Hambleton, Richmondshire and Whitby
Clinical Commissioning Group

Primary Care Strategy and plan for the delivery of the General Practice Five Year Forward View

DRAFT FOR GOVERNING BODY APPROVAL

Version 1.3

A note on strategy development:
This version of the document is a further iteration of the draft strategy from the version circulated in November across the primary care community.

A number of smaller changes have been made to the main text following feedback. However the main change is the addition of an action plan outlining how the strategy will be taken forward in response to feedback that more detail is required on how the strategy would be delivered.

This version of the document will be submitted in line with the 23 December 2016 national planning requirement once it has received Governing Body approval..

1. Introduction

This primary care strategy is focused on general medical services, for which the CCG took on joint commissioning responsibility with NHS England from 1 April 2015. NHS England remains solely 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.

The document also responds to the NHS England planning requirement to produce a development plan in response to the General Practice Five Year Forward View. This document sets out a clear, articulated vision of the care redesign that will deliver sustainable services today and transformed services tomorrow, including how greater use will be made of self-care, technology and a wider workforce, and other actions to address challenges with general practice capacity.

This strategy and development plan has been developed through the CCG's Primary Care Co-commissioning Committee and through wider co-production with primary care partners.

2. Our Vision and Principles

The CCG believes that enhanced Primary Care is the cornerstone to reducing health inequalities and reducing variability in the provision of services. We believe that this requires Primary Care to be organised around larger practices or federations of practices with the critical mass to provide more services, peer support and opportunities for learning and workforce development. Leadership from within the profession is vital to achieving this aim.

Primary care which is fit for the future needs to be:

- Comprehensive – primary care is accountable for meeting the majority of patients' physical and mental healthcare needs, including: wellness, prevention, acute care and chronic care. Where the right skills or services are not available within the primary care organisation, staff play a central role in coordinating virtual care teams involving professionals from other community services and specialists in secondary care and signposting people to relevant local welfare and other social support services.
- Person-centred - this is relationship-based, premised on trust and concerned about the whole person. Patients and their carers are recognized as core participants in decision making about care and treatment. When registered with

a primary care organisation the patient benefits from continuity of care with a professional. Person-centred care also recognizes the impact of broader life experiences (such as wealth, housing and family circumstances) on an individual's health and care.

- Population-oriented – primary care is responsible for providing services not only to those who attend their premises, but also for a specified population. Depending on the model in question, this might include: all individuals registered with the organisation, all those who are resident in a specific geographic area and/or individuals who belong to a specific population group (e.g. the frail elderly or homeless).
- Coordinated - care is coordinated across all elements of the healthcare system, with particular attention paid to overseeing and being accountable for transitions between providers, and building and sustaining open and clear coordination between the patient and their various care teams.
- Accessible - appropriate waiting times for initial consultation and advice, diagnosis and care. Patients have 24/7 access to medical and nursing advice and care and organizations are responsive to patient preferences around access.
- Safe and high quality - care is evidence-based whenever possible, and clinical decisions are informed by peer support and review. Clinical data is shared to inform quality assurance and improvement. The organisation is financially sustainable, such that safety and quality standards will not be compromised by resource pressures.

And sustainable in terms of:

- finance
- workforce
- public trust
- fit with wider health system.

Our Vision for Primary Care in Hambleton, Richmondshire and Whitby: 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.

3. Context – why we need to change

3.1 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.

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:

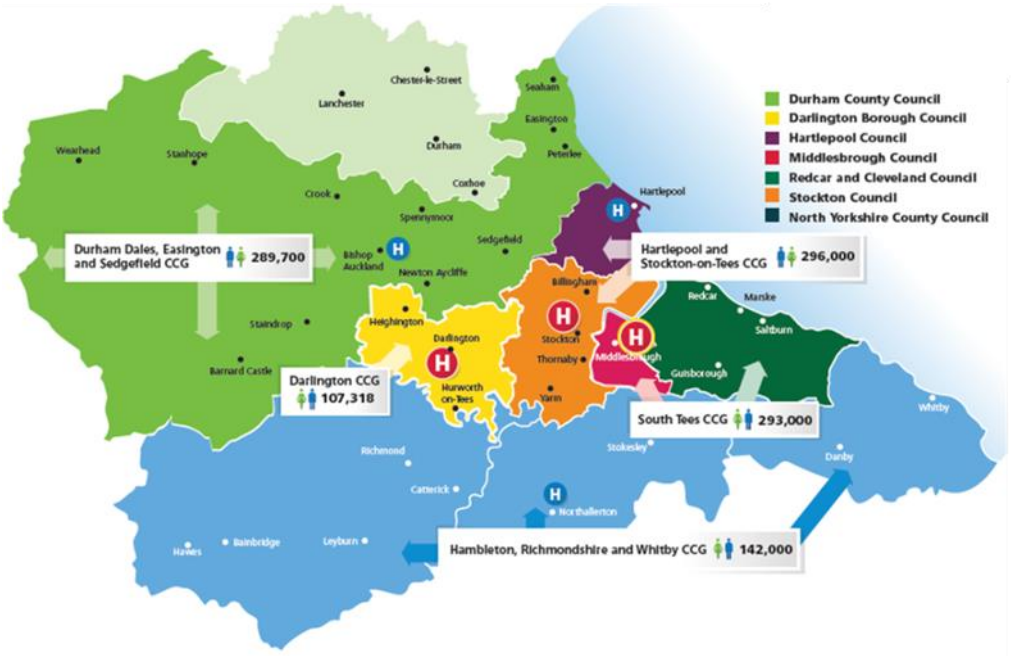
- A new deal on workforce
- A new deal on infrastructure
- A new deal on access with a 7 day NHS
- A new deal on assessing the quality of care provided
- Bureaucracy and burnout
- Responsibilities for doctors

[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

The implementation requirements for the General Practice Five Year Forward View have been further developed in the Primary Care annex to the September Planning Guidance. This guidance clarified the requirement on CCGs to work with NHS England to ensure the sustainability of general practice by implementing plans for Practice Transformational Support, and the 10 high impact changes. In particular, the aim is to support general practice at scale, the expansion of Multispecialty Community Providers, and enable and fund primary care to play its part in wider NHS developments, for example the forthcoming framework for improving health in care homes.

3.2 STP context

Hambleton, Richmondshire and Whitby CCG is within the Durham, Darlington, Teesside, Hambleton, Richmondshire & Whitby Sustainability Transformation Plan (STP) Footprint.



The STP system vision, “meeting our communities needs now and for future generations, with consistently better health and social care delivered in the best place”, is one of equity, access and prevention. Too many people die many years sooner than they would if they lived in other parts of the country. Across our communities there are unacceptably significant differences in health between the most deprived and least deprived areas.

The STP footprint community faces a decreasing health and care workforce, and the pressure to maintain staffing levels limits the opportunities to meet the growing demands in the quantity and quality of care and delivery of the performance challenges that this brings in maintaining standards.

We know that locally we have historically relied too much on hospital based care due to limited and disjointed alternative solutions. We will continue to maintain an

important focus on the further development of services to support those who fall ill. However, a critical change is our emphasis on ensuring levels of ill health are reduced through prevention, effective screening and early intervention alongside reducing the demand on hospital based care by shifting more care closer to home through enhanced integrated care models.

In relation to primary care specifically, change is needed for a number of reasons:

- GPs tell us that they get frustrated at not having enough time to provide effective care to the growing number of patients with one or more complex chronic conditions
- GPs feel that they are currently limited in terms of the way they deliver care in a responsive and timely manner for those who require short term intervention.
- People resort to an A&E attendance when their needs could be met within the community.
- There is a high proportion of GPs over the age of 50
- Levels of access and experience across general practice in CDDTHRW have been largely positive for a long time but trends across a number of key measures in the national GP Survey are all going in the wrong direction

The future state ambition of the STP is therefore to:

- Increase the levels of investment in primary care
- Expand and support GPs and wider primary care staffing
- Reduce practice burdens and help release time
- Develop the primary care estate and invest in better technology

The anticipated benefits (outcome measures) include:

- Increase in GP numbers and skill mix with healthcare professionals
- Increased access times to primary care
- Increased 111 access to general practice appointment systems
- Improved information sharing and data flows across health services
- Increased scope of services available in primary care
- Improved satisfaction rates for access to primary care
- Increased funding in primary care
- Increase inter practice referrals and greater use of technologies e.g. Skype and telehealth

3.3 Local context

Background to local primary care
Hambleton, Richmondshire and Whitby Clinical Commissioning Group was authorised in April 2013 and is the NHS organisation responsible for commissioning the majority of health services across Hambleton, Richmondshire and Whitby.

We are a membership organisation, made up of 22 GP practices. The practices are grouped into three localities – Hambleton (8 practices), Richmondshire (9 practices), and Whitby (5 practices). Each of the three localities has a Locality Group where

representatives from each practice meet with the CCG clinical lead and Senior Management lead for their locality. These groups meet monthly and any matters of significance would be reported directly to the Senior Management Team and the Governing Body if appropriate. This structure, alongside the formal Council of Members which meets quarterly, forms the main communication and governance route for the CCG as a membership organisation.

Most local GP practices have also federated together into a single organisation, Heartbeat Alliance. This was an original first wave 'Prime Minister's Challenge Fund' site. The first phase achieved many successes, including: the creation and development of an organisation; culture change through joint working between groups of practices as they tested 'open for longer'; and pioneering of new technological approaches and other ways of working. However, while there was considerable learning across practices across Hambleton, Richmondshire and Whitby, ultimately 'open for longer' proved unsustainable due to poor patient demand for appointments, problems with accessing medical records at different sites.

A second phase was therefore launched with additional funding from NHS England. This focused on piloting a new skill-mix in primary care (clinical pharmacists, physiotherapists), testing new technologies (on-line consultations, telemedicine for care homes) and testing what demand patients really have for extended services. This approach aimed to establish a package of measures that met, on a sustainable basis, increasing and changing patient demand for access to primary care with transformative change in the supply of primary care medical services, within the constraints of a finite funding envelope. This phase, which completed in July 2016, has similarly had a number of successes, particularly in terms of establishing the principle of a wider skill-mix in primary care, based on use of clinical pharmacists and physiotherapists.

Local geography and practice distribution

The CCG covers a large geographical area of roughly 1,093 square miles, with a population of around 154,000 resident within that area (143,000 registered to a HRW CCG member practice).

Ours is a large and deeply rural area. The largest centre of population is the North Yorkshire county town of Northallerton (population 18,9704). There are a number of smaller market towns, with the remainder of the population living in more remote and rural areas.

Practice list size data as at 1 October 2015 shows a registered population of 143,538. Appendix 1 provides more detail on the individual practice population list sizes as at 1 October 2015. It also shows that we have 17 dispensing practices.

[4] This figure includes the wards of Northallerton North, Northallerton Central, Northallerton Broomfield, Romanby and Brompton

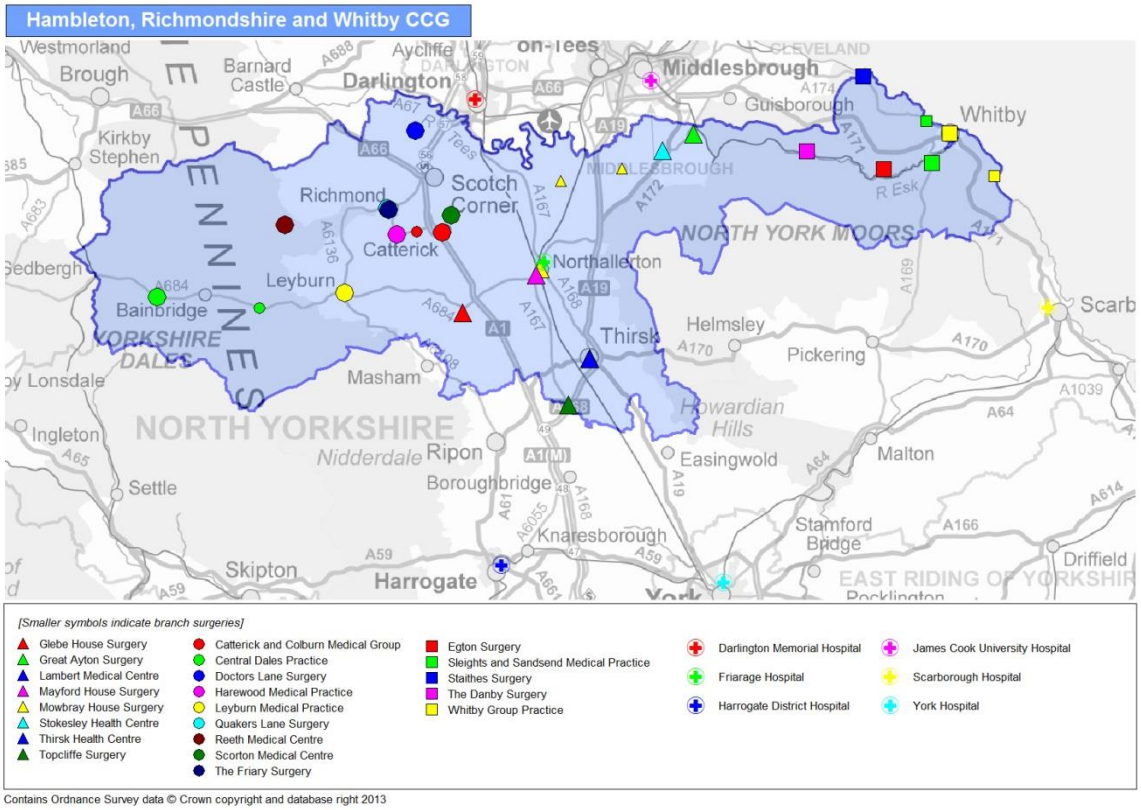


Table 1 Hambleton, Richmondshire and Whitby CCG area with spread of GP practices marked.

Health needs and population

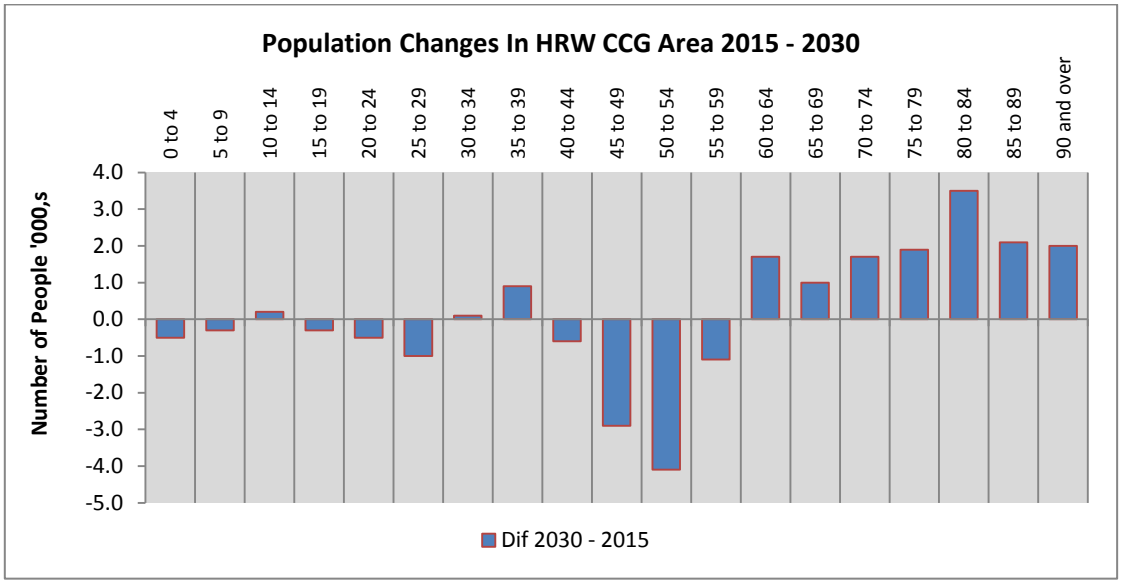
Overall the health of the population in Hambleton, Richmondshire and Whitby is good; both male and female life expectancy is significantly higher than the national figures. Similarly, rates of all age all-cause mortality for males and females are significantly lower than the national figures. Life expectancy has increased in the total population in the last decade and all age all-cause mortality has decreased. However, inequalities in health persist in Hambleton, Richmondshire and Whitby 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 Hambleton, Richmondshire and Whitby 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 across the area
- Lifestyle risk factors to health are of a concern to the health of the population in Hambleton, Richmondshire and Whitby 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

Hambleton, Richmondshire and Whitby has a larger number of older people than many other locations across the country. The 2011 Census results show 31,000

people aged 65 years and over being resident in Hambleton, Richmondshire and Whitby. This is an increase of 26 per cent between 2001 and 2011. Hambleton, Richmondshire and Whitby has experienced significantly higher growth in this age group than nationally (11 per cent). In 2001, the over 65s represented 17 per cent of the total Hambleton, Richmondshire and Whitby population. This rose to 21 percent in 2011, compared to 16.4 per cent for England and Wales.



Like many rural areas, in Hambleton, Richmondshire and Whitby 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.

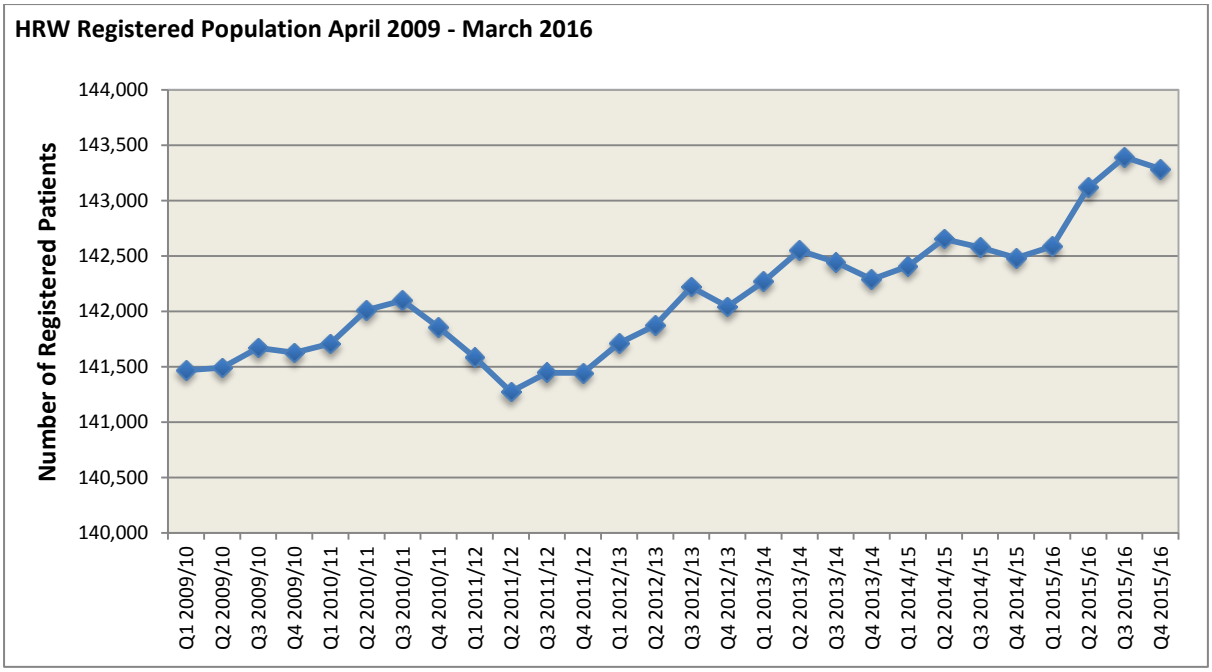
In Hambleton, Richmondshire and Whitby, approximately seven per cent of over 65s have dementia; this figure is expected to increase to 7.5 per cent for all people aged 65 and over by 2021. The expected increase in Hambleton, Richmondshire and Whitby is likely to be at a faster pace than the expected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

Rurality

Hambleton, Richmondshire and Whitby covers a large area of 1,093 square miles; a minority of this comprises suburban and rural development and continuous urban land which means the vast majority of land is very rural. The rural nature of our area'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 Hambleton, Richmondshire and Whitby has increased from 141,627 on 1 January 2010 to 143,395 on 1 October 2015.



Urban/Rural	Percentage of CCG	Grouped
Rural town and fringe	22.1%	
Rural town and fringe in a sparse setting	8.4%	
Rural village and dispersed	24.2%	
Rural village and dispersed in a sparse setting	17.9%	72.6%
Urban city and town	17.9%	
Urban city and town in a sparse setting	9.5%	27.4%
Grand Total	100.0%	100.0%

Primary care budgets

Hambleton, Richmondshire and Whitby CCG took on joint commissioning responsibility for commissioning primary care services from 1 April 2015. This includes taking on a joint commissioning budget for primary care (as shown in table 1 below).

	2015-16 Budget £
Premises Cost Reimbursement	2,292,239
Other Premises Cost	4,207
Dispensing/Prescribing Drs	2,079,824
Enhanced Services	905,653
General Practice - APMS	2,538,326
General Practice - GMS	10,178,251
Other GP Services	79,296
QOF	1,955,204
Total	**20,033,000**

(Table 2)

The annual budget per head of registered population is £139.57

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.

	HRW CCG	England
GPs (exc. Registrars, Retainers and Locums) per 1,000 patients - FTE	0.59	0.42
GPs (inc. Registrars, Retainers and Locums) per 1,000 patients – FTE	0.62	0.46
Percentage of GPs (exc.Registrars, Retainers and Locums) that are Male	50.48%	54%
Percentage of GPs (inc. Registrars, Retainers and Locums) that are Male	49.55%	53%
% of GPs (exc. Registrars, Retainers and Locums) aged 55 and over - FTE	12.96%	20.87%
% of GPs (inc. Registrars, Retainers and Locums) aged 55 and over - FTE	12.73%	19.41%
Practice Nurses per 1,000 patients – FTE	0.3	0.17
% of Nurses aged 55 and over - FTE	18.18%	27.57%

This data shows that the picture in Hambleton, Richmondshire and Whitby is not dissimilar to the country as a whole. 50% of the GP workforce (including Registrars, Retainers and Locums) is male and 13% 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 substantially higher than the country as a whole, with almost a fifth 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 https://gp-patient.co.uk/surveys-and-reports) show the following for Hambleton, Richmondshire and Whitby CCG as a whole in relation to GP access:

- 86% of patients were satisfied with their practice's opening hours, with 6% being dissatisfied (compared to a national average of 75% and 10% respectively).
- 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, 92% of

patients said ‘yes’ and 5% said ‘no’ (compared to a national average of 85% and 11%).

- 88% of patients rated their overall experience of making an appointment as ‘very good’ or ‘fairly good’, with 4% rating this as ‘very poor’ or ‘fairly poor’ (compared to a national average of 73% and 12% respectively).

Estate and practice premises

In developing the Primary Care Estates Strategy, the general estates profile of HRW CCG was identified through asset mapping by locality and condition surveys including the results of new 6 facet surveys. This was undertaken on behalf of Heartbeat Alliance by Community Ventures and the work was shared with the CCG. All premises, with the exception of a village hall venue in Appleton Wiske and the building under construction at Sandsend were visited to undertake the 6 facet survey of the buildings. Consideration has also been given to the latest national primary estates guidance including the Schedule 1 Minimum Statutory and Contractual Standards for Practice Premises (NHS [General Medical Services] – Premises Costs Directions 2013).

The condition of the primary care estate overall is fair, however there are noticeable differences in condition and functionality which reflects historical decision making and investment in premises and the standard of operational estate management of each building. All buildings surveyed need ongoing, effective estate management particularly for compliance with Fire, Health and Safety and Access in line with the Disability Discrimination Act (DDA) and backlog maintenance to achieve or maintain the Condition B standard.

In addition, a more detailed piece of work was undertaken to address key estate issues already known, relating to Harewood Surgery and Brentwood Lodge in Leyburn.

Overall Condition

The NHS standard for acceptable buildings is “Condition B” or better. (Condition A, which is “as new”). The estate across HRW CCG overall is in a fair condition for the age of the buildings in situ however some are challenged in terms of fitness for purpose which is shown in the table below:

Facets	Condition A (%)	Condition B (%)	Condition B/C or below (%)	Other (%)
	Low Risk	Medium Risk	High Risk	
Physical Condition	0%	4%	96%	0%
Functional Stability	8%	58%	21%	12%
Health and Safety Compliance	0%	4%	96%	0%

Many aspects of the physical condition and health and safety compliance identified in the table above can be addressed through routine maintenance or operational management.

Functional stability, 58% Condition B and 21% at B/C or below, is more challenging due to the age and design of many buildings. They are at a higher risk as they would not necessarily be suitable to accommodate significant changes in service delivery outlined in the advanced primary care model.

Utilisation/Occupancy
The response from the GP questionnaire element of the 6 facet survey reported that 83% of GP premises are fully occupied and 17% stating they were over occupied. It is important to note that whilst the rooms have been identified by the practice as allocated to functions it is not possible to judge utilisation from this data. Further work would be required using sensors/counters to determining actual activity within rooms.

3.4 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.

4. The future of local primary care services

4.1 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 –

- British Medical Association (2015): *Responsive, safe and sustainable – Towards a new future for general practice*
- *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 –

- 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 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.

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[5] BMA, p17; HEE, p16
[6] BMA, p17; HEE, p25
[7] BMA, p9; HEE, p16
[8] BMA, p19; HEE, p36; NAPC, p2; KF, p30
[9] BMA, p21; HEE p26

4.2 Hambleton, Richmondshire and Whitby Perspective

Primary Care continues to evolve at pace and 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 Hambleton, Richmondshire and Whitby.

The opportunities and possible responses in relation to practice size, inter-practice collaboration and integrated care will necessarily be different in our local area which is heavily rural, as described above. 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.

5. Development Plan to address these challenges and implement the Five Year Forward View

The first section of this strategy clearly establishes an overwhelming case for change and a range of the drivers - local, STP and national. This section of the document starts to set out the local development plan to respond to start to transform the services across the CCG area.

5.1 A federated approach: the Benefits of Scale and Collaboration between Practices

The CCG will continue to 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. In addition, this approach may enable primary care to start to provide a range of services, such as more specialist treatment currently only available through outpatient services or those requiring significant expertise where only small numbers of patients may be seen, e.g. aspects of diabetes care or complex wound care.

At the same time, the CCG recognises that working at scale will not be viable for all our practices, especially those in the more rural parts of the area 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 Heartbeat Alliance or otherwise; collaboration could occur at both area-wide and locality 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 localities are 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. To facilitate this the CCG is actively commissioning a number of schemes and services which encourage practice co-operation. These include our model of extended access and our nursing workforce project (both described in more detail below). The CCG will also need to consider as part of this strategy how it works with Heartbeat Alliance and local practices to fundamentally review current provision of primary care and explore collaboration at a scale that goes far beyond individual schemes and projects. This approach will need to drive a much greater level of inter-practice dialogue and enable practices to work more effectively together to design, plan and execute projects with sufficient scope and potential impact to achieve meaningful, lasting transformation of local service provision.

Ultimately, the CCG is looking to develop the concept of the Multi Community Specialty Provider (MCP) model. The precise organisational and contractual structure has not yet been determined, but the intended outcome is to deliver a greater range of services in a primary care setting that require effective multi-disciplinary working. MCPs will be about whole system provision of care. In order to start to establish the principle of the approach, the priorities of the initial delivery plan are based on developing comprehensive care pathways and service models to delivered improved outcomes for frailty, diabetes and extended access. These models and pathways will be underpinned by appropriate commissioning arrangements, for example alliance contracts and outcome-based contracts, ultimately leading to the establishment of an MCP organisation. This provide a model which can deliver the greater range and volume of out-of-hospital services which is a core ambition of both CCG and STP plans.

To facilitate the model of an MCP, as part of the CCG's 5YFV development plan, consideration will be given to resourcing projects and preparatory work that will enable providers to collaborate, initially as partners and then potentially under one organisational roof. This potentially could include supporting joint posts or facilitating joint governance arrangements.

5.2 Integrated care

The development of federated approaches to care and the creation of an MCP will be underpinned by effective systems of integrated working. Our Fit 4 the Future programme aims to develop integrated care by 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".

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 primary care strategy. 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 Hambleton, Richmondshire and Whitby is likely to be based on a locality or cluster arrangement, built around local communities and multi-disciplinary teams' One of early objectives will be for the CCG and partners to work together to establish

the composition of these arrangements and how these might fit with the over-arching development of an MCP(s) for locality areas.

There are various organisational models described in current literature and the Vanguard process which will provide valuable examples of how the integration of primary and community services is being taken forward in different areas. 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 Hambleton, Richmondshire and Whitby:

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.

The development of these integrated approaches will principally be taken forward as part of our approach to developing an integrated community system, underpinned by a new frailty model and pathway.

5.3 Services close to home

The CCG already commissions a wide range of GP out-of-hospital services, for example minor injuries, amber drugs, PSA monitoring, ring pessary, anticoagulation and complex wound care. These are undertaken through a standard NHS constitution and are commissioned on the basis that all practices will provide all services. The current budget is c. £1 million.

The CCG would look to continue to commission more of such services as part of a systematic transition of work away from acute care to a primary care setting. This is closer to home for patients, which reduces travelling, which is particularly important in a rural area.

Also, as part of developing the concept of the MCP and facilitating primary care to work at scale, consideration will also be given to re-evaluating the provision of enhanced / out of hospital services such as these. The CCG and partners, including Heartbeat Alliance, can look at how these services could be offered either across a larger geography, or at across practice clusters. As the challenges facing General

Practice, particularly workforce issues, become greater, it may be possible that services could be provided through a hub and spoke model that could still provide care closer to home, but also be sustainable in the long term and be run more efficiently. This recognises the complex nature of these services and the expertise that may increasingly be required as more services are commissioned in primary care.

5.4 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. Addressing the recruitment and retention challenges in primary care and in particular, General Practice, requires ambitious initiatives, for example: introducing blended roles, new models for integrated care that require staff to acquire new skills, work in multiple settings and work in new ways.

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 our 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.

HRW CCG is a deeply rural area, which can make recruitment more difficult to achieve. The CCG recognises that recruiting and retaining staff is of critical importance. To do this, we need to maximise the quality of life and job satisfaction for our local staff and promote and celebrate the successes of local services, for example the fact that our GP practices enjoy the highest patient satisfaction in the country, in order to help attract more staff and clinicians to our area.

Working with Heartbeat Alliance and local practices, the CCG has already had considerable success in developing new clinical workforce models.

- In 2015, the CCG established a 2 year nursing workforce development project, based on £3 per head funding provided by the CCG. This project was intended to develop the role of practice nurses in outreaching from the practice into patient's own homes, care homes and extra care housing. The approach was based on clusters of practices working together to reduce practice nurse isolation and promote with other community and social care services.
- Following the success of the Heartbeat Alliance established a 12 month project to continue the recruitment of clinical pharmacists to be part of individual practice primary care teams, where they are responsible for delivering key medicines management and practice objectives. This is equivalent to 8 WTE clinical pharmacists appointed to our primary care teams.

The next stage of the development of the local clinical workforce will include the following:

- Consolidating the development of practice nurses within the wider frailty integrated model of care
- Consolidating the development of clinical pharmacists within a primary care setting and making stronger links to community pharmacy
- Establishing the role of the physiotherapist in primary care through a review and potential re-commissioning of our local model of MSK service provision
- Working with mental health services to consider the opportunity to establish closer links to local IAPT services
- Establishing a wider skill-mix as part of the new model of extended access (see below)
- Working across the STP footprint and with local Education Providers to maximise participation in local educational schemes and placements, and hence maximise recruitment to our area

5.4 Extended Access

As a Prime Minister's Challenge Fund pilot, Heartbeat Alliance will be part of the first phase of the national roll-out of the revised extended access arrangements from November 2016. This means they will provide a minimum additional 30 minutes consultation capacity per 1000 population, rising to 45 minutes per 1000 population. For HRW this equates to a minimum of an additional 71 hours per week consultation capacity, rising to 106.5 hours per week. The CCG and NHS England are working in partnership to commission this service. This will initially be delivered through a five month contract held by NHS England to end March 2017, after which the CCG will need to take on commissioning responsibility for the ongoing extended access service from April 2017 onwards.

As part of '21st century primary care', a two-phase engagement campaign was undertaken by NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group (HRW CCG) in collaboration with Heartbeat Alliance (HBA) during the period February – July 2016. The 'Your Health' campaign engaged almost 80,000 stakeholders, service users, carers, providers and the general public in a discussion about the future shape of access to seven day GP services. Key messages include:

- The public agrees that expectations for GPs are too high, and that there is a need to respect the service and staff more. It was felt that there is too much pressure on GP practices surgeries and that patients should make use of other services and attempt more self-care.
- "I can get appointments that suit my needs, why do we need weekend care?" is a question raised particularly by elderly and retired people. Further discussion about issues for young families or those who work full time who struggle to get appointments suggests that they would use weekend care. Alternatively, longer weekday opening hours has been suggested as a possible solution.
- People believe that with multiple services in their area, seven day access already exists and is working to a suitable standard. (A&E is available at weekends, there is an out of hours service; 24/7 pharmacies).

- Most respondents want access to extended hours at a physical hub, local to them, where they can receive treatment from someone they know.
- 25% would prefer appointment times between 6pm and 8pm weekdays
- 67% of respondents want to access to routine GP, nurse, blood test and minor injuries treatments outside of current working hours, as the main priorities for services
- 76% of respondents prefer extended hours at their own practice or by telephone.
- 62% of respondents would prefer to access extended hours at a physical hub rather than virtually
- Only 3% of respondents prefer appointment times available on Sundays, Saturday afternoons and after 8pm weekdays.

The local model for extended access therefore needs to respond to the outcomes of this patient engagement in order to deliver care that corresponds to the patient needs identified and address the concerns about new service delivery models. Our locally defined outcomes for extended access are therefore as follows:

- Improve access with more pre-bookable appointments during the out-of-hours period to enable patients, particularly working age adults and those with young families, to more easily access routine appointments for primary care
- Alleviate pressure of workload on individual GP practices through offering a greater range of evening and weekend appointments, which improve overall patient flow and efficiency and help reduce avoidable demand across the local health system
- Provide continuity of care with patients' local GP practice so patients are confident to access extended access services and extended access services do not duplicate practice workload
- Improve confidence and utilisation of new delivery models, for example utilising the skills of physiotherapists, clinical pharmacists or mental health professionals, so patients become more comfortable accessing routine primary care delivered by other professionals
- Through successful delivery of extended access by practices working together and at-scale, laying the foundations for transforming the way in which other general practice and community services can be delivered collectively too, for example leading to the development of a Multi-Community Specialty Provider model.
- Promote more joined up services, for instance, effective working arrangements and possible co-location with out-of-hours hubs, establishing improved links to community nursing teams and other professionals, and providing greater access to diagnostic services.

The local plan for extended access also needs to be developed in conjunction with a range of other services.

Local GP practices – Effective engagement with practices to understand their patient demand and requirements from the local extended access model will be crucial to

the successful delivery of this service. Delivering improved evening and weekend access is not about every GP or every practice nurse having to work seven days a week. Nor does it mean that every practice needs to be open seven days a week. It is about groups of local practices and other providers collaborating to staff improved in and out of hours services.

Integrated urgent care provider / GP out-of-hours - Extended access should dovetail with CCG plans to develop integrated urgent care and GP out of hours services, being developed at the Friarage Hospital, Northallerton, and Whitby Hospital. There are opportunities to develop a mixed commissioning model, for example where the GP Federation supplies additional capacity on weekdays and Saturdays, with the integrated urgent care service providing pre-bookable GP appointments on a Sunday.

Community services – The provider also needs to establish closer partnerships with community service providers, particularly those providing chronic disease / long term condition (such as diabetes or COPD) and mental health services. These are services where new models of care where greater specialist expertise delivered in a primary or community care setting may be appropriate. Over time these partnerships need to be broadened to also include dental, optometry, community pharmacy.

Extended hours DES – There is an existing national DES and the majority of practices in the CCG already offer a level of extended access through this scheme. The additional extended access capacity commissioned through this service needs to be over and above capacity currently provided through the extended hours DES.

5.5 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 a Technology group which has strong 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 roll out
- Making best use of current systems to communicate with patients and professionals alike to offer a consistent service across the area
- 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

Locally the CCG working with Heartbeat Alliance has trialled a number of technological advances, including telehealth for care homes, developing a MIG, establishing WiFi within practices, and testing on-line consultations (the latter of which didn’t prove successful at this stage).

Technology is also a core ambition within the STP. The STP future state for technology is:

- By 2021 the Great North Care Record will make a lasting contribution to the health and well-being of our population through the sharing of information securely and effectively.
- The Great North Care Record will make information more widely available and accessible to support frontline care, individual self-management, planning and research.
- Through the use of TECS patients should feel more in control of their condition.
- Digitally enabled health and care system with a move from isolation to integration.

The CCG will continue to work with practices to ensure effective use of IT as an enabler in line with national policy and, following the publication in 2014 of *Personalised Health and Care 2020 – a Framework for Action,* the CCG, working with partners, will develop – by June 2016 – a 'local 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 a key opportunity to significantly advance our system-wide technological capabilities. 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".

In terms of specific plans:

- Through the Local Digital Roadmap we already linked to part of the STP footprint, i.e. South Tees CCG and Middlesbrough LA. Our plan for the coming years will be to establish greater links through the LDR to the STP and continue to pioneer new initiatives.
- At present, based on the pilot of 'e-consult' and 'AskMyGP', it would seem more appropriate to focus on alternative uses of technology, such as telemedicine, remote consultations and innovative applications of consumer hardware in the case of the wound-care project that has been included in the LDR.
- Practices were equipped with superfast broadband and WiFi under the GP Access Fund pilot and the focus should be on finding ways of using that capability to facilitate flexible, co-located delivery of integrated primary care. A flexible approach to accessing consultations with a GP will help to make primary care more accessible to those who would otherwise find it difficult to access a doctor within surgery hours.

5.6 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 staff.

The CCG has developed an embryonic Primary Care Estates Strategy. This includes a stock-take of current facilities and identification of potential areas for development. The strategy supports the development of a list of priority schemes for inclusion in the CCG's submission to the Estates and Technology Transformation Fund in June 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 South Tess Hospitals NHS Foundation Trust and North Yorkshire County Council regarding the potential to develop a more broadly-based health and care estates strategy during 2016.

Through the Estates and Technology Transformation Fund, the CCG and local practices have submitted a range of different premises and technology schemes. Currently the schemes listed in Appendix 2 are currently 'live' within the ETTF application process.

5.7 Supporting Transformational Change

Time to Care is a new national development programme for general practice. The flexible programme is designed to be primary care-led and to take place at a time and a pace that is convenient for local GP practices and their staff. The programme focuses on 10 High impact actions to release time for care:

- Active signposting
- New consultation types

- Reduce DNAs
- Develop the team
- Productive work flows
- Personal productivity
- Partnership working
- Social Prescribing
- Support self care
- Develop QI expertise

The CCG will work with Heartbeat Alliance and local practices to develop a clear plan for the delivery of a local Time for Care development programme, to implement member practices' choice of the 10 High Impact Actions.

This programme will be augmented by the development of an approach to care navigation / signposting / development of receptionists / creation of new roles. This will be supported by £12K non-recurrent funding.

Leadership for 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.

Market development - The CCG has a responsibility to develop local primary organisations so that they are able to both compete in and contribute to a market which starts to deliver services in a more integrated way. This is particularly important in developing potential MCP models.

'Chapter 3' events – Heartbeat Alliance currently runs hugely successful education and information events as a means for engagement with GPs, practice managers and nurses. The CCG would seek to continue to work with Heartbeat Alliance and practices to continue such work. The events have a vital role in generating ideas, informing practices of developments and stimulating proper debate.

5.8 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.[10]

In particular, as discussed above, a range of contracting models would need to be considered to effectively commission an MCP model.

6. Governance arrangements to support the strategy and development plan

Co-commissioning level 2 - The CCG is a co-commissioner at level 2 with NHS England. This responsibility is fulfilled with through a primary Care Co-commissioning Committee which is a public meeting. Contractual issues relating to General Practice performance and other aspects of core workload will be managed through this Committee. Minutes and papers of the meeting are published on the CCG web-site.

Primary and Community service development - The CCG is in the process of re-establishing its community system transformation board to be an integrated Primary and Community Transformation Board. This will provide a vehicle to develop integrated care and Multi Community Specialty provider models. The Board will also be supported by an appropriate range of project / task and finish groups, to take forward different aspects of the over-arching strategy, for example the frailty pathway and diabetes model of care.

Primary care engagement - In order to engage and represent the views of primary care effectively, the CCG needs to undertake a range of actions.

- The Primary and Community Transformation Board will be reconstituted to include a wider range of primary care representation, including Heartbeat Alliance.
- Progress with development and delivery of the strategy will need to be reported regularly at the bi-monthly CCG locality meetings with GPs and at the Council of Members
- The CCG already attends the Local Medical Committee (HRW) meetings.
- Meetings are already starting to be established with Community Pharmacy and Optometry representatives. These will need to be developed over time as the primary care strategy broadens in scope.

Patient engagement - The CCG has a successful programme of engagement through a Health Engagement Network, patient congresses, and regular programmes of consultation. HEN representation is already included on the Primary Care Co-commissioning Committee. Heartbeat Alliance and the CCG also undertook significant patient engagement as part of the delivery of 21st century primary care. As part of delivering this strategy, the CCG will need to consider with its primary care partners where further engagement needs to be strengthened.

STP - The governance arrangements for the STP are set out in Appendix 3.

[10] With thanks & reference to NHS Shropshire CCGs Primary Care Strategy

CCG Programme management approach - As part of the planning for 2017-19, specific projects to underpin delivery of this strategy and development will also need to be established. These will be tracked, reported and managed through the CCG's established project Management approach.

Risks and mitigation – There are number of key risks, including: capacity, complexity of provider landscape, new contracting models, availability of financial resources, primary care engagement. These risks will be managed through the governance arrangements outlined above.

7. Financial Plan

The CCG will need to develop a full investment plan for primary care as part of its Operational Plan.

At the moment, committed investment through the CCG already includes:

- GP out of hospital services (c. £ 1million)
- Primary Care Nursing Workforce project (£1.50 per head in 2017/18) [This will help deliver the CCG's requirement to provide £3 per head transformational support]
- Clinical pharmacist project £250K for 12 months from July 2016 to end June 2017

To deliver the strategy and the national GP5YFV requirements, the CCG will need to identify:

- A further £1.50 per head in either 2017/18 or 2018/19. (This may be fulfilled through a continuation of either or both of the nursing workforce or clinical pharmacist projects)
- £6 per head funding for extended access (which should be a recurrent addition to the CCG's budget in 2017/18)
- Funding delegated to the CCGs for local delivery of Online general practice consultation software systems and Training care navigators and medical assistants for all practices (TBC - £12K in 2016/17)

The remainder of primary care commissioning and investment would be for joint decisions with NHS England as co-commissioners with the CCG at level 2.

8. Conclusion

This documents sets out a comprehensive and forward-thinking strategy and development plan that delivers on national, STP and CCG-level objectives. Primary Care development is a fundamental issue underpinning the future success of the NHS in all respects. Delivery of this strategy will have a significant impact on improving services for patients and delivering cost and clinical efficiencies and improved outcomes for the NHS as a whole.

Document authors:
Lisa Pope - Deputy Chief Operating Officer
Sam Haward – Head of Strategy (Planned Care and Primary Care)
Shirley Moses - Service Improvement Manager – Planned Care, Primary Care and Technology

Appendix 1

HRW CCG practices

Practice Code	Practice Name	Dispensing Practice?	HRW Locality	Population
B82017	WHITBY GROUP PRACTICE	Y	Whitby	14,316
B82019	TOPCLIFFE SURGERY	Y	Hambleton	2,967
B82022	GREAT AYTON SURGERY	N	Hambleton	5,537
B82023	CATTERICK VILLAGE SURGERY	N	Richmondshire	6,595
B82029	ALDBROUGH ST JOHN SURGERY	Y	Richmondshire	3,178
B82034	QUAKER'S LANE SURGERY	Y	Richmondshire	6,300
B82035	SCORTON MEDICAL CENTRE	Y	Richmondshire	3,519
B82042	LAMBERT MEDICAL CENTRE	Y	Hambleton	8,262
B82044	STOKESLEY SURGERY	N	Hambleton	9,336
B82045	CENTRAL DALES PRACTICE	Y	Richmondshire	4,292
B82046	STAITHES SURGERY	Y	Whitby	2,778
B82049	THIRSK DOCTORS SURGERY	Y	Hambleton	7,097
B82050	MOWBRAY HOUSE SURGERY	Y	Hambleton	19,688
B82062	EGTON SURGERY	Y	Whitby	2,286
B82066	GLEBE HOUSE SURGERY	N	Hambleton	9,591
B82072	THE FRIARY SURGERY	Y	Richmondshire	5,796
B82075	MAYFORD HOUSE SURGERY	Y	Hambleton	9,870
B82078	LEYBURN MEDICAL PRACTICE	Y	Richmondshire	5,954
B82086	DANBY SURGERY	Y	Whitby	2,341
B82101	SLEIGHTS AND SANDSEND MEDICAL PRACTICE	Y	Whitby	5,168
B82104	HAREWOOD MEDICAL PRACTICE	N	Richmondshire	7,101
B82622	REETH MEDICAL CENTRE	Y	Richmondshire	1,566
	TOTALS		Hambleton	72,348
			Richmondshire	44,301
			Whitby	26,889
			HRW	**143,538**

Appendix 2

ETTF applications (currently live)

			NHSE agreed		Response received	66%/34%	CCG Ranking	Owner	Scheme £	**Funding Criteria**
12164-42408	Premises Extension/Improvement	Staithes Surgery Extension	Cohort 2	Staithes	Y	?	5	GP	100,000	**A**
12152-42412	Premises Extension/Improvement	GP led Health and Wellbeing Community Hub	Cohort 2	Sleights	Y	?	8	GP	373,920	**A**
12181-42413	Premises Extension/Improvement	The Future of Primary Care Access	Cohort 2	Whitby			8	GP	365,000	**A**
12110-42410	Premises Extension/Improvement	Egton Surgery Extension	Cohort 2	Egton			7	GP	600,000	**A**
11925-42405	Premises Extension/Improvement	Quakers Lane Surgery, Richmond	Cohort 2	Quakers	Y	Y	3	GP	517,500 20,000	**A**
11914-42409	Premises Extension/Improvement	Development of Glebe House Surgery (to support the Bedale locality)	Cohort 2	Glebe House	Y	Y	6	NHS PS GP	2,001,028 42,000	**B/C**
12173-42406	New building	Thirsk Integrated Hub Project	Cohort 2	Thirsk	Y	?	4	NHS PS GP	3,630,000 20,000	**B/C**
12130-42404	New building	Stokesley Integrated Primary Care Centre	Cohort 2	Stokesley	Y	?	2	NHS PS	3,360,000	**B/C**
12194-42403	New building	Catterick Integrated Care Centre	Cohort 2	Catterick	HRW to respond		1	NHS PS ASSURA	6,770,000 218,400	**B/C**
12103-42411	Digital & Technology	Medical devices and digital cameras to assist with remote healthcare monitoring	Cohort 2							**D**

Appendix 3

STP governance arrangements