
Primary Care Strategy

Shropshire CCG

Shropshire Clinical Commissioning Group was authorised in April 2013 and is the NHS organisation responsible for commissioning health services across Shropshire.

We are a membership organisation, made up of 44 GP practices. The 44 practices are grouped into three localities – North (15 practices), South (15 practices), and Shrewsbury and Atcham (14 practices). Each of the three localities has a Locality Committee, which are established as committees of the CCG Governing Body Board. These committees have a GP and Practice Manager representative from each practice as well as patient representatives. The committees meet every 4-6 weeks, reporting directly to the Governing Body Board; this structure forms the main communication and governance route for the CCG as a membership organisation.

Our Vision and Principles

CCG Vision

To have the courage to develop a health system that empowers the delivery of excellent outcomes founded on individual relationships which nurture compassion, respect and dignity.

The CCG's five principles are:

- *A continually improving healthcare and patient experience*
- *To create a 'true' membership organisation*
- *Financial sustainability*
- *To influence and lead the development of the local health economy*
- *To grow the leadership for future organisations*

Purpose of the strategy

This primary care strategy is focused on general medical services, for which the CCG took on delegated responsibility from NHS England from 1 April 2015. NHS England remains responsible for optometry, dental and pharmacy services and this strategy does not cover those primary care services.

As a membership organisation of GP practices, the CCG is uniquely placed to develop a primary care strategy which has a balanced focus on population health, the place of general practice provision in the wider health and care system, and securing safe and sustainable general practice.

The strategy seeks to establish a shared vision and direction of travel for patient care services, and to address the challenges facing general practice, which are recognised both nationally and locally. Our strategy will note in particular the challenges of delivering primary care in rural areas, and cover the particular concerns felt locally around workload; workforce; financial sustainability; premises; and the relationship of general practice with the wider health and care system.

Our Vision for Primary Care in Shropshire

Our patients value and expect personalised care from their GP practice, with continuity of their care and treatment within the community or as close to home as possible. They also expect timely access to primary care, day and night, seven days a week and rightly expect this to be of a consistently high quality. Increasingly, patients also expect the NHS, including primary care services, to make effective use of technology to enhance access, quality and patient experience.

Our GP practices want and need to be working from suitable premises, with financial security and to provide the right working environment for individuals to flourish and reach their professional potential within a supportive environment. They also expect to be part of a health and care system which supports them to provide excellent care to their patients.

To achieve these ideals, and provide a resilient and sustainable service, practices will need to work together in clusters or groups of practices, allowing a sharing of skills and assets including workforce and premises.

Out of hours care, community services, hospital out-reach and social care will work more closely with primary care, providing integrated services organised around natural geographies.

CONTEXT – WHY WE NEED TO CHANGE

National context

It has been recognised by Simon Stevens, Chief Executive of NHS England, that there has been a systematic under-investment in general practice for at least a decade. The share of NHS funding allocated to general practice has reduced from 10.6% in 2005/6 to 8.2% in 2013/14[1].

At the same time, GPs are facing rising patient demand, particularly from an ageing population with complex health conditions. By 2011 the number of people aged over 65 had reached 10,494,000 and by 2031 it is predicted to reach 15,778,000[2]. The number of people with multiple long-term conditions is set to grow from 1.9 to 2.9 million from 2008 to 2018.

The Government has acknowledged that there is a need to train more GPs to meet growing demand. However despite the longstanding Department of Health policy to increase GP training numbers in England to 3,250 per annum, GP recruitment has remained below this target, at around 2,700 per annum, for the last four years[1].

The NHS England *Five Year Forward View*[3], published in October 2014, acknowledges the challenges being faced in terms of ever increasing demand in a climate of limited resources, both in terms of finance and workforce. It also reinforces the importance of primary care as the foundation of NHS care.

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

In June 2015, the Secretary of State set out the first steps in the 'new deal' for GPs. This contained six main strands:

- A new deal on workforce
- A new deal on infrastructure
- A new deal on access with a 7 day NHS
- A new deal on assessing the quality of care provided
- Bureaucracy and burnout
- Responsibilities for doctors

[1] Thomas Powell and Elizabeth Blow, *General Practice in England,* House of Commons Library Briefing Paper 07194 (June 2015) available at http://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7194

[2] Figures from the NHS Federation

[3] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

Local context

Shropshire CCG took on delegated responsibility for commissioning primary care services from 1 April 2015. This includes taking on a delegated budget for primary care (as shown in table 1 below).

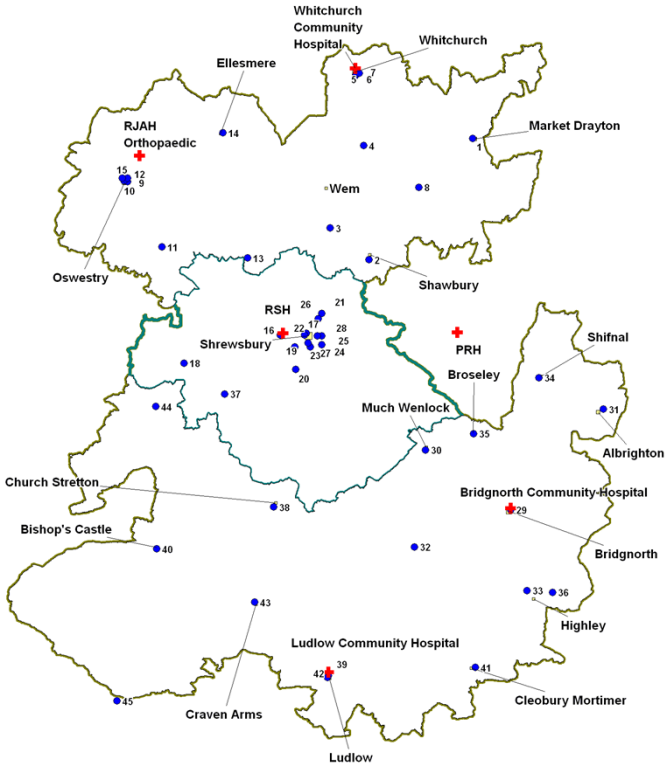
	2015-16 Budget £
Premises Cost Reimbursement	5,536,419
Dispensing/Prescribing Drs	2,456,679
Enhanced Services	2,124,578
General Practice - APMS	1,133,130
General Practice - GMS	19,035,242
General Practice - PMS	5,085,874
Other GP Services	1,847,707
QOF	4,074,371
Total	**41,294,000**

(Table 1)

The annual budget per head of registered population is £135.93

Shropshire CCG – local picture

The CCG covers a large geographical area of roughly 1235 square miles, with a population of around 306,100.



Shropshire CCG area with spread of GP practices marked.

Practice list size data as at 1 October 2015 shows a registered population of 303,799. Table 2 below shows the individual practice population list sizes as at 1

October 2015. It also shows that we have 18 dispensing practices and nine PMS practices.

Practice code	Practice Name	List Size (01.10.15)	GMS/PMS/ APMS	Dispensing	Locality
M82021	ALBRIGHTON MEDICAL PRACTICE	**8,233**	**PMS**	**Y**	**South**
M82601	ALVELEY MEDICAL PRACTICE	**2,318**	**PMS**	**Y**	**South**
M82048	BELVIDERE MEDICAL PRACTICE	**5,226**	**GMS**		**Shrewsbury**
M82033	BISHOPS CASTLE MEDICAL PRACTICE	**5,208**	**GMS**		**South**
M82045	BRIDGEWATER FAMILY MEDICAL PRACTICE	**4,689**	**GMS**		**North**
M82004	BRIDGNORTH MEDICAL PRACTICE	**16,385**	**GMS**		**South**
M82051	BROSELEY MEDICAL PRACTICE	**4,636**	**GMS**		**South**
M82024	BROWN CLEE MEDICAL PRACTICE	**3,276**	**GMS**	**Y**	**South**
M82026	CAMBRIAN MEDICAL CENTRE	**12,682**	**GMS**		**North**
M82008	CHURCH STRETTON MEDICAL PRACTICE	**7,441**	**GMS**		**South**
M82034	CLAREMONT BANK SURGERY	**7,443**	**GMS**		**Shrewsbury**
M82041	CLEOBURY MORTIMER MEDICAL CENTRE	**7,055**	**PMS**		**South**
M82017	CLIVE SURGERY	**4,512**	**GMS**	**Y**	**North**
M82046	CRAVEN ARMS MEDICAL PRACTICE	**3,829**	**GMS**	**Y**	**South**
M82044	DODINGTON SURGERY	**5,005**	**GMS**		**North**
M82010	DRAYTON MEDICAL PRACTICE	**17,443**	**GMS**		**North**
M82025	ELLESMERE MEDICAL PRACTICE	**7,463**	**PMS**	**Y**	**North**
M82032	HAUGHMOND VIEW MEDICAL CENTRE	**8,698**	**GMS**		**Shrewsbury**
M82031	HIGHLEY MEDICAL CENTRE	**2,902**	**GMS**		**South**
M82058	HODNET MEDICAL CENTRE	**3,500**	**PMS**	**Y**	**North**
M82020	KNOCKIN MEDICAL CENTRE	**3,238**	**GMS**	**Y**	**North**
M82047	MARDEN MEDICAL PRACTICE	**7,146**	**GMS**		**Shrewsbury**
M82040	MARYSVILLE MEDICAL PRACTICE	**5,119**	**GMS**		**Shrewsbury**
M82050	MOUNT PLEASANT MEDICAL CENTRE	**8,077**	**GMS**		**Shrewsbury**
M82019	MUCH WENLOCK & CRESSAGE MEDICAL PRACTICE	**7,888**	**GMS**	**Y**	**South**
M82002	MYTTON OAK SURGERY	**10,126**	**GMS**		**Shrewsbury**
M82005	PLAS FFYNNON MEDICAL CENTRE	**9,005**	**GMS**	**Y**	**North**
M82030	PONTESBURY MEDICAL PRACTICE	**7,212**	**GMS**	**Y**	**Shrewsbury**
M82043	PORTCULLIS SURGERY LUDLOW	**8,094**	**GMS**		**South**
M82023	PRESCOTT SURGERY BASCHURCH	**6,367**	**GMS**	**Y**	**North**
M82016	RADBROOK GREEN SURGERY	**9,177**	**PMS**		**Shrewsbury**
M82055	RICHMOND HOUSE SURGERY	**4,017**	**GMS**		**North**
M82006	RIVERSIDE MEDICAL PRACTICE	**10,024**	**GMS**		**Shrewsbury**
M82011	SHAWBURY MEDICAL PRACTICE	**3,720**	**GMS**	**Y**	**North**
M82038	SHIFNAL & PRIORSLEE MEDICAL PRACTICE	**9,786**	**GMS**		**South**
M82060	SOUTH HERMITAGE SURGERY	**7,586**	**PMS**		**Shrewsbury**
M82014	STATION DRIVE SURGERY	**8,006**	**GMS**		**South**
M82018	THE BEECHES MEDICAL PRACTICE	**6,023**	**GMS**	**Y**	**Shrewsbury**
M82022	THE CAXTON SURGERY	**12,836**	**PMS**		**North**
M82620	THE MEADOWS MEDICAL PRACTICE	**3,783**	**GMS**	**Y**	**South**
M82035	WEM & PREES MEDICAL PRACTICE	**10,550**	**GMS**	**Y**	**North**
M82013	WESTBURY MEDICAL CENTRE	**2,945**	**PMS**	**Y**	**North**
Y02495	WHITEHALL MEDICAL PRACTICE	**3,087**	**APMS**		**Shrewsbury**
M82604	WORTHEN VILLAGE SURGERY	**2,043**	**GMS**	**Y**	**Shrewsbury**

(Table 2)

Health needs and population

Overall the health of the population in Shropshire is good; both male and female life expectancy is significantly higher than the national figures. Similarly, rates of all age all-cause mortality for males and females are significantly lower than the national figures. Life expectancy has increased in the total population in the last decade and all age all-cause mortality has decreased. However, inequalities in health persist in Shropshire and the increases in life expectancy and reductions in all age all-cause mortality have not had equal impact across all sections of the population.

Key issues affecting Shropshire people's health include:

- An ageing population – see detail below
- Health inequalities - have been identified in life expectancy and mortality rates between the most and least deprived populations in the county
- Lifestyle risk factors to health – are of a concern to the health of the population in Shropshire as they are impacted on by health inequalities, e.g. more smokers in more deprived areas, and the ageing population, e.g. fewer people are physically active in older age groups
- Long-term conditions and non-communicable disease, for example cardiovascular disease, obesity, cancer and dementia

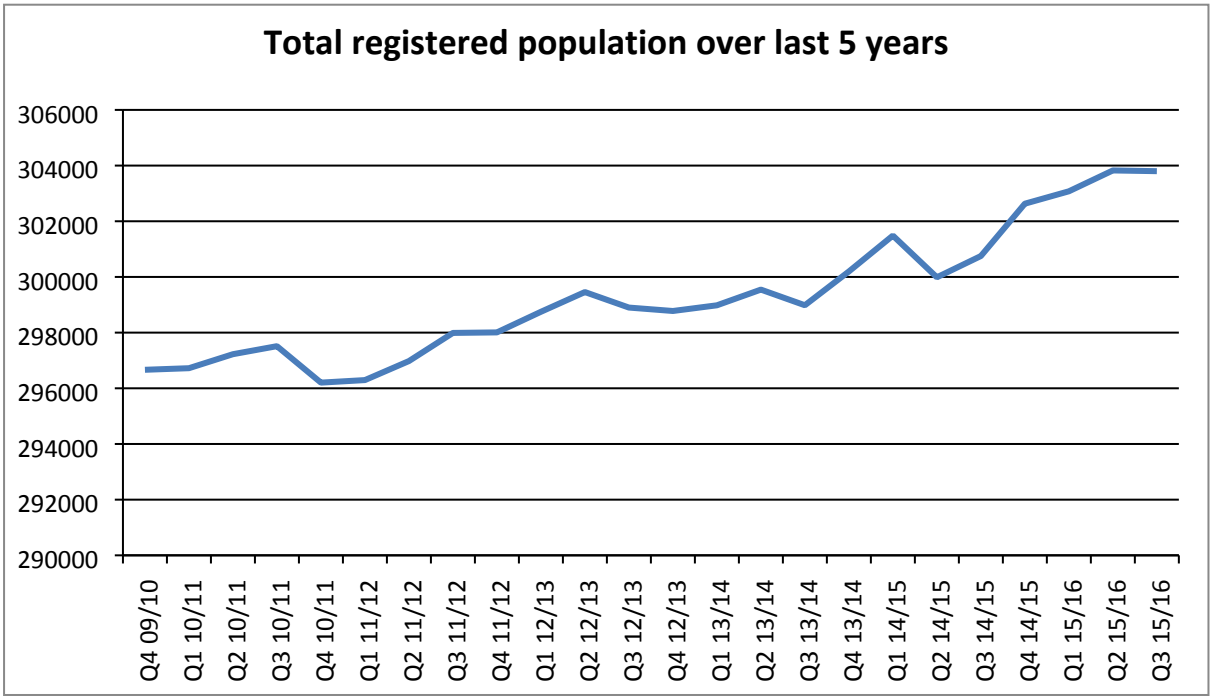
Shropshire has a larger number of older people than many other locations across the country. The 2011 Census results show 63,400 people aged 65 years and over being resident in Shropshire. This is an increase of 23.8 per cent between 2001 and 2011. Shropshire has experienced significantly higher growth in this age group than nationally (10.9 per cent) and regionally (12.6 per cent). In 2001, the over 65s represented 18.1 per cent of the total Shropshire population. This rose to 20.7 per cent in 2011, compared to 16.4 per cent for England and Wales. Like many rural areas, in Shropshire the number of people aged 65 years and over is expected to rise and it is anticipated that by 2030, 1 in 4 people will be over 65. Future population growth and ageing will result in increased numbers of people with long term conditions and non-communicable disease and consequently a rise in demand for health and social care services.

In Shropshire, approximately seven per cent of over 65s have dementia; this figure is expected to increase to 7.5 per cent for all people aged 65 and over by 2021. The expected increase in Shropshire is likely to be at a faster pace than the expected increase in England overall.

Rurality

Shropshire covers a large area of 1235 square miles; around six per cent of this comprises suburban and rural development and continuous urban land which means the vast majority of land is very rural. The southern and western parts of the county are generally more remote and self-contained and have been identified as rural regeneration zones. The rural nature of our county's geography poses major challenges when planning health care services and rural isolation is a significant issue today for the CCG.

Total GP registered population
The total GP registered population across Shropshire has increased from 296,665 on 1 January 2010 to 303,799 on 1 October 2015.



Primary care workforce / workload
The following workforce data is taken from the Health and Social Care Information Centre (HSCIC) General and Personal Medical Services, England March 2015 Practice Level Indicator Tool.

	Shropshire CCG	England
GPs (exc. Registrars, Retainers and Locums) per 1,000 patients - FTE	0.47	0.42
GPs (inc. Registrars, Retainers and Locums) per 1,000 patients – FTE	0.52	0.46
Ratio of male:female GPs (exc. Registrars, Retainers and Locums)	58:42	54:46
Ratio of male:female GPs (inc. Registrars, Retainers and Locums)	54:46	53:47
% of GPs (exc. Registrars, Retainers and Locums) aged 55 and over - FTE	20.03	20.87
% of GPs (inc. Registrars, Retainers and Locums) aged 55 and over - FTE	18.40	19.41
Practice Nurses per 1,000 patients – FTE	0.22	0.17
% of Nurses aged 55 and over - FTE	26.75	27.57

This data shows that the picture in Shropshire is not dissimilar to the country as a whole. 46% of the GP workforce (including Registrars, Retainers and Locums) is female and around one fifth aged 55 years or over so we can assume the majority of this number will retire over the next 5-10 years. Practice Nurse numbers are also

similar to the country as a whole, with over a quarter (both locally and nationally) aged 55 years or over. Again, we can assume that the majority of this number will retire over the next 5-10 years.

In terms of workload, it is recognised both nationally and locally that changes to the NHS over recent years has impacted on general practice. The introduction of Care Quality Commission (CQC) registration requirements, and the increased involvement of GPs in commissioning, introduced by the Health and Social Care Act 2012, has led to increased time being spent on non-clinical activities.

GP access

The latest published GP Patient Survey results (fieldwork July to September 2014 and January to March 2015, data published July 2015[4]) show the following for Shropshire CCG as a whole in relation to GP access:

- 76% of patients were satisfied with their practice's opening hours, with 8% being dissatisfied (compared to a national average of 75% and 10% respectively). Individual practice satisfaction results ranged from 52% to 92%.

- When asked whether they were able to get an appointment to see or speak to someone the last time they wanted to see or speak to a GP or nurse, 88% of patients said 'yes' and 8% said 'no' (compared to a national average of 85% and 11%). Individual practice results ranged from 67% to 98%.

- 82% of patients rated their overall experience of making an appointment as 'very good' or 'fairly good', with 7% rating this as 'very poor' or 'fairly poor' (compared to a national average of 73% and 12% respectively). Individual practice satisfaction results ranged from 47% to 98%.

Premises

GP practices were asked to complete a premises audit questionnaire in November 2015, with a view to the information informing a CCG-wide primary care estates strategy.

Four practices declined to complete the audit. Responses were received about 46 sites (of the 40 practices who responded, two submitted a joint response, three also responded about their branch surgery sites and four operate dual site practices). The following information is therefore for 46 sites rather than 40 practices:

Premises type:
- 37 sites have purpose built premises or are housed within a wider health centre
- 6 sites are residential conversions (one with purpose built annex)
- 1 site is an office conversion
- 2 responded 'other'

Age of property in years ranged from 0 to 275, with a median age of 28 years.

Condition of premises:

[4] https://gp-patient.co.uk/surveys-and-reports

- 3 poor
- 2 poor/barely satisfactory
- 10 satisfactory
- 24 good
- 7 excellent

33 freehold and 13 leasehold premises.

When asked whether the premises have existing capacity to enable the practice to increase its existing patient list size, 24 responded ‘no’, 16 responded ‘yes’ and 5 responded ‘yes but limited’ or with conditions. One did not respond.

32 sites would be interested in extending their premises to meet future population growth. 33 were aware of future housing development plans in their practice area.

Financial sustainability
The NHS has seen minimal growth funding over the last six years and continues to plan for minimal growth for the foreseeable future. Overall the NHS has seen average uplifts of 1.1% per year with primary care receiving uplifts out of this of 2.5% per year.

Given the levels of funding required to meet statutory changes to minimum wages and employers contributions to National Insurance and Pensions, the uplift represents a real terms decrease in Primary Care funding requiring practices to improve efficiencies in order to maintain financial stability. This is proving to be increasingly difficult to sustain over an increasing time period and practices will need to consider strategic transformational change in order to remain financially sustainable in the longer term.

National Perspectives

The challenges facing general practice and ways in which these challenges might be addressed have been discussed in a number of recent national publications. Different organisations/reports come to the question from different perspectives:

GP Provider/Professional perspective – 1) British Medical Association (2015): *Responsive, safe and sustainable – Towards a new future for general practice; 2) National Association of Primary Care (2015) – The Primary Care Home*

Workforce perspective – Health Education England (2015): *The future of primary care – Creating teams for tomorrow*

Commissioner perspective – 1) Kings Fund (2014): *Commissioning and funding general practice – Making the case for family care networks;*

From these different starting points there is an emerging – perhaps established - consensus about the ways in which primary care can evolve to create new and more sustainable models of service delivery, building on the strengths of traditional general practice, that will address the key problems facing the service and meet the changing needs of a growing and ageing population:

1. The Benefits of Scale: Practices should, wherever possible, be large enough to provide the full range of services that patients would expect to receive in any practice and have a large enough workforce to be able to deliver these services in a sustainable way.[5]

2. Workforce: There are opportunities, particularly within larger practices and/or through collaborative working between practices, to develop different staffing models – including new types of worker - to help address workload issues, improve the patient experience and sometimes deliver savings.[6]

3. Collaboration between practices: "GP Networks" - to use the language of the BMA report – can support member practices to manage workload and provide services by sharing good practice, functions, support staff and services. Such networks – whatever their organisational form – can enable practices to provide a wider range of services, offer better opportunities for staff development and training and work more effectively with commissioners, specialists, hospitals and social services. [7]

4. Integrated care: Primary and community health and care services should work in a more closely integrated way, supported by hospital specialists.[8] These integrated services would have a focus on the health of a defined population, including patients living in the area but not registered with a general practice. The Primary Care Home model proposed by the NAPC suggests an optimal

[5] BMA, p17; HEE, p16
[6] BMA, p17; HEE, p25
[7] BMA, p9; HEE, p16
[8] BMA, p19; HEE, p36; NAPC, p2; KF, p30

population size for such a model would be not less than 30,000 but normally not more than 50,000 people.

5. Information Technology: New technology will enable different methods of communication with patients and can facilitate the development of new models of care and the provision of a more integrated service.[9]

6. Premises: Primary and community services need appropriate facilities from which to provide their services.

7. Supporting change: Changes of this nature and scale will require investment – of time and money – to support organisational development, clinical leadership and the professional development of front line staff.

8. Commissioning: Commissioners need to consider how they can use the levers and flexibilities available to them to facilitate innovation, improvement and integrations.

The evolution of primary care appears to be going through a Cambrian explosion: examples of innovations that are being implemented in individual practices and areas across England are included in all of the reports noted above.

Our challenge is to find the approach – or approaches – that will best meet the needs of patients, practices and the wider health and care system in Shropshire.

Shropshire Perspective

Shropshire is a large and diverse county. The largest centre of population is the county town of Shrewsbury (population c72,000). There are a number of smaller market towns, with the remainder of the population living in more remote and rural areas.

The opportunities and possible responses in relation to practice size, inter-practice collaboration and integrated care will necessarily be different in these different contexts. For instance, the BMA report notes that the ideal of all practices being large enough to offer a full range of services will not be achievable in remote and rural areas.

And each practice will have its own particular circumstances, so that what is right for one practice may not be the preferred approach in another practice which appears to have similar characteristics. It is important also to note that each general practice is an independent organisation and will make its own decisions based on what it believes is in the best interest of the practice and the population it serves.

Whilst the Clinical Design work-stream of the Future Fit programme did not specifically address the future of primary care, the principles outlined above are consistent with some of the key features of the vision set out in the Future Fit clinical design. Of particular note are the sections on integrated and partnership care and the discussion of workforce issues.

[9] BMA, p21; HEE p26

HOW WE PLAN TO ADDRESS THESE CHALLENGES

1. The Benefits of Scale and Collaboration Between Practices

   The CCG will encourage member practices to consider the potential benefits of working at a scale which enables the practice – or a group of practices - to offer the full range of services that a patient would expect to receive from any general practice and to achieve efficiencies in service provision and non-clinical costs. At the same time, the CCG recognises that working at scale will not be viable for all practices, especially those practices in the more rural areas of the county where there is a defined population size / area.

   The CCG is not advocating a particular solution: some practices may wish to merge to form larger partnerships; some of the benefits of scale might be achieved through a form of collaboration other than formal merger, either through the STW Federation or otherwise; collaboration could occur at both county-wide and more local levels, with different aspects of collaborative working managed at these different levels.

   Whilst changes of this nature can and do take place at any time, the county is more likely to achieve a degree of consistency and coherence in the future provision of primary care if practices considered their response to these issues in a co-ordinated way. This would encourage dialogue between practices and enable options to be considered which would be unlikely to emerge from piecemeal development.

2. Workforce

   The CCG will support general practice to develop a workforce strategy to meet the future needs of the service. This will include looking at skill-mix and new roles, identifying training and education needs and engaging with providers and funders of training and education. The CCG will also ensure that primary care is effectively represented in the Workforce work-stream of the Future Fit programme.

   As with issues of organisational size and structure, decisions about staffing and skill-mix will be made by individual practices and the CCG will not seek to impose a particular model. The development of a workforce strategy, however, will support practices by creating opportunities to review and test different models (for example, looking at a more multi-disciplinary approach to patient care), to secure external funding and support, and for primary care to engage effectively on workforce issues with the wider health and care system.

   The STW Federation has secured funding through the Prime Minister's Challenge Fund to develop new roles in general practice, including Urgent Care Practitioners and Physician's Associates.

3. Integrated care

The Future Fit models of care report, drawing on a report from the Kings Fund[10], talks about integrated care in terms of creating "a simple pattern of services […] based around primary care and natural geographies and with a multi-disciplinary team. These teams need to work in new ways with specialist services; both community and hospital based, to offer patients and much more complete and less fragmented service".[11]

The CCG proposes that the development of more integrated primary and community services should be taken forward as an integral part of the CCG's strategy for primary care. Our initial view – to be tested with practices, partners and the public - is that the 'natural geography' for the development of integrated primary and community services in Shropshire is for five areas: South East, South West, North East, North West and Central (Shrewsbury).

Whilst mostly concerned with larger systems, a recent King's Fund report sets out 10 principles to guide the development of "place-based systems of care" which might usefully be applied to the development of integrated primary and community services in Shropshire:

1. Define the population group served and the boundaries of the system.

2. Identify the right partners and services that need to be involved.

3. Develop a shared vision and objectives reflecting the local context and the needs and wants of the public.

4. Develop an appropriate governance structure … which must meaningfully involve patients and the public in decision-making.

5. Identify the right leaders to be involved in managing the system and develop a new form of system leadership.

6. Agree how conflicts will be managed and what will happen when people fail to play by the agreed rules of the system.

7. Develop a sustainable financial model …

8. Create a dedicated team to manage the work of the system.

9. Develop 'systems within systems' to focus on different parts of the group's objectives.

10. Develop a single set of measures to understand progress and use for improvement.

[10] Edwards N (2014) Community Services: how they can transform care, Kings Fund
[11] NHS Future Fit, Clinical Models of Care report, p64

There are various organisational models described in the literature and the Vanguard progress will also provide valuable examples of how the integration of primary and community services is being taken forward in different areas.

4. Information Technology

Information Technology is an enabling resource that needs to be harnessed to ensure appropriate, timely and safe services are provided at the point of need for patients. The CCG already has in place an IT forum which has significant GP membership representation with the remit of:

- Ensuring compliance with the national Primary Care IT Framework
- Providing local system leadership to national projects such as the Electronic Prescribing Service (EPS2) roll out
- Making best use of current systems to communicate with patients and professionals alike to offer a consistent service across the county
- Finding solutions to overcome concerns around data sharing
- Reviewing IT developments that fall out of local commissioning strategies including the use of assistive technologies where appropriate
- Leading on the development of a Digital Roadmap across the Health and Social care economy

The CCG will continue to work with practices to ensure effective use of IT as an enabler in line with national policy and the local IT strategy

The STW Federation has also secured funding through the Prime Minister's Challenge Fund to support the enhanced use of technology in primary care. This includes developing the EMIS system to better support collaborative working between practices.

Following the publication in 2014 of *Personalised Health and Care 2020 – a Framework for Action* the CCG, working with partners, will develop – by April 2016 – a 'digital roadmap' setting out how the ambition of being paper-free at the point of care by 2020 will be achieved.

The 'digital roadmap' is seen as an opportunity not to be missed. It is a key part in a nationally driven process where the 'digital maturity self-assessment' will monitor the progress of our key partners on an annual basis.

The key priorities within primary care settings - 'Digital Primary Care' are:

- GPs using core clinical system outside the practice
- Electronic prescriptions across general practice and community pharmacy

Whilst the key priorities across care settings - 'Interoperability' are:

- GP summary information utilised across U&EC settings
- Child protection information accessed in unscheduled care settings
- Electronic referrals made in the GP practice
- GPs receiving timely electronic discharge summaries from secondary care
- Digital ordering of diagnostics by GPs
- Digital access of diagnostic results by GPs
- End-of-life preference information utilised across care settings

We will build on the work that has already started in these areas and whenever we look at innovation or transformation of services we will be seeking an IT solution to assist us in that work. The offer to both primary care and our patients will enhance access to data at all levels, thereby making the system simpler to navigate, reducing duplication, raising quality and improving patient experience.

The Electronic Health Record should no longer be seen as a digital typewriter but "an interactive medium for practicing medicine (and delivering care) based on the highest standards in the world".

5. Premises

Good premises are another important part of the primary care infrastructure. High quality premises support practices to provide a full range of services, improve patient experience and provide a good working environment for staf.

The CCG is developing a Primary Care Estates Strategy. This will include a stock-take of current facilities and identify potential areas for development. The strategy will support the development of a list of priority schemes for inclusion in the CCG's submission to the Primary Care Transformation Fund in February 2016.

Department of Health guidance also encourages CCG to work with other NHS and public sector partners to maximise the value of the wider public sector estate. Initial discussions have been held with partners at The Shrewsbury and Telford Hospital NHS Trust, Shropshire Community Health NHS Trust and Shropshire Council regarding the potential to develop a more broadly-based health and care estates strategy during 2016.

6. Supporting Transformational Change

Delivering the strategy will require leadership from general practice teams and the capacity and skills to plan and implement transformational change. The CCG will work with the membership to develop a framework and, as plans are developed for practice development, intra-practice collaboration, integrated primary and community services and new models of care, the CCG will work with practices to determine what external support could be made available to support personal, professional and organisational development.

Working with the STW Federation, the funding available through the Prime Minister's Challenge Fund might be used to support implementation of elements of the primary care strategy where this aligns with the objectives and outcomes of the PMCF plans.

7.

7. Commissioning

Engagement with member GP practices regarding co-commissioning (December 2014) identified at that time that local GPs would not want to consider developing local alternatives to the national GMS contract.

As plans for the implementation of the primary care strategy develop, the CCG will consider how contracting arrangements, including flexibilities in the application of the GMS contract, the development of enhanced services and contracts with other providers could be used to support planned changes, for instance through contracting arrangements with provider networks designed to support integrated provision.